HULL AND EAST YORKSHIRE HOSPITALS TRUST
TRUST BOARD

TUESDAY 7 MARCH 2017, THE BOARDROOM, HULL ROYAL INFIRMARY AT 2:00PM

AGENDA: PART 1 – MEETING TO BE HELD IN PUBLIC

OPENING MATTERS		
1. Apologies	verbal	Chair
2. Declaration of interests 2.1 Changes to Directors' interests since the last meeting 2.2 To consider any conflicts of interest arising from this agenda	verbal	Chair
3. Minutes of the Meeting of the 26 January 2017	attached	Chair
4. Action Tracker	attached	Director of Corporate Affairs
5. Matters Arising	verbal	Chair
6. Chair's Opening Remarks	verbal	Chair
7. Chief Executive's Briefing	attached	Chief Executive Officer
QUALITY		
8. Patient Story	verbal	Chief Nurse
9. Quality Report	attached	Chief Nurse
10. Nursing and Midwifery Staffing Report	attached	Chief Nurse
11. Care Quality Commission Report	attached	Chief Nurse
PERFORMANCE		
12. Performance Report	attached	Executive Team
13. Revenue Support Loan	attached	Chief Financial Officer
STRATEGY & DEVELOPMENT		
14. 2017-18 Contract	attached	Chief Financial Officer
ASSURANCE & GOVERNANCE		
15. Board Cycle of Business	attached	Director of Corporate Affairs
16. Unadopted Minutes from Board Standing Committees		Chair of Committee
16.1 – Performance & Finance 30.1.17, 27.02.17	attached	
16.2 – Charitable Funds 7.02.17	attached	
16.3 – Quality 27.02.17	attached	
16.4 – Audit 07.02.17	attached	

17. Any Other Business

18. Questions from members of the public

19. Date & Time of the next meeting:
Tuesday 4 April 2017, 2:00pm, The Boardroom, Hull Royal Infirmary

Attendance 2016/17

	28/4	26/5	28/7	29/9	27/10	24/11	22/12	26/1	Total
M Ramsden	✓	✓	✓	✓	✓	✓	✓	✓	8/8
C Long	x	✓	✓	✓	✓	✓	✓	✓	7/8
L Bond	✓	✓	✓	✓	✓	✓	✓	✓	8/8
A Snowden	✓	✓	✓	✓	✓	✓	✓	✓	8/8
M Gore	✓	✓	✓	✓	✓	✓	✓	x	7/8
S Hall	✓	✓	✓	✓	✓	✓	✓	✓	8/8
M Wright	✓	✓	✓	✓	✓	✓	✓	✓	8/8
K Phillips	✓	✓	✓	✓	✓	✓	✓	✓	8/8
T Sheldon	✓	✓	✓	x	✓	✓	✓	x	6/8
V Walker	x	✓	✓	✓	✓	✓	x	✓	6/8
T Christmas	✓	✓	✓	✓	✓	✓	✓	x	7/8
E Ryabov	✓	✓	✓	✓	✓	✓	✓	✓	8/8
In Attendance									
J Myers	✓	✓	✓	✓	x	✓	✓	✓	7/8
L Thomas	✓	✓	✓	✓	✓	✓	-	-	6/6
S Nearney	✓	✓	x	✓	✓	✓	✓	✓	7/8
C Ramsay	-	-	-	-	-	✓	✓	x	2/3

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
TRUST BOARD
HELD ON 26 JANUARY 2017
THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT	Mr M Ramsden	Chairman
	Mr C Long	Chief Executive Officer
	Mr M Wright	Chief Nurse
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mr A Snowden	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mr K Phillips	Chief Medical Officer
	Mrs V Walker	Non-Executive Director
IN ATTENDANCE	Mr S Nearney	Director of Workforce & OD
	Ms J Myers	Director of Strategy & Planning
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES

Apologies were received from Prof T Sheldon, Non-Executive Director, Mr M Gore, Non Executive Director, Mrs T Christmas, Non Executive Director and Ms C Ramsay, Director of Corporate Affairs.

2. DECLARATION OF INTERESTS

2.1 – Changes to directors' interests since the last meeting

There were no declarations made.

2.2 – To consider any conflicts of interest arising from this agenda

There were no declarations made.

3. MINUTES OF THE MEETING OF THE MEETING 22 DECEMBER 2016

There was a typo in item 11 of the minutes which was corrected. Mrs Coggin should have read Mrs Coggan.

Following this change the minutes were approved as an accurate record of the meeting.

4. ACTION TRACKER

The action tracker was reviewed by the Board. The item relating to the Workforce Race and Equality Standard was a yearly report and was not yet due. This would be added back onto the tracker. Mrs Walker had specific questions relating to this item and Mr Nearney agreed to meet with her outside of the meeting. **SN**

5. MATTERS ARISING

There were no matters arising from the minutes.

6. CHAIR OPENING REMARKS

Mr Ramsden welcomed the Organ Donation team, Mr Corral (Chief Pharmacist) and Miss Cattermole (Guardian of Safe Working Hours) to the meeting.

Mr Ramsden advised that the Trust was still waiting for the Care Quality Commission report following the inspection in June 2016.

Mr Ramsden paid tribute to the work that Mrs Coggan and the Hull Daily Mail had done whilst visiting the Emergency Department in December 2016, supporting the hospital

and educating members of the public regarding other methods of receiving care. He thanked the Hull Daily Mail on behalf of the Board.

He spoke about the new offices at Castle Hill Hospital and the relocation of staff to enable the capital demolition programme to commence. He thanked staff for their hard work and flexibility regarding these changes.

7. CHIEF EXECUTIVE BRIEFING

Mr Long advised that the Trust has not received its Care Quality Commission report yet, but a quality summit has prospectively been arranged for 17th March 2017. He advised that the report would be received and actions would be in place by the end of March 2017.

Mr Long spoke about the internal changes that had been implemented in the Emergency Department, which have meant that performance has been in line with the national average or in some months above it. He thanked all staff for their efforts and stated that there had been positive moves forward with the Trust's partners with an improved system-wide approach.

Mr Snowden praised the new Trust branding 'Remarkable People' and asked if this was helping to recruit new medical staff. Mr Wright advised that 82 nurses had been secured for interviews following an event at the University and praised Trust staff for their professionalism at the event.

8. PATIENT STORY

Mr Phillips presented two contrasting stories. He reported that a patient had been trying to contact the eye injection clinic to make an appointment and rang several times without getting through. Issues regarding appointment times had also been raised as the patient lived out of town and early morning appointments were proving difficult to attend. Mr Phillips advised that two dedicated staff had now been appointed to answer appointment calls.

Mr Phillips also presented a positive story about an elderly patient that had received excellent care following a clot on their lung. The patient praised staff highly for their compassionate care and professionalism.

9. QUALITY REPORT

Mr Wright presented the report and highlighted findings from the recent serious incident investigation into the misplaced nasogastric tube Never Event, which occurred last year. He advised that the patient had recovered from the incident itself but remained very ill due to his originating condition. The patient had died subsequently but this was not thought to be linked to the Never Event. Improved processes were being put in place to try and avoid a recurrence, which included the use of qualified Radiologists to report on check chest x-rays for the purpose of checking the siting of nasogastric feeding tubes.

Mr Wright also included the Trust's response to a National Patient Safety Alert on this issue, which was attached as appendix one to the quality report. The Trust Board was requested to receive and approve the Trust's response. This was approved by the Trust Board.

Mr Wright presented the most recent Safety Thermometer (ST) performance and set this in the context of the benchmarking reports that were used and that these should be used as guidance rather than being fully accurate comparisons. Mr Wright assured the Board that the audits carried out at HEY were robust and considered all patients in a hospital bed on census day. Overall performance against the ST indicators was very

positive, particularly in relation to falls with harm and pressure ulcers. Catheter associated urinary tract infections had spiked in recent months but were relatively low in numbers. However, Mr Wright advised that this was due to infections being attributed to the Trust if diagnosed, even though the infection could have been in place before the patient's admission into the hospital. Nonetheless, Mr Wright advised that focused work was taking place in this area. Venous thromboembolism episodes (VTE) were being reviewed by the Thrombosis Committee. With regard to Healthcare Associated Infections, the Trust had seen good performance regarding *clostridium difficile* infections for the year. The Trust had reported 2 cases of MRSA bacteraemia year-to-date; one in the Neonatal Intensive Care Unit and the second in Critical Care/Cardiology at CHH. Both patients had recovered well. The Trust had accepted the lessons that needed to be learned from the NICU case, however, the second case had been sent to Public Health England for third party attribution. The outcome of this will be reported to the Trust Board in due course.

75% of staff had received the flu vaccination which had secured the CQUIN payment from the Clinical Commissioning Groups. The Trust had seen a reduction in complaints and the national impatient survey results had been received but were currently embargoed. Mr Wright agreed to share them with the Board when they were available. Mr Wright reported that the Trust had achieved its training compliance for Level 3 Safeguarding.

Mrs Walker stated that it would be useful to follow a patient journey and it was agreed that the Quality Committee should review this at a future meeting. Mr Snowden praised the introduction of the new e-patient leaflets. Mr Snowden also asked how well tested the roll out of clinical governance alerts is and whether new staff would be aware of historical incidents. Mr Wright advised that there were numerous mechanisms for disseminating learning including via the monthly team brief and health group governance arrangements. However, he agreed that this was an area that should be looked into and tested more closely in the future and would discuss it with the governance team. **MW**

Resolved:
The Board received the report and requested further scrutiny of patient experience journeys through the Quality Committee. The Trust's response to the National Patient Safety Alert NHS/PSA/RE/2016/006 – Nasogastric Tube misplacement: continuing risk of death and severe harm (issued on 22 July 2016; response due by 21st April 2017) was approved.

10. NURSING AND MIDWIFERY STAFFING REPORT

Mr Wright presented the report and advised that staff fill rates had been sustained even with the winter ward still in place. There would be another 154 new nurses coming to the Trust for interviews from the University of Hull that are due to qualify in autumn 2017. This was a really positive development The programme of international recruitment of nurses from the Philippines had commenced, with the first intake of 20 nurses expected in the early summer. The Trust had become a 'fast follower' site for the trainee nurse associate roles and these would be NMC regulated roles, once qualified at the end of the two year programme. Mr Wright also reported that nursing and midwifery revalidation was going well, with only a few registered nurses and midwives choosing not to revalidate but for justifiable reasons. The Trust's revalidation attrition rate was only half of the national average, which was positive news. Mr Bond praised the progress shown in the report and stated that a similar report should be presented for the medical staff as well.

KP

Resolved:
The Board received the report and noted the positive progress made.

11. NURSING AND MIDWIFERY FUNDAMENTAL STANDARDS REPORT

Mr Wright presented the report which gave an update on the latest nursing and midwifery fundamental standards results for the Trust's wards. Mr Wright advised that a lot of progress was being made and that the process had also proved helpful in highlighting some challenges and issues on ward H70. This had enabled timely action to be taken on this ward. He also advised that Mrs Ledger, Deputy Chief Nurse meets with all ward sisters to discuss performance and record keeping. Mr Wright encouraged the Board to ask questions of staff on the wards about these audit results when on their ward visits.

Mr Snowden asked about the nutrition issues and Mr Wright assured him that this was primarily a record keeping matter. Mr Wright provided assurance that this was not due to patients not being given appropriate nutrition and hydration. Mr Hall asked what was being done about the overdue reviews and Mr Wright reported that he had mandated that all overdue reviews would be completed by the end of March 2017.

Resolved:
The Board received the report positively and noted that the overdue reviews would all be completed by the end of March 2017.

12. PERFORMANCE REPORT

Mrs Ryabov updated the Board and advised that the Emergency Department had seen an improvement in performance in December of 6.6%. Attendances had reduced slightly and the media coverage from the Hull Daily Mail had helped with patient numbers, but since Boxing Day the Trust had seen major increases. Mrs Ryabov reported that there was massive effort in the department to ensure performance was maintained.

She advised that there was huge pressure on diagnostics resulting in a number of breaches in December 2016. In January 2017 there would be less MRI/CT van capacity which would impact on referral to treatment times. The ISTC had been supporting the Trust for almost a year and were now preparing their final report.

There had been 5 x 52 week breaches due to incorrect pathway pauses. All 5 patients had now been treated.

Resolved:
The Board received the performance update.

FINANCE REPORT

Mr Bond presented the finance headlines and reported that the Trust had a £1.6m deficit at month 9 which was £1m above plan.

The Health Groups were overspent at month 9 and Mr Bond was concerned that if this carried on at the same level the end of year position would worsen. Mr Bond had met with all the Health Groups and asked them to review all unplanned expenditure.

Agency spend was being reviewed and extra management support was being given to the Surgery and Medicine Health Groups to ensure all capacity, productivity and financial issues were addressed.

Mr Bond added that unidentified actions totalling £2.4m were required over the final

quarter in order for the Trust to meet its year end control total. He added that this presented a significant risk to the Trust and that every effort was required, particularly from the Health Groups to limit expenditure in the period.

Resolved:
The Board received the update and delegated further scrutiny of the Health Group financial positions to the Performance & Finance Committee.

13. HOSPITAL PHARMACY TRANSFORMATION PLAN – LORD CARTER

Mr Bond presented the report which highlighted 7 recommendations following the Lord Carter review published in 2016. He reported that the Lord Carter initiatives were not just about saving money but improving clinical quality and becoming more efficient. Mr Corral added that the actions the Pharmacy Team had put into place were realistic and deliverable.

There was a discussion around stockholding and rationalisation of stocks and Mr Corral advised that the Trust had reduced its stockholding days from 21 to 18. He advised that there were further savings to be made with direct ward deliveries and the proposed development of a regional store.

Mrs Walker asked if patients could be sent home with prescriptions to collect at their local chemist and Mr Corral advised that this was being reviewed alongside community pharmacy and e-prescribing.

Resolved:
The Board received the report and delegated further scrutiny to the Quality Committee.

14. PROCUREMENT PLAN – LORD CARTER

Mr Bond presented the report, which set out the procurement plan for the Trust. Mr Bond advised that he had attached a draft procurement strategy at Appendix 1 and asked the Board to approve the overall direction of the plan.

He spoke about inventory control, price and cost reductions, e-Invoicing and the GS1 system (bar codes). The roll out of the GS1 system would enable transparent identification of clinical practice and give benchmarking information relating to costs to assist medical staff when purchasing equipment and goods.

Resolved:
The Board received the report and approved the overall direction of the plan. The Board delegated further review of the plan to the Performance & Finance Committee.

15. ORGAN DONATION REPORT

Mr Phillips presented the report to the Board and paid tribute to the team who continued to work hard in this important and sensitive area. The Trust had seen 17 donors which compared favourably with the rest of England. There was further work to be done regarding consent and referrals.

Mr Snowden asked what publicity campaigns had been carried out and the team advised that there was an Organ Donation week in September, they were involved in the City of Culture programme, information packs had been given to GP s and work carried out in schools and colleges. There was also work ongoing with the local fire service and the medical school.

Resolved:
The Board thanked the Organ Donation team for their report and agreed to delegate the

discussion regarding a memorial to the Charitable Funds Committee.

16. BOARD AND ASSURANCE FRAMEWORK

Mr Ramsden presented that report and highlighted potential risk rating changes to risks F1 and F3.

The Board were also asked to approve the process to strengthen the 'Ward to Board' escalation of corporate risks linked to the Board Assurance Framework.

Resolved:

The Board approved the changes to risk ratings F1 and F3 and the process highlighted in Appendix 4 relating to 'Ward to Board' escalation.

17. STANDING ORDERS

The report highlighted the proposed changes to the Standing Financial Instructions (SFIs) which had been reviewed at the Audit Committee in December 2016 with a recommendation to the Board. The table being added into the SFIs clarified the 6 Official Journal of the European Union thresholds.

Resolved:

The Board received the report and approved the changes to the Standing Financial Instructions.

18. GUARDIAN OF SAFE WORKING – QUARTERLY UPDATE

Mr Phillips presented the report, which highlighted that the Trust had 600 junior doctors in training and that the new national junior doctor contract was being implemented. Rotas were being reviewed and rota gaps addressed. The report presented the Trust's compliance against the Guardian of Safe Working standards and the areas that will be routinely reported to the Trust Board.

Mr Hall asked when all junior doctors would be on the rotas and Mr Phillips assured the Board that all new junior doctors on the new contract would have rotas in place. Miss Cattermole added that the new system was more user-friendly and flexible.

Mr Ramsden asked what the mood of the junior doctors was following the new contract implementation and Miss Cattermole reported that in practice it was not much different and there was good engagement with HR and herself as guardian. She reported that there could be more challenge at registrar level and was attending national meetings to gain information and support from other Trusts.

Resolved:

The Board received the report and thanked Miss Cattermole for her efforts and support to the junior doctors.

19. UNADOPTED MINUTES FROM BOARD STANDING COMMITTEES

The Board received draft minutes from the Performance & Finance (19.12.16), Charitable Funds (17.11.16), Quality (15.12.16) and Audit (15.12.16) Committees.

20. ANY OTHER BUSINESS

There was no other business discussed.

21. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the members of the public.

22. DATE AND TIME OF THE NEXT MEETING:

Tuesday 7 March 2017, 2pm, The Boardroom, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

TRUST BOARD ACTION TRACKING LIST (March 2017)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
January 2017						
01.01	Fundamental Standards	Quarterly Fundamental Standards report to be received at the Board	MW	Apr 2017		Not yet due
01.02	Workforce race equality standard 2016 return	Annual progress report to be received	SN	Jun 2017		Not yet due
01.03	Action Tracker	Guardian for Safe Working report to be presented	HC	May2017		Not yet due
01.04	Staff survey	Staff survey to be carried out following the relocation to CHH (HR Staff)	SN	TBC		

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHIEF EXECUTIVE BRIEFING

MARCH 2017

National context

NHS Improvement published its Quarter 3 2016-17 performance figures for the NHS provider sector this week. The key headlines are that:

- 5.34 million patients attended providers' A&E units between October and December 2016, which is 200,000 more than at the same period last year
- Providers saw a 3.5% increase in the number of patients requiring major further in-hospital treatment
- The intense demand for emergency treatment coupled with a significant reduction in bed availability has led to providers collectively underperforming against several key national healthcare standards, and having to postpone some planned care
- These pressures have been exasperated further by the loss of 390,392 'bed days' between October and December 2016 nationally - a 28% increase on the same period last year - because of issues with discharging medically fit patients due to constraints on community or social care
- The sector's financial position is £1.3 billion better than at the same point last year; as it ended the quarter £886 million in deficit. In addition, 135 providers ended the quarter in deficit which is 44 fewer compared to the same period last year.

However, as noted in the national media, the national NHS financial position has been eased by a number of one-off transactions that will not be repeatable – the underlying financial position in the NHS therefore remains under close scrutiny as we near the end of the financial year. In addition, there has been significant media coverage on the impact of cuts to social care funding on the NHS, particularly over this winter, and continued calls from across the country for additional funding to health as well as to social care.

The Trust Board received the headlines our organisation's winter performance at its last Board meeting, with further detail included in this meeting's reports.

Trust Board Development

The Trust Board welcomed Roy Lilley, NHS commentator and blogger, to the Trust Board Development day on 8 February 2017. He facilitated two thought-provoking discussions sessions with the Trust Board, focussed on national policy and a strategic overview of quality of care in the NHS. Mr Lilley also walked around the Emergency Department, Frail Elderly Unit and Wards 8 and 80 to see the quality of care for our elderly patients, the feedback on which was extremely positive. We thank Roy for his time and for sharing some of his knowledge and experience.

Trust welcomes NHS England Executive

The Trust was pleased to host the NHS England Executive team for their regular Executive Group meeting on 16 February 2017, wherein the NHS England team visit a different NHS trust for each meeting. Simon Stevens, Chief Executive, Professor Sir Bruce Keogh, National Medical Director and Professor Jane Cummings, Chief Nursing Officer met with Strategic Transformation Plan leaders from Yorkshire prior to their Executive meeting. Following their formal meetings, the NHS England team held a Question and Answer session with Trust staff, which was very well attended by colleagues, with questions ranging from the anticipated impact of Brexit on the NHS to new clinical roles in the NHS.

CQC Media Coverage
Coverage of our latest CQC report was balanced and accurately reflected where we are as an organisation. The Trust rated itself as Requires Improvement and nothing in the report was a surprise to us. Along with the CQC and our commissioners we were keen to send out a message that we accept where we need to improve but which also highlighted areas where significant improvements have already been made. The reporting of this, particularly in the Hull Daily Mail, was gratefully acknowledged as being fair and accurate.

Allison Coggan
The Trust Board would like to note that Allison will be moving on from her role as Health Reporter at the Hull Daily Mail, having accepted a job with the Health Service Journal. It is the job of the local media to scrutinise us as a publicly funded organisation. During her time as Health Reporter we have experienced some significant challenges but even when coverage has been a difficult read for us she has always shown an excellent understanding of health issues and coverage has been proportional. We wish Allison every success in her new role.

Dignity Day
To tie in with national Dignity Action Day, staff celebrated with their own special Dignity Day event at the Queen's Centre for Oncology and Haematology in Cottingham.

Running from 9am to 4pm on Wednesday 1st February, the event brought together examples of how staff have been working to ensure patients are treated with both dignity and respect.

This was the seventh consecutive year in which we've marked Dignity Action Day with an event of our own, showcasing the lengths which staff are going to in order to provide care and develop services which are suitably respectful and considerate of patients' needs and feelings.

Nurse Recruitment
Over 150 student nurses are set to be interviewed over the next few weeks in a bid to increase nurse recruitment.

The Remarkable People, Extraordinary Place campaign has helped to secure interviews with 154 final year nursing students out of a total cohort of 183. The students are set to qualify in September, but will be interviewed for permanent roles at the Trust, subject to successful completion of their studies.

Furthermore the Trust has announced that 19 Nurse Associates will start work in April 2017.

Nationally, over 2,000 Nursing Associates will begin training in 2017 in a new role that will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. Associates will be expected to work alongside care assistants and registered nurses, focusing on ensuring patients continue to get the compassionate care they deserve.

Better Access to Patient Information
Patients can get condition-specific information at the touch of a button, following the introduction of QR codes to all patient leaflets.

This means that, simply by scanning a leaflet's code with a QR reader installed on a mobile phone or tablet, a person can download a copy of the information straight to their device whilst they are still in the clinic.

We have previously relied on giving out paper leaflets; now electronic information can be accessed immediately on mobile phones.

Big Name Revealed for Song for Hull
Children across Hull will perform alongside Jonathan Ansell (G4) live on the City Hall stage in celebration of Hull 2017 UK City of Culture.

'A Song for Hull' is a joint project between Hull Children's University, HPSS, and the Hey! Let's Sing Hull and East Yorkshire Hospitals NHS Trust staff choir. In September last year, it was announced that the group's bid to stage the performance had been successful, and that the team would receive a grant from Hull 2017's Creative Communities Programme, which is being delivered in partnership with the Big Lottery Fund, to help get it off the ground.

Talent for Care Awards 2017
For the third year running, the Trust will be well represented at the forthcoming Yorkshire and Humber NHS Talent for Care Awards. Organised by Health Education England, the event is designed to promote support staff learning opportunities and highlight the many benefits that investment in training and development of this staff group makes to organisations and communities. Seven members of HEYHT staff have been shortlisted in six award categories, including Apprentice of the Year, the Support Staff Learner Award and Rising Star. The Trust is also one of three organisations vying for the title of 'Employer of the Year'. Having been shortlisted, Laura Marks, Samantha Hewitt, Charlotte Robinson, Samantha Tranmer, Christine Charlton, Michael Duke and Beth Walker will attend the awards ceremony being held in Hull on 10th March to coincide with the 2017 City of Culture celebrations.

Chris Long
Chief Executive

March 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

Trust Board date	7 March 2017	**Reference Number**	2017 – 3 - 9
Director	Mike Wright, Executive Chief Nurse	**Author**	Mike Wright, Executive Chief Nurse Kevin Phillips, Executive Chief Medical Officer Sarah Bates, Deputy Director of Governance and Assurance
Reason for the report	To provide information and assurance relating to the quality of patient care being delivered in the Trust.		

Type of report	Concept paper		Strategic options		Business case	
	Performance	**Y**	Information	**Y**	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to receive this report and: • Decide if this report provides sufficient information and assurance • Decide if any further information and/or actions are required.

2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information	**Y**	Assurance	**Y**	Delegation	

3	**STRATEGIC GOALS:**	
	Honest, caring and accountable culture	**Y**
	Valued, skilled and sufficient staff	**Y**
	High quality care	**Y**
	Great local services	**Y**
	Great specialist services	
	Partnership and integrated services	
	Financial sustainability	

4	**LINKED TO:**			
	CQC Regulation(s): All			
	Assurance Framework Ref: Q1, Q2, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N

5	**BOARD/BOARD COMMITTEE REVIEW** The Trust Board receives this report monthly on the quality aspects of its services (Patient safety, service effectiveness and patient experience).

QUALITY REPORT
MARCH 2017

EXECUTIVE SUMMARY

The purpose of this report is to inform the Trust Board of the current position in relation to:

- Patient Safety Matters
- CQC
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required.

TRUST BOARD QUALITY REPORT
MARCH 2017

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the current position in relation to:

- Patient Safety Matters
- CQC
- Safety Thermometer
- Healthcare Associated Infections (HCAI)
- Patient Experience Matters
- Other Quality Updates

The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required.

2. PATIENT SAFETY

2.1 Never Events

There have been no Never Events reported since September 2016.

There are no current ongoing investigations into Never Events.

The actions from the last completed Never Event investigation (misplaced naso-gastric tube) are progressing as planned.

To complete this investigation, the Chief Nurse and other staff met with the family of the patient on 14 February 2017 to share the findings of the report.

2.2 Serious Incidents

The rate of reporting of Serious Incidents in 2016/17 continues to be below the level reported in the same period last year. 58 Serious Incidents have been declared since the start of this financial year compared with 120 for the whole of 2015/16 year.

There were two serious incidents declared in January 2017, which are summarised in the following table:

2.2.1 Serious Incidents declared in January 2017

Ref. Number	Brief Description of SI	Health Group
35	Treatment Delay relating to a patient admitted to the Winter Ward	Surgery
1060	Patient Fall within the ED department	Medicine

Each of these serious incidents is under investigation currently.

2.3 Serious Incident actions

At each month end, serious incident investigations are summarised and sent to all Health Groups along with all the full reports for their dissemination. The summary includes the actions to be taken, by whom and when.

The Trust completed nine investigations into Serious Incidents in January 2017. These related to:

- an absconded paediatric patient

- a hospital acquired pressure ulcer
- two treatment delays; one relating to a patient not receiving a follow up x-ray after discharge from hospital and one relating to failure to follow up a biopsy result
- an inappropriate surgery to a patient's gallbladder
- two unexpected deaths; one relating to a gastrointestinal bleed and one due to a deteriorating patient not receiving a timely senior medical review
- a treatment delay due to a patient not being accepted via air ambulance

The majority of actions resulting from these investigations are being addressed by the respective clinical teams/area and the evidence of delivery of these is monitored by the central governance team. In summary, these include training for staff, reminding staff of the correct processes and procedures to be followed and some changes to Trust Policies. Further information regarding these incidents is available to Trust Board members on request.

2.4 Additional updates on the Serious Incident Process

As part of its contract with commissioners, the Trust meets monthly with them to review its quality performance. At the February 2017 Quality Review Group meeting, the Trust was informed that commissioners have revised the Trust's ratings for its serious incident processes from 'limited assurance' to 'significant assurance'. This is a positive step forward for the organisation and reflects on the progress made to improve the Trust's serious incident processes.

On 15 February 2017, commissioners undertook a quality review visit to Maternity and Neonatal Intensive Care Services. The full day review arose as a result of some recent serious incidents that have been declared in these areas. This was a supportive review to help commissioners understand the services and see at first hand the level and quality of care being provided. The initial feedback from the review was highly positive. A formal written response will follow in due course.

On 16 February 2017, the Deputy Director of Quality Governance and Assurance and the Trust's Risk Manager presented on the Trust's Serious Incident and Never Event learning journey at an NHS England hosted 'Never Event and System-wide Learning' event in Durham. The event focused on how Trusts can improve their processes, investigations and learning from these adverse events. The presentation from Hull and East Yorkshire Hospitals NHS Trust was to share, with openness and candour, how the organisation has come a long way from having more of a closed, under-reporting culture to the current situation of improved reporting, escalation and declaration, improved quality of investigations and standards of report writing, and increasing awareness and evidence of lessons learned. The presentation also touched on how this has helped to improve relationships with commissioners. The presentation received very positive feedback from both NHS England and NHS Improvement, in terms of the improvements made.

3. CARE QUALITY COMMISSION (CQC) – COMPREHENSIVE INSPECTION – JUNE 2016

On 14th February 2017, the Trust received the final reports from the comprehensive inspection undertaken by the CQC in June 2016. The Trust has maintained an overall rating of 'Requires Improvement' and has improved from an 'Inadequate' to a 'Requires Improvement' in the responsive domain from the May 2015 re-inspection. These findings are in line with the self-assessment that the Trust undertook and submitted to CQC prior to the commencement of the inspection last June. The full inspection reports were published on the CQC's website on 15 February 2017.

The following tables provide an overview of the overall Trust ratings for its last two large inspections alongside those of Hull Royal Infirmary and Castle Hill Hospital.

Overall – Trust

Domain	Revised Rating 2016	2015 Rating
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Requires Improvement
Caring	Good	Good
Responsive	Requires Improvement	Inadequate
Well-led	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement

Hull Royal Infirmary

Domain	Revised Rating 2016	2015 Rating
Safe	Requires Improvement	Requires Improvement
Effective	Good	Requires Improvement
Caring	Good	Good
Responsive	Requires Improvement	Inadequate
Well-led	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement

Castle Hill Hospital

Domain	Revised Rating 2016	2015 Rating
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Not rated
Caring	Good	Good
Responsive	Requires Improvement	Requires Improvement
Well-led	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement

The following tables show the ratings of the individual services and by site.

Overview of ratings

Our ratings for Hull Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

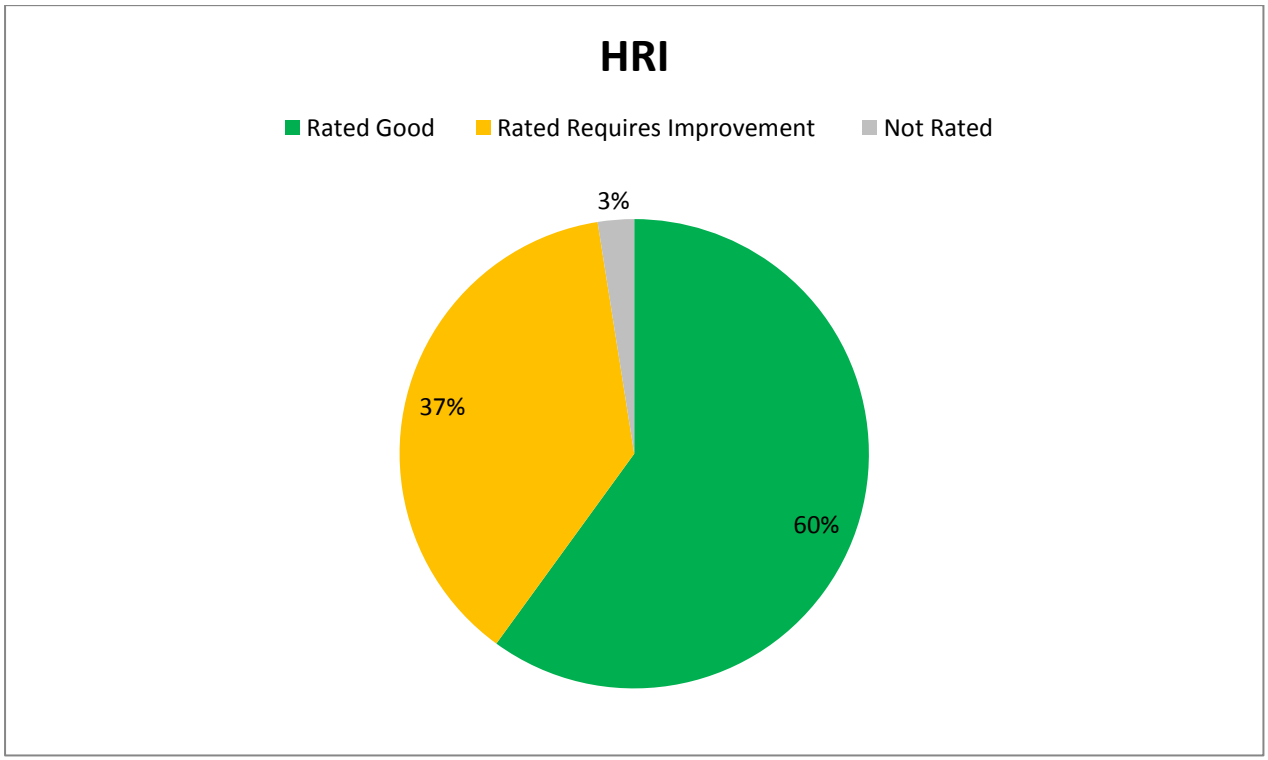
Our ratings for Castle Hill Hospital

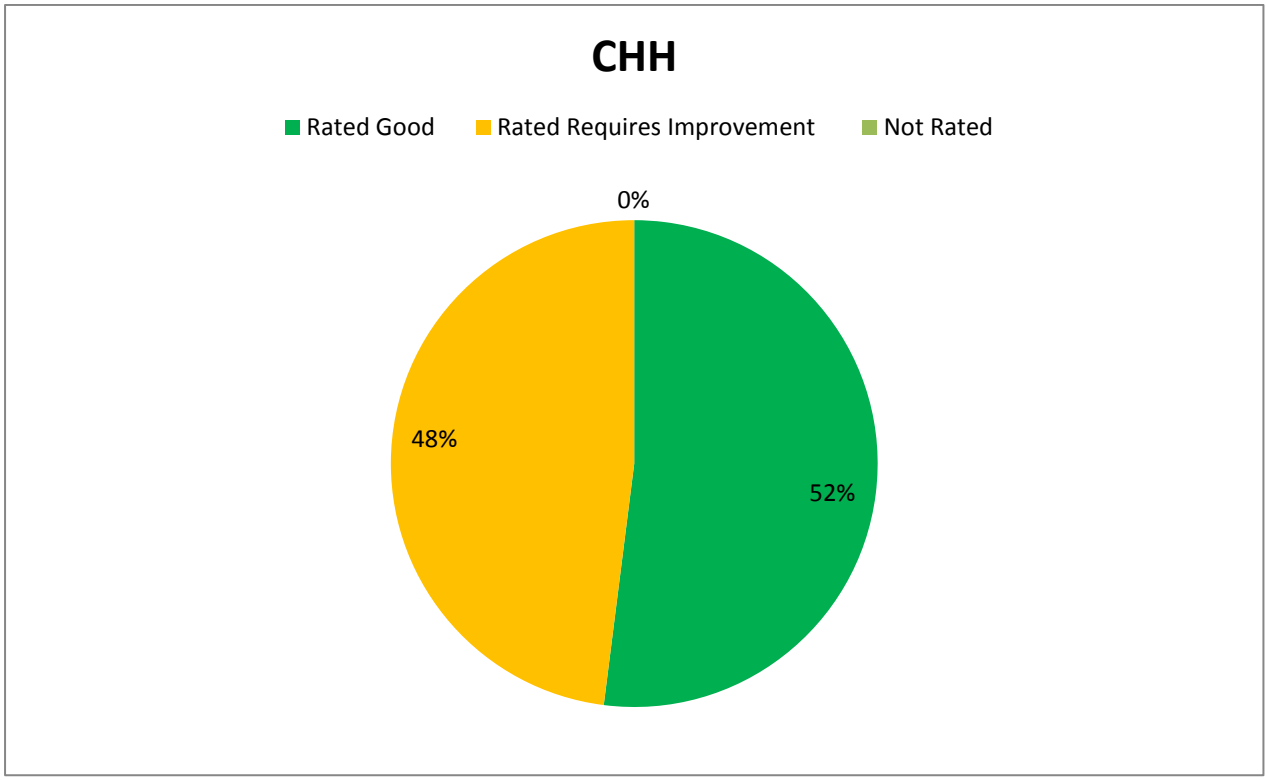
	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Hull and East Yorkshire Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

When presented in pie chart format, it can be seen that there are more areas rated as ‘Good’ than ‘Requires Improvement’. These are really positive results for the Trust.





There were lots of positive areas recognised by inspectors, most significantly the improvements in the emergency department, an overall rating of 'Good' for both Caring and End of Life Care and the positive changes to the Trust's culture. Inspectors also recognised the significant achievements that had been made since their last inspection in 2015, including the improved management of serious incidents and the theatres' refurbishment at HRI. However, improvements are required in a number of areas.

The reports contain 23 'must do' actions and 10 'should do' actions for improvement, which the Trust has accepted. Most of these were issues that the Trust was aware of already and had started to take action on both before and following the inspection. All of the required actions have now been incorporated into the Trust's overarching Quality Improvement Plan. Progress against these actions will be reviewed monthly and, also, reported to the Quality Committee and Trust Board at regular intervals.

The Quality Summit from this inspection is scheduled for Friday 17 March 2017 with the CQC, NHS Improvement, commissioners, other key partners and the Trust to respond formally to the areas of improvement and to provide a progress update on improvements made so far. It is anticipated that this will enable the Trust to demonstrate good progress in many areas since the inspection.

Overall, the inspection findings are in line with the Trust's own self assessments, which recognise many really positive developments and the amazing achievements of the Trust's staff but, also, the work still required to do.

4. SAFETY THERMOMETER – HARM FREE CARE

The NHS Safety Thermometer point prevalence audit results for January 2017 are attached as **Appendix One**. 843 in-patients were surveyed on Friday 13th January 2017, with the results as follows:

- **95%** of patients received 'harm free' care (none of the four harms either before coming into hospital or after coming into hospital)
- **1.27% [n=14]** patients suffered a 'New Harm' (whilst in hospital), with the remainder not suffering any new harms, resulting in a New Harm Free Care rating at **98.73%.** This is positive overall performance against this indicator.
- VTE risk assessments reviewed on the day = **89% (n=751)** compliance. Clearly, this is more positive than is being reported (via Lorenzo) in the Integrated Performance Report and is improving steadily but these rates still need to improve further.
- VTE incidence on the day of audit was **4** patients; all of which were with pulmonary embolisms.
- New pressure ulcers remain relatively low **(n=6)**; all grade 2.
- There were **8** patient falls recorded within three days of the audit day; **7** of which resulted in no harm to the patient and **1** with low harm. Falls with harm remain relatively low overall in the Trust.
- Patients with a catheter and a urinary tract infection remain relatively low at **4**. Of the **4** patients with infections, **3** were infections that occurred whilst the patient was in hospital. This remains a focused area for the Trust.

Overall, performance with the Safety Thermometer remains relatively positive but continues to be reviewed monthly. Each ward receives its individual feedback and results.

Note: The improvement academy has not updated the benchmarking information since the last report so this has not been presented in this report.

5. HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

5.1 HCAI performance 2016/17– as of 31st January 2017

The Trust is required to report monthly on performance in relation to four key HCAI's. These are summarised in the following table along with the current performance against the upper threshold for each:

Organism	2016/17 Threshold	2016/17 Performance (Trust Apportioned)
Post 72-hour *Clostridium difficile* infections	**53**	**37 (70% of threshold)**
MRSA bacteraemia infections (post 48 hours)	**Zero**	**1 + (1 x pending Post Infection Review Arbitration) (200% of threshold)**
MSSA bacteraemia	**46**	**42 (91% of threshold)**
E.coli bacteraemia	**95**	**66 (69% of threshold)**

Performance against these upper thresholds is now reported in more detail, by organism.

5.1.1. Clostridium *difficile (C.difficle)*

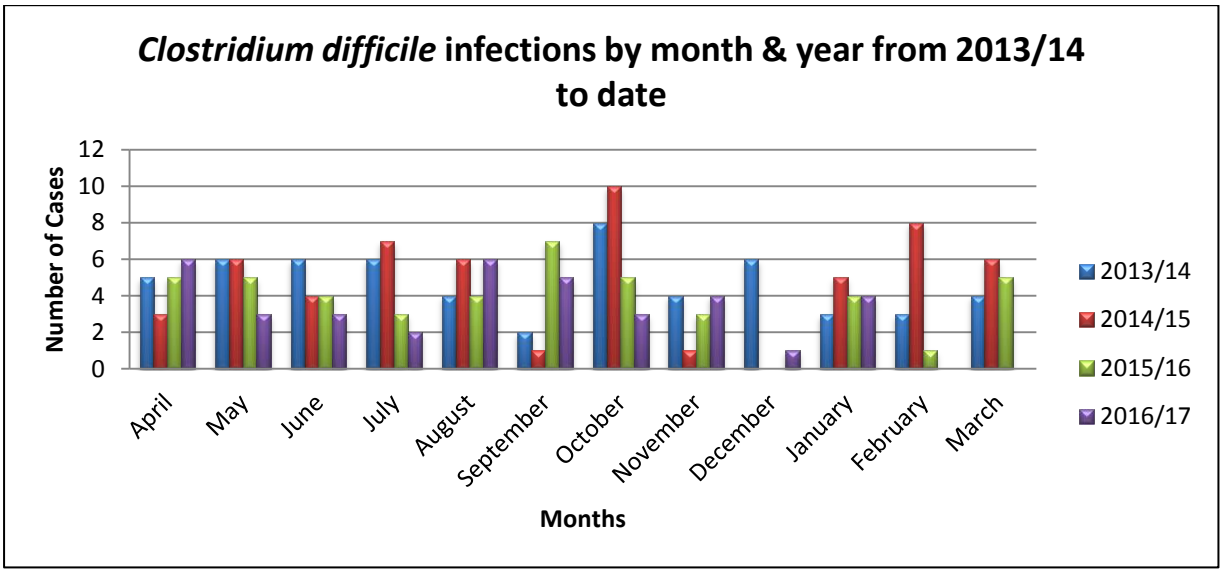
A Clostridium *difficile* infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. The symptoms of a C.*difficile* infection can range from mild to severe and include: diarrhoea, a high temperature (fever) and painful abdominal cramps. In extreme cases, C. *difficile* infections can also lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (termed toxic megacolon). In certain cases they can cause or contribute to the death of a patient.

For rates attributable to the Trust, 4 cases were reported in January 2017, bringing the total to date to 37 against an upper threshold of 53 for the year. Ongoing Trust efforts continue to enable a further and sustained reduction in cases. Root cause analysis investigations are conducted for each infection and, whilst identifying minor areas of improvement, continue to demonstrate sustained positive management of patients with this infection. Cases of this infection are now investigated collaboratively with commissioners, reviewing 3 months prior to the detection of the case in line with the pending revised reporting requirements for 2017/18.

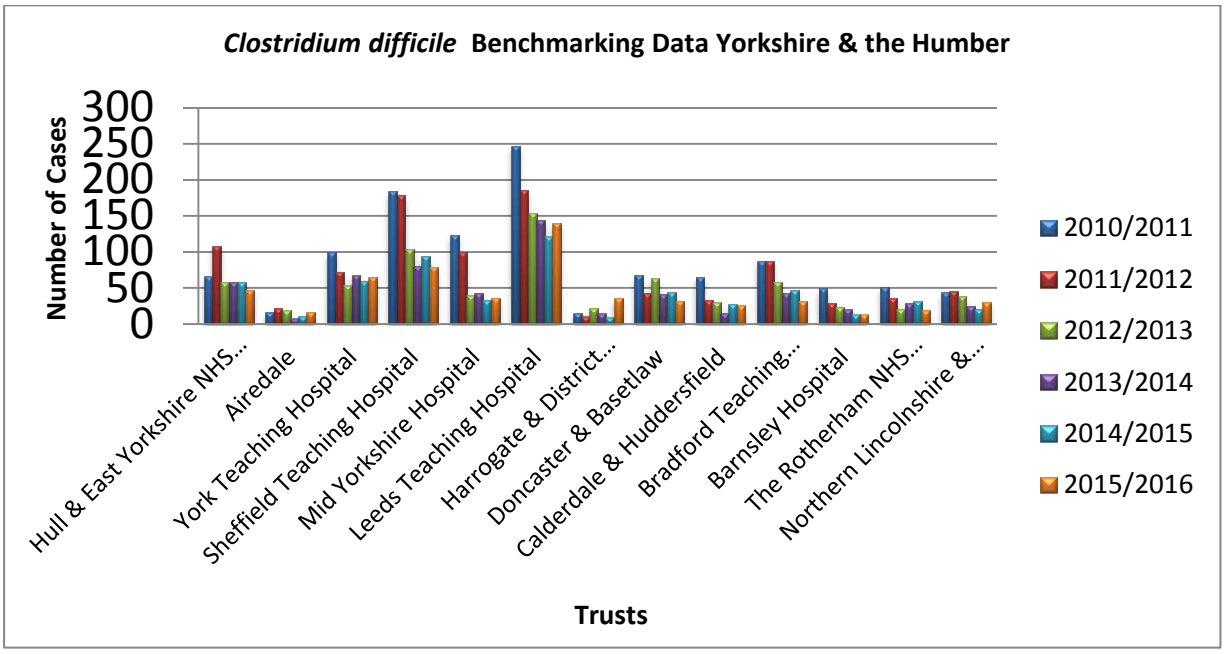
The 4 cases reported during January 2017 were identified in Medicine (three cases), with the fourth case identified in Surgery. In spite of ongoing diarrhoea and vomiting outbreaks during January 2017 and associated faecal sampling, no additional increase in Clostridium difficile cases have been detected.

Trends following root cause analysis investigation identify the need for continued and sustained improvements in antimicrobial stewardship. Improvements with appropriate faecal sampling and prompt isolation are being realised.

The following graph highlights the Trust's performance from 2013/14 to date in relation to this infection:



The following graph provides some context in relation to the performance compared to other trusts acorss Yorkshire and The Humber:



As can be seen, in view of the size and configuration of the Trust's services, it compares relatively favourably when compared against peers and this is being sustained.

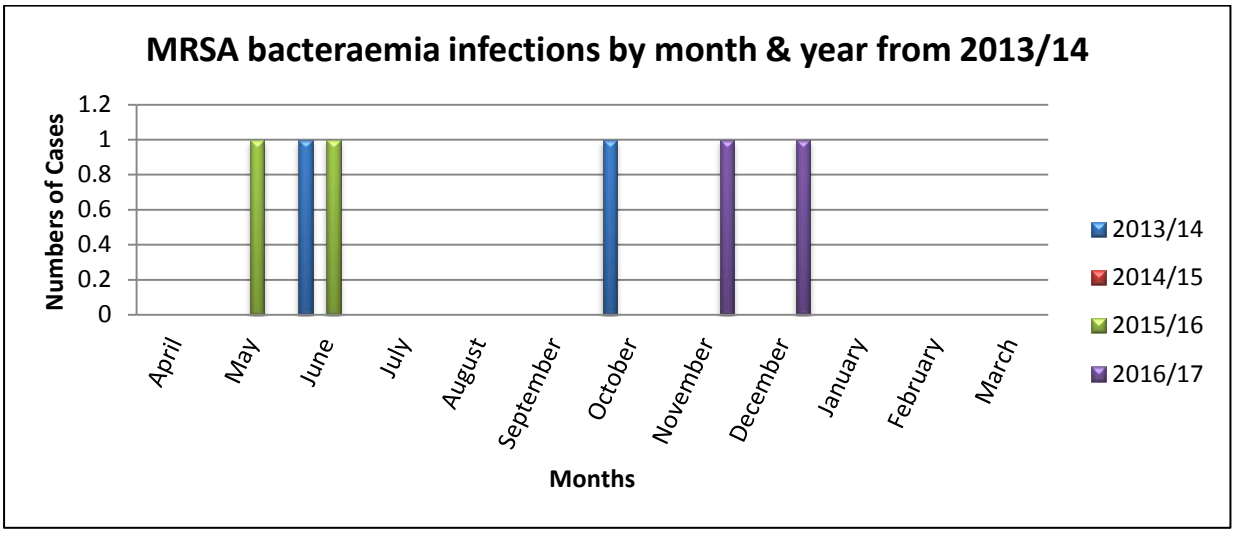
5.1.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia
Staphylococcus aureus (also known as staph) is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and impetigo. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning (bacteraemia).

MRSA is a type of bacteria that is resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

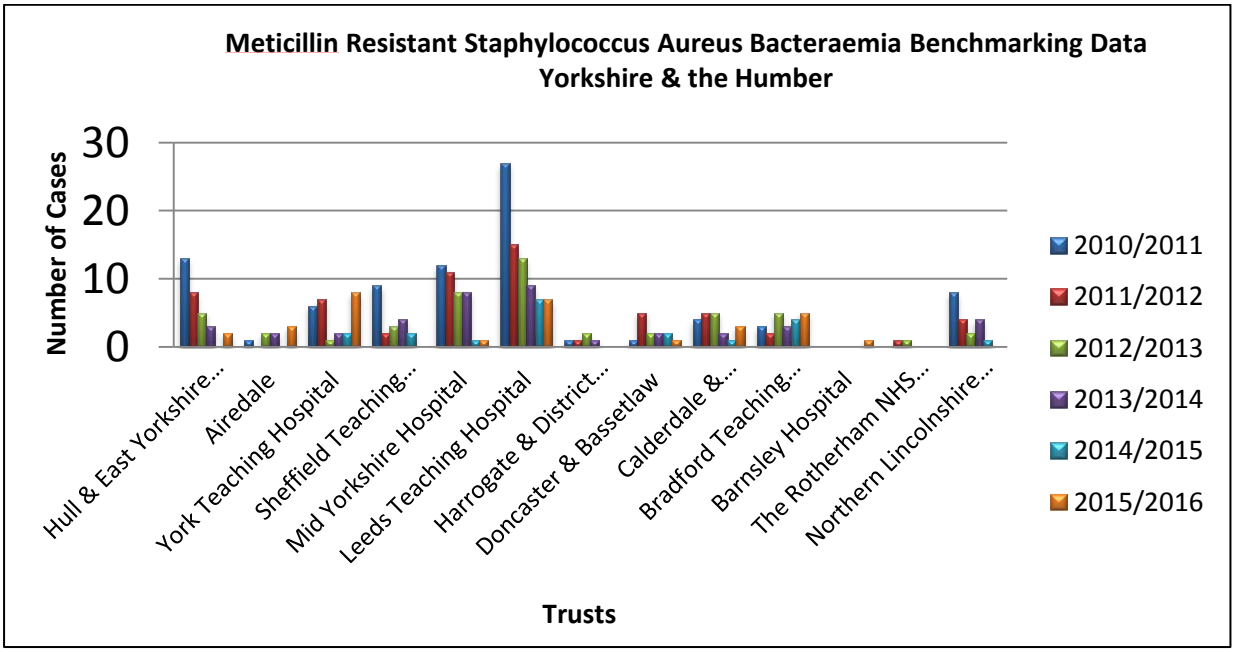
There have been no further cases of Trust apportioned MRSA bacteraemia detected during January 2017. However since 1st April 2016 there have been 2 MRSA bacteraemia cases detected. This is against a Zero Tolerance objective for 2016/17.

One case identified during November 2016 in Family and Women's Health Group was deemed Trust-apportioned following Post Infection Review (PIR) investigation. A further case was identified during December 2016 in Medicine. This latter case was initially apportioned to the Trust pending Post Infection Review investigation. However, on completion of the investigation and due to the complexity of the case and the involvement of two other acute Trusts (Harrogate and District NHS Foundation Trust and The James Cook University Hospital (South Tees Hospitals NHS Foundation Trust)) in the patient's care pathway, a decision was made to decline apportionment and initiate MRSA bacteraemia arbitration by NHS England North. Outcome of the MRSA arbitration panel is expected to be available sometime in March 2017. The Trust Board will be apprised of this outcome in due course.

The following graph highlights that cases of this infection are now extremely rare, thankfully. The performance from 2013/14 to date and demonstrates the variability in numbers year on year.



The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:



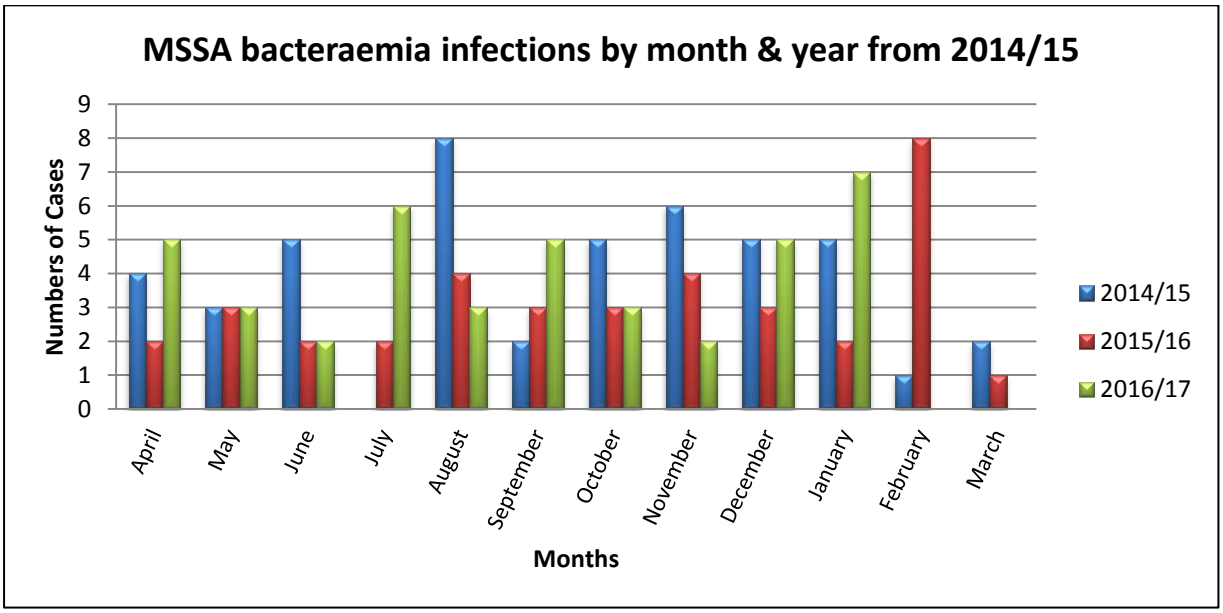
As can be seen from this, the relative improvements of this Trust over recent years are positive when compared peers in the region.

5.1.3 Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemia

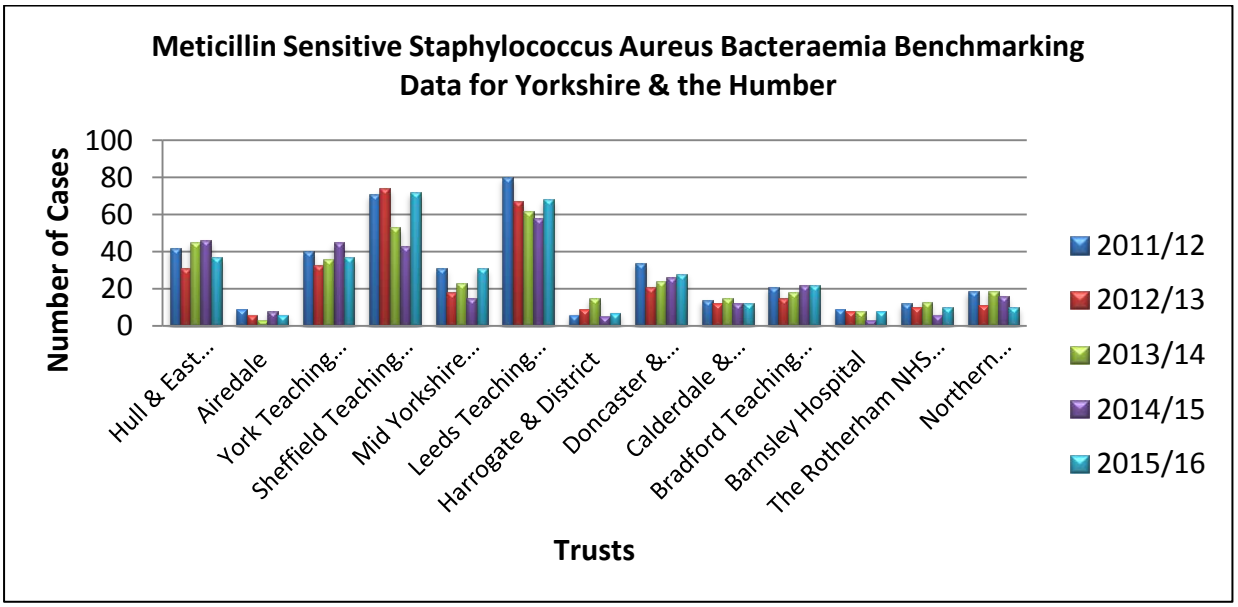
Meticillin-sensitive Staphylococcus aureus is a type of bacteria that lives harmlessly on the skin and in the nose, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

However MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds. MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream. However unlike MRSA, MSSA is more sensitive to antibiotics and therefore easier to treat. There are no national thresholds for this infection.

MSSA bacteraemia performance is provided in the following table. Cases of patients with this infection are represented across Health Groups and provide an opportunity to investigate and analyse further any trends to improve practice. The Trust continues to see improvements overall in the management and prevention of this infection but fluctuations in the number of cases reported have occurred throughout the year.



The following graph provides some context in relation to the performance of other trusts acorss Yorkshire and The Humber:



As can be seen, this is more evenly spread both across organisations and, also, recent years.

The Infection Reduction Committee has agreed to undertake more reviews in this area to see if any further preventative measures can be taken by the Trust.

The cases identified during January 2017 have been detected across the Trust in three out of the four Health Groups. The cases have been complex and in patients with multiple morbidities and risk factors.

The need for continued and sustained improvements regarding this infection since November 2017 is evident due to the month on month increase in cases. Actions on device/ line management have commenced with a review of existing documentation including policies/ procedures and implementation of new documentation in piloted areas related to evidence based device management.

5.1.4 Escherichia-coli Bacteraemia

There are many different types of *Escherichia coli* (*E. coli)* bacteria, most of which are carried harmlessly in the gut. These strains of *E. coli* make up a significant and necessary proportion of the natural flora in the gut of people and most animals.

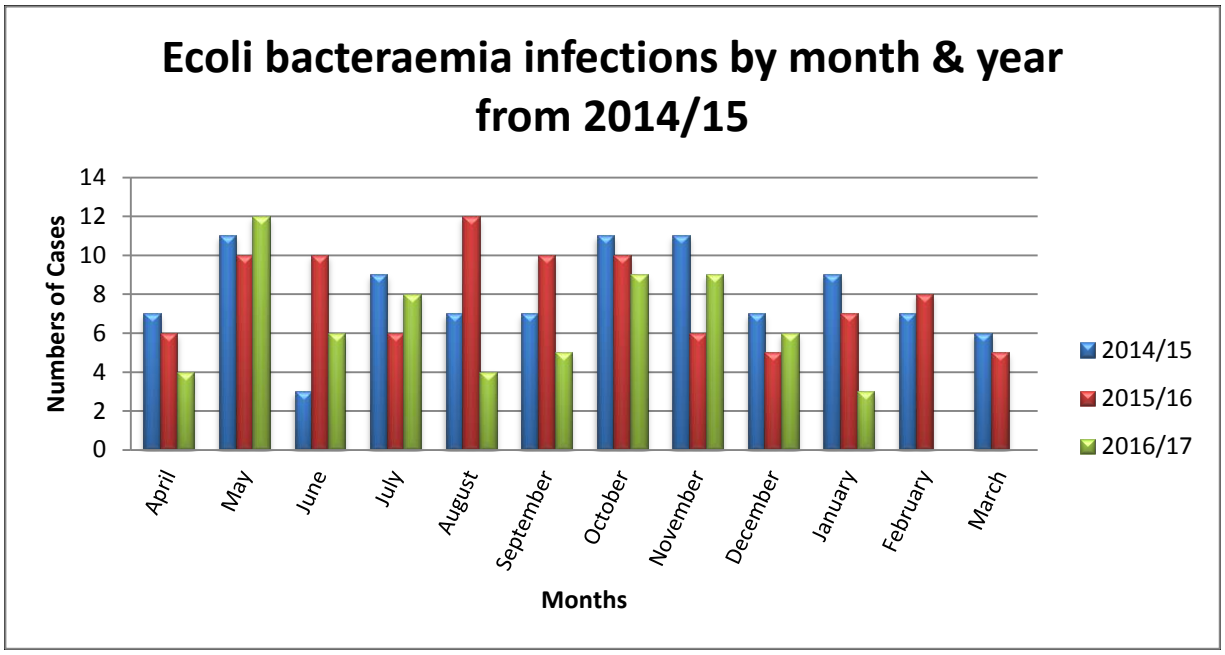
However, when strains of *E. coli are* outside their normal habitat of the gut, they can cause serious infections, several of which can be fatal. Potentially dangerous *E. coli* can exist temporarily and harmlessly on the skin, predominantly between the waist and knees (mainly around the groin and genitalia), but also on other parts of the body, i.e. a person's hands after using the toilet.

E. coli is now the commonest cause of bacteraemia reported to Public Health England. *E. coli* in the bloodstream is usually a result of acute infection of the kidney, gall bladder or other organs in the abdomen. However, these can also occur after surgery, for example. There are no national thresholds for this infection.

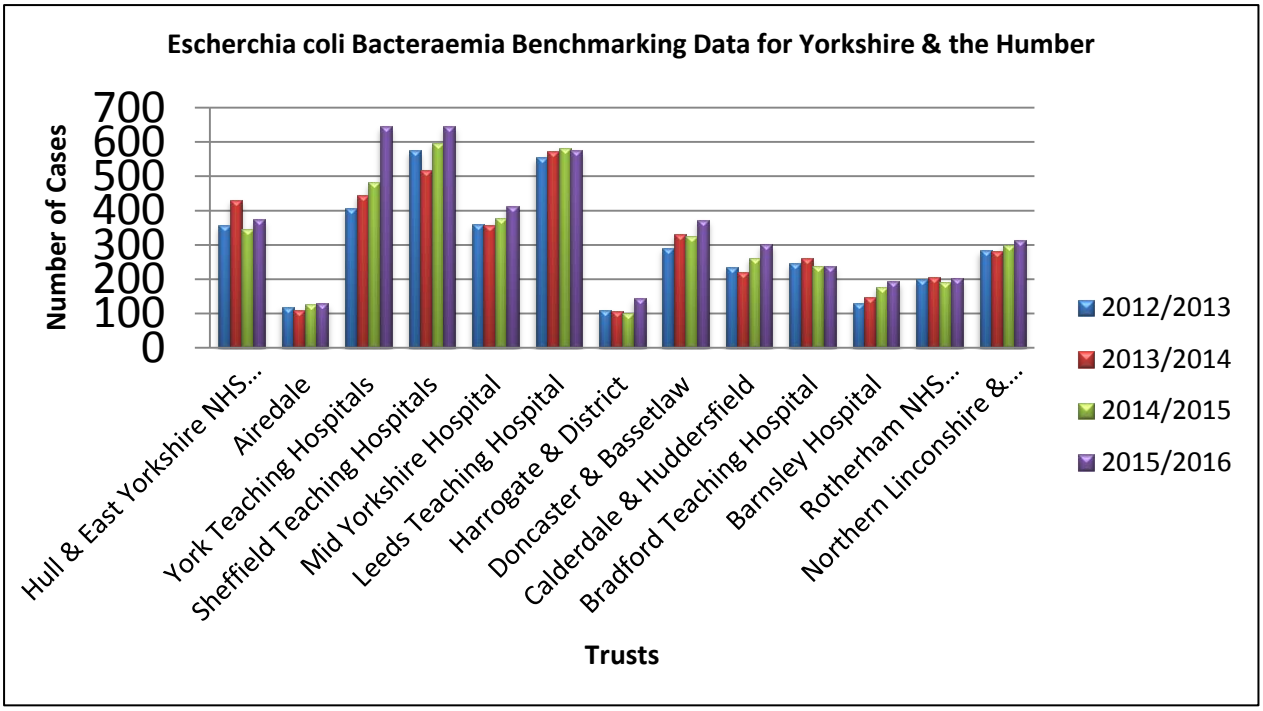
For 3 months from July – September 2016 the Trust in collaboration with the City Healthcare Partnership's Infection Prevention & Control Team collected data on E.*coli* bacteraemia cases. The purpose of this is to understand trends for both Trust and Community-apportioned cases and develop robust systems and processes for the prevention of these infections.

In line with national data, surveillance identified a burden of infection within the community, both Hull and East Riding, with an increased burden of this infection in males compared to females (dependent on age). The age group most affected is the 70 to 90 year old people. Other trends identified that the source of infection related to the urinary tract, hepatobiliary and respiratory systems and a previous history of E.*coli* infection.

E.*coli* bacteraemia performance is provided in the following tables, demonstrating month on month variability in numbers. Most patients are admitted with this infection to hospital and have invariably acquired it whilst in the community.



The following graph provides some context in relation to the perofrmance of other trusts acorss Yorkshire and The Humber:



Again, the patterns across all trusts are pretty consistent, which demonstrate the overall challenges with dealing with this infection.

5.2 Infection Outbreaks
An outbreak is defined by two or more patients with the same infection in the same ward/area.

5.2.1 Diarrhoea and vomiting episodes
During January 2017, the Trust continued to experience diarrhoea/vomiting outbreaks affecting a number of wards, some of which were confirmed as Norovirus. In total, 4 wards were affected.

Wards at Hull Royal Infirmary and Castle Hill Hospital were affected, with the main burden of infection noted in the Medical Health Group, especially medical elderly wards. In the majority of cases, the outbreaks were contained within bays and only one ward out of four affected resulted in the full ward being closed. All affected bays/wards were deep cleaned prior to reopening.

Collaborative working with internal and external partners has provided the opportunity to review possible delays in patient pathways, in particular discharge from hospital from these wards that occur during outbreaks of diarrhoea and vomiting. This has resulted in improved communication, especially in relation to discharge planning, providing clarity on Norovirus aetiology and a review existing documentation such as posters, leaflets and policies.

5.2.2 Influenza trends

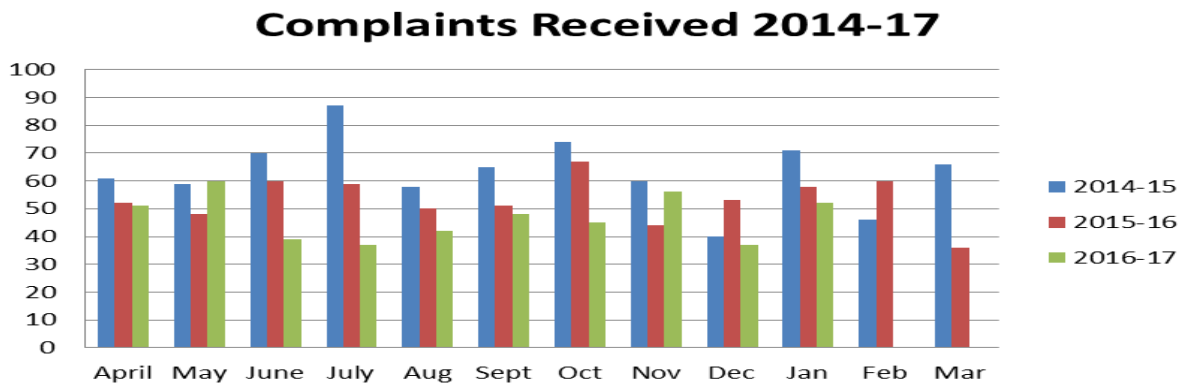
During January 2017 an increase in confirmed Influenza A cases was noted across Yorkshire & the Humber. The Trust experienced and managed isolated cases amongst patients, reiterating the importance of prudent communication of patient screening, isolation and ongoing management. Early identification of respiratory viruses in the respective laboratories enabled prompt management of patients.

The Occupational Health Department continued to offer the Influenza vaccine during January 2017 to staff that had not had the opportunity to take up the offer previously.

6. PATIENT EXPERIENCE

6.1 Complaints

The table below sets out comparative complaints data from 2014 to date.



The table below indicates the number of complaints by subject received for each Health Group during the month of January 2017.

Complaints by Health Group and Subject (primary)	Attitude	Care and Comfort	Communication	Discharge	Safeguarding	Treatment	Total
Clinical Support	1	0	0	0	0	0	1
Family & Women	0	1	1	0	0	11	13
Medicine	1	3	2	1	1	14	22
Surgery	0	0	3	0	0	13	16
Totals:	**2**	**4**	**6**	**1**	**1**	**38**	**52**

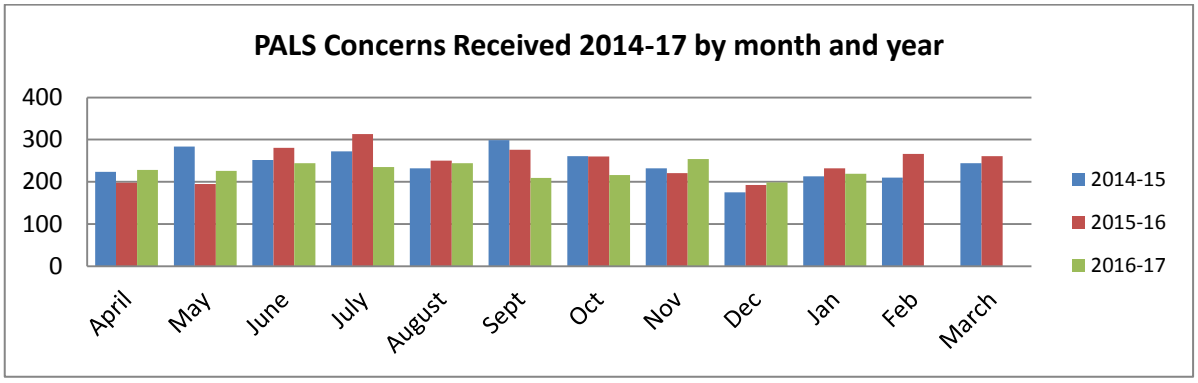
Complaints about treatment continue to receive the highest number. The two key themes relate to patients that are not being happy with the treatment plan (19) and the outcome of the surgery undertaken (7).

5.1.2 Performance against the 40 day complaint response standard
The following table sets out performance against the Trust's standard of closing 90% of complaints within 40 days:

Health Group	Closed	Closed within 40 days
Clinical Support	3	1 (33%)
Family and Women's	8	8 (100%)
Medicine	21	17 (81%)
Surgery	23	13 (59%)
Total	55	39 (72%)

The Patient Experience Team is continuing to work closely with each of the Health Groups to enable timely responses to complaints whilst maintaining the quality of responses. Of the closed complaints, 20 were not upheld, 24 were partly upheld and 9 were upheld. One complaint was escalated to a Serious Incident and one was not taken forward at this time at the request of the complainant. Monthly training sessions are now in place to support staff who will be involved in the investigation and writing of responses to complainants.

6.2 Patient Advice and Liaison Service (PALS)
In the month of January 2017, PALS received 219 concerns as well as 20 compliments, 71 general advice issues and 3 comments/suggestions. The majority of concerns continue to be regarding delays, waiting times and cancellations, in particular in respect of waiting times for appointments. 39 contacts were made via the new Internet method of reporting PALS matters this method during January.



The table below indicates the number of PALS received by Health Group and primary subject in January 2017

	ADVICE	ATTITUDE	CARE & COMFORT	COMMUNICATION	DELAY, WAITING TIMES AND CANCEL	DISCHARGE	ENVIRONMENT	HOTEL	SPECIAL NEEDS	TREATMENT	Total
Corporate Functions	7	1	0	9	2	0	0	2	0	0	21
Clinical Support	0	0	0	4	7	1	0	0	0	2	14
Family & Women's	1	2	1	8	20	0	0	0	1	10	43
Medicine	6	3	0	13	18	9	1	2	1	11	64
Surgery	1	3	1	12	40	2	0	1	0	17	77
Totals:	15	9	2	46	87	12	1	5	2	40	219

6.3 Compliments
The Trust has received a large number of compliments this month which include, praise for the stroke services for their caring and attentive treatment.

A patient wanted to thank the physiotherapy department for the care they received throughout the department, which started with a warm welcome from the receptionist and care from the whole of the physiotherapy department team.

Compliments have been received for the Surgery Health Group from a patient who reported that his surgery has changed his life and that he can now walk without pain for the first time in two years. He expressed his appreciation to the whole team.

6.4 Parliamentary and Health Service Ombudsman (PHSO)
The Trust has nine cases under review by the PHSO currently. No new cases have been received during January.

6.5 Friends and Family Test (January 2017 Data)
The Trust is out to tender currently to find new partners for the Friends and Family test. The Patient Experience team has been working alongside the Procurement team to award the new contract. In the interim period, the Patient Experience team has been collating FFT information in-house and analysing the data until a new partner is finalised. Therefore, this information is summarised for this report.

The Trust's Friends and Family results for January for all areas excluding the Emergency Department indicate that there was an increase in the number of responses for the month of January 2017 with 5,506 responding compared to 4,169 in December 2016. From these 99.4% were extremely likely/likely to recommend the Trust to friends and family.

6.5.2 Emergency Department (ED)
The Trust is now collecting the ED Friends and Family test results by two different methods; paper and SMS text messaging. This has resulted in a significant increase in the response rate from 7.5% of attendances to 22%.

With regard to the paper feedback, 469 patients gave feedback. Of these, 91.6% (n=427) said they were extremely likely/likely to recommend ED to friends and family. 2.7% (n=13) said they were extremely unlikely/unlikely to recommend.

With regards to SMS text messaging 83% of patient gave positive feedback and 12% gave negative feedback.

6.6 National Inpatient Survey 2016 Results
The National Inpatient Survey 2016 was undertaken in August 2016 and the results have now been received. The Trust has performed significantly better in 12 areas in comparison to other large acute Trusts nationally and significantly worse in 2 areas.

Q	Question (lower scores are better)	HEY Score %	Large Acute Trust Average %	Picker Average %	Significantly better or worse
5	Planned admission: not offered a choice of hospitals	80	69	69	➖
9	Admission: had to wait long time to get to bed on ward	38	42	36	➕
17	Hospital: room or ward not very or not at all clean	1	3	3	➕
18+	Hospital: toilets not very or not at all clean	4	6	5	➕
22+	Hospital: food was fair or poor	37	41	39	➕
23	Hospital: not offered a choice of food	18	22	20	➕
24+	Hospital: did not always get enough help from staff to eat meals	30	39	36	➕
32	Nurses: did not always know which nurse was in charge of care	49	54	51	➕
41	Care: not always enough privacy when being examined or treated	7	10	9	➕
43	Care: staff did not do everything to help control pain	27	32	29	➕
59+	Discharge: did always get enough support from health or social care professionals.	54	47	46	➖
61	Discharge: not given any written/printed information about what they should or should not do after leaving hospital	31	39	36	➕
74+	Overall: rated experience as less than 7/10	14	18	15	➕
76	Overall: did not receive any information explaining how to complain	60	64	60	➕

These results will now be reviewed by the Patient Experience Forum and the Patient Council.

6.7 Voluntary Services
The number of volunteers continues to increase throughout the Trust and the Patient Experience team has received additional requests from wards requesting voluntary support. A young health champion has been placed within HEY! Let's Shop at Castle Hill Hospital. This individual has shown great reliability and enthusiasm and even undertakes an afternoon per week to volunteer at the shop over and above his agreed hours.

The Patient and Public Council continues to integrate within the services and areas across the Trust. The Council has assisted recently with the Trust's arts project in giving its opinion and experiences relating to the transformation of the ground floor of Hull Royal Infirmary. Particular

skills within the Council include those relating to people with dementia and learning disabilities. This has been useful in choosing colours, patterns and words for the art work, taking into account the difficulties that some patients may have with regards to vision. Additionally, the Council is working with the Falls Management Committee in agreeing the protocols for assessing patients' mobility to ensure timely discharge from hospital when patients are clinically ready for discharge.

6.7.1 Young Volunteers

The Trust now has over one hundred Young Volunteers. Twenty of these are Young Health Champions who will be with the Trust for twelve to twenty four weeks gaining their Royal Society of Public Health certificates. On completion of this, all champions want to become Trust volunteers. Five of the Young Volunteers managed to secure themselves full time jobs in 2016. The Trust recently held one of its Young Health Champion/Volunteer events, which was very well attended and saw another thirty five young people wanting to become volunteers in the Trust and wanting to learn more about the NHS. These are all really positive developments.

7. OTHER QUALITY UPDATES

7.1 Mortality Structured Case Note Reviews - Themes and Trends – Structured Judgement Reviews in Mortality

The Trust Board will be aware that the Trust has changed the way it reviews patient deaths by using a structured case-note/judgement review process. A total of 56 patients have now had a structured judgement mortality review under these new arrangements.

A report was submitted to the monthly Mortality Committee, which provided a summary of first set of findings by examining occurring trends in patient care and highlighting areas that need improvement, as well as highlighting areas of exemplary care.

As the table shows, the average care scores reflect that good care was given throughout each phase of the patient's stay. Any of the care scores that were given as two or less triggered a Tier 2 review, and these are being reviewed currently.

Of these 56 reviews, nine of them required a Tier 2 review (16%). This is due to poor care scores given at one or more phase of care.

Phase of Care Scores - The average care score is out of 5.0 (5.0 being the best score).

1. Phase of care	Average Score	Very poor 1	2	3	4	Excellent 5
Admission & initial care (1st 24hrs)	4.0	3.6% 2	8.9% 5	12.5% 7	30.4% 17	44.6% 25
Ongoing care	4.0	1.9% 2	5.6% 5	24.1% 7	31.5% 17	37.0% 25
Care during a procedure	4.4	0.0% 0	0.0% 0	21.3% 10	21.3% 10	57.4% 27
Perioperative care	4.2	5.9% 1	0.0% 0	5.9% 1	41.2% 7	47.1% 8
End of life care	4.3	1.8% 1	1.8% 1	19.6% 11	23.2% 13	53.6% 30
Overall assessment of care	4.0	1.8% 1	7.1% 4	17.9% 10	32.1% 18	41.1% 23

At this early stage, reoccurring themes are already starting to appear as shown in the following table. These include core/expected standards that are not being met, e.g. record keeping

standards, failure to document a clear plan or ceiling of care, lack of appropriate multi-disciplinary care, sufficiently senior decision making/involvement and a lack of evidence of learning.

3. Themed Analysis	Count	
Ceiling of care	6	9.0%
Communication with patient/family	2	3.0%
Documentation	9	13.4%
Management plans	10	14.9%
Missed opportunity for end of life care	3	4.5%
Multi-disciplinary care	3	4.5%
No identified learning	21	31.3%
Other	6	9.0%
Senior clinical involvement	6	9.0%
Sepsis management	1	1.5%
Total	67	

Issues relating to documentation within case notes have been identified via these themed analyses and reviewer comments, relating to one or more of the following:

- Lack of Consultant time/date, printing of name and designation within case notes after a patient review.
- Poor condition of case notes/pages out of order
- Sporadic entries made at varying locations within case note (e.g. entries written on “inpatient” page, and then continued within a separate booklet).

At the moment, the system is still under development and a robust method of capturing action plans/outcomes and evidence of learning and improvement is being trialled. This will be an integral part of the review process, which will allow positive changes to be made to patient care, improvements in professional standards and current practices and for lessons to be learned and shared where necessary.

Phase 2 of the Structured Judgement Review system roll-out is underway currently, which will see the new methodology implemented across the remaining Health Groups: Medicine, Family and Women’s and Clinical Support. The Trust Board will be apprised in due course of further developments in this area.

7.5 Venous Thromboembolism Risk Assessments (VTE)
The performance in relation to the VTE risk assessments (95% target) is provided in the following table. Although three Health Groups have not met 95% target, all Health Groups have improved performance. Focused attention continues in this area.

Health Group	January 2017	February 2017
Clinical Support	89.9%	96.4%
Family and Women’s	78.0%	92.1%
Medicine	72.8%	82.4%
Surgery	85.0%	89.4%

7.6 Operational Quality Committee
The Operational Quality Committee met in January 2017. Key issues discussed at the committee included:

- Review of the Quality Improvement Programme (QIP), particularly those areas rated as 'Amber'
- VTE risk assessments and Health Group commitments to work with their teams to improve the level of compliance
- World Health Organisation checklist compliance

8. ACTION REQUESTED OF THE TRUST BOARD
The Trust Board is requested to receive this report and:

- Decide if this report provides sufficient information and assurance
- Decide if any further information and/or actions are required.

Mike Wright
Executive Chief Nurse

Kevin Phillips
Executive Chief Medical Officer

Sarah Bates
Deputy Director Quality,
Governance and Assurance

February 2017

Appendix One: Safety Thermometer Results – January 2017

Hull and East Yorkshire Hospitals NHS Trust

Absence of harm from

Pressure ulcers + Falls + Urinary infections (in patients with catheters) + VTE = Harmfreecare

SAFETY THERMOMETER NEWSLETTER January 2017

The NHS Safety Thermometer tool measures four high-volume patient safety issues (pressure ulcers, fall, urinary infection (inpatients with a catheter) and treatment for venous thromboembolism. It requires surveying of all appropriate patients on a single day every month. This survey data was collected on Friday 13th January across both hospital sites. 843 patients were surveyed

95% of our patients received HARM FREE CARE

Harm Free Care is defined as the number/percentage of patients who have not suffered any of the four harms measured by the safety thermometer before or since admission to hospital.

1.7% (14) of our patients suffered a New Harm

New Harm is defined as the number/ percentage of patients who have suffered or have started treatment for one of the four harms measured by the safety thermometer since admission to hospital

98.3% Of our Patients received NO NEW HARM

No New Harm is defined as the number/ percentage of patients who have not suffered any of the four harms measured by the safety thermometer since admission to hospital.

HARM FREE CARE %: How is HEY performing June 16 – Jan 17

	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
Harm Free Care %	95.4%	93.7%	94.6%	94%	94.7%	94.5%	95.8%	95%
Sample: Number of patients	871	937	907	879	896	930	890	843
Total Number of New Harm	13	20	18	15	18	16	11	14
NEW HARM FREE CARE %	98.5%	97.8%	98.0%	98.3%	98%	98.2%	98.6%	98.3%

Harm Descriptor: Venous Thromboembolism	Number	%	PE Pulmonary Embolism	DVT Deep Vein Thrombosius	OTHER
Total Number/Proportion of patients treated for a **NEW VTE** A new VTE is defined as treatment starting for the VTE after the patient was admitted to hospital. Four of these patients where admitted with a primary diagnosis of pulmonary embolism	4	0.45%	4	0	0

Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT**	751	89%
Total Number/Proportion of patients documented with a **VTE RISK ASSESSMENT not applicable**	49	5.8%
Total Number/Proportion of patients with **NO** documented **VTE RISK ASSESSMENT**	43	5.1%

Harm Descriptor: Pressure Ulcers	Number	%	Cat 2	Cat 3	Cat 4
Total Number/Proportion of **Pressure Ulcers**	33	3.91%	29	1	3
Total Number/Proportion of **OLD Pressure Ulcers** An OLD pressure ulcer is defined as being present when the patient came into our care, or developed within 72 hours of admission.	27	3.2%	23	1	3
Total Number/Proportion of **Pressure Ulcers** that were classed as **NEW** A NEW pressure ulcer is defined as developing 72 hours since admission.	6	0.71%	6	0	0

Harm Descriptor: Falls A fall is defined as an unplanned or unintentional descent to the floor, without or without injury, regardless of cause	Number	%
Total Number/Proportion of patients recorded with a **Fall** (During the last 3 days whilst an inpatient)	8	0.95%
Severity **No Harm**: fall occurred but with no harm to the patient	7	0.83%
Severity **Low Harm**: patient required first aid, minor treatment, extra observation or medication	1	0.12%
Severity **Moderate Harm**: longer stay in hospital	0	0%
Severity **Severe Harm**; permanent harm.	0	0%
Severity **Death**; direct result of fall	0	0%

Harm Descriptor: Catheters and Urinary Tract Infections	Number	%
Total Number/Proportion of patients recorded with a Catheter	153	18.15%
Total Number/Proportion of patients recorded with a Urinary Tract Infection with a urinary catheter insitu	4	0.47%
Total Number/Proportion of patients recorded with an OLD Urinary Tract Infection with a urinary catheter insitu **An OLD urinary tract infection is defined as diagnosis or treatment started before the patient was admitted to hospital**	1	0.12%
Total Number/Proportion of patients recorded with a NEW UTI with a urinary catheter insitu **An NEW urinary tract infection is defined as diagnosis or treatment which started after the patient was admitted to hospital**	3	0.36%

Next Classic SAFETY THERMOMETER DATA COLLECTION DAY IS:

Friday 11th February 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

Trust Board date	7th March 2017		**Reference Number**	2017- 3 - 10		
Director	Mike Wright – Chief Nurse		**Author**	Mike Wright – Chief Nurse		
Reason for the report	The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations) and the Care Quality Commission					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Trust Board is requested to: • Receive this report • Decide if any if any further actions and/or information are required					
2	**KEY PURPOSE:**					
	Decision		Approval		Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					✓
	High quality care					✓
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): E4 – Staff, teams and services to deliver effective care and treatment					
	Assurance Framework Ref: Q1, Q3	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** The report is a standing agenda item at each Board meeting.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

NURSING AND MIDWIFERY STAFFING REPORT

1. PURPOSE OF THIS REPORT

The purpose of this report is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations)[1,2] and the Care Quality Commission.

2. BACKGROUND

The last report on this topic was presented to the Trust Board in January 2017 (December 2016 position).

In July 2016, the National Quality Board updated its guidance for provider Trusts, which sets out revised responsibilities and accountabilities for Trust Boards for ensuring safe, sustainable and productive staffing levels. Trust Boards are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.
The new guidance sets out specifications for the future format of these reports, which form part of Lord Carter's work in relation to developing a 'Model Hospital' Dashboard. However, there has been no further progression since last reported in the September Board report 2016. This format will be adopted as soon as it is released and available. However, the piece of work commissioned by the Chief Nurse to look at the Trusts current nursing metrics and how these metrics can be deployed and monitored at ward level continues and will be reported back to the Trust Board in due course.

This report presents the 'safer staffing' position as at 31st January 2017 and confirms on-going compliance with the requirement to publish monthly planned and actual staffing levels for nursing, midwifery and care assistant staff[3]. In addition, nursing and midwifery staffing establishments have been revised during September 2016 and the summary results of these are presented, also.

3. NURSING AND MIDWIFERY STAFFING - PLANNED VERSUS ACTUAL FILL RATES

The Trust Board is advised that the Trust continues to comply with the requirement to upload and publish the aggregated monthly average nursing and care assistant (non-registered) staffing data for inpatient areas. These can be viewed via the following hyperlink address on the Trust's web-page:

http://www.hey.nhs.uk/openandhonest/saferstaffing.htm

These data are summarised, as follows:

[1] National Quality Board (2012) How to ensure the right people, with the right skills, are in the right place at the right time - *A guide to nursing, midwifery and care staffing capacity and capability*
[2] National Quality Board (July 2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing
[3] When Trust Boards meet in public

3.1 Planned versus Actual staffing levels

The aggregated monthly average fill rates (planned versus actual) by hospital site are provided in the following graphs and tables. More detail by ward and area is available in **Appendix One** (data source: Allocate e-roster software & HEY Safety Brief).

Fig 1: Hull Royal Infirmary

HRI	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	80.86%	88.23%	85.26%	103.39%
May-16	80.58%	91.24%	86.70%	105.93%
Jun-16	80.25%	89.41%	85.20%	102.22%
Jul-16	82.28%	90.96%	86.30%	103.33%
Aug-16	80.56%	89.30%	87.74%	99.85%
Sep-16	86.38%	93.40%	93.28%	101.70%
Oct-16	88.51%	100.79%	90.58%	106.38%
Nov-16	91.30%	97.10%	95.70%	107.30%
Dec-16	91.23%	100.10%	97.00%	100.76%
Jan-17	93.00%	103.50%	99.10%	101.10%

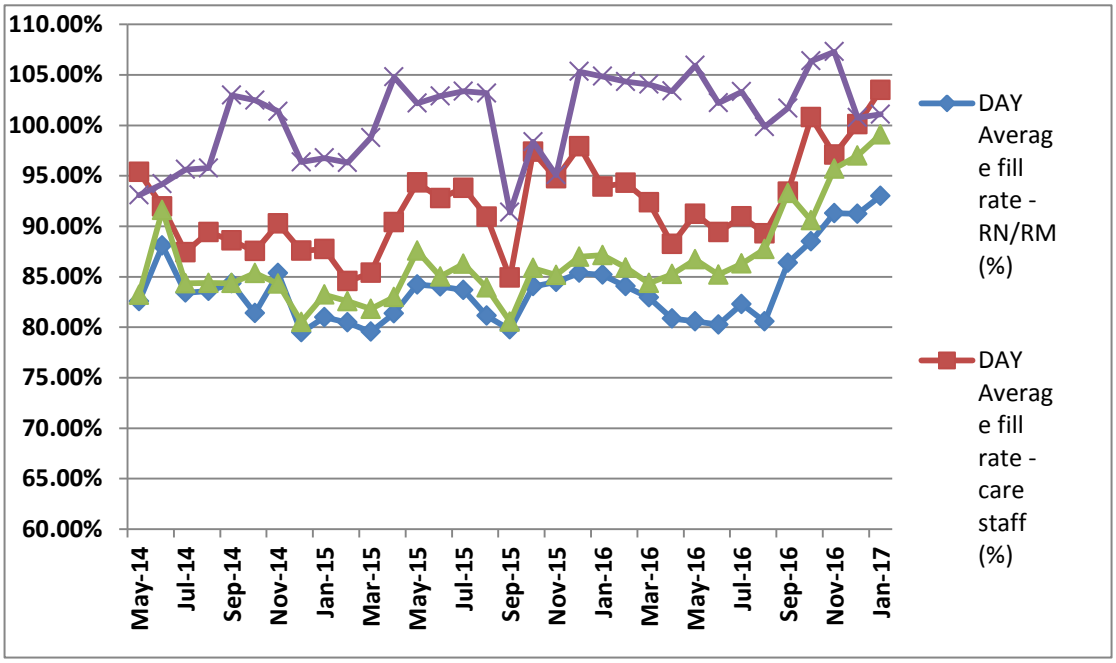
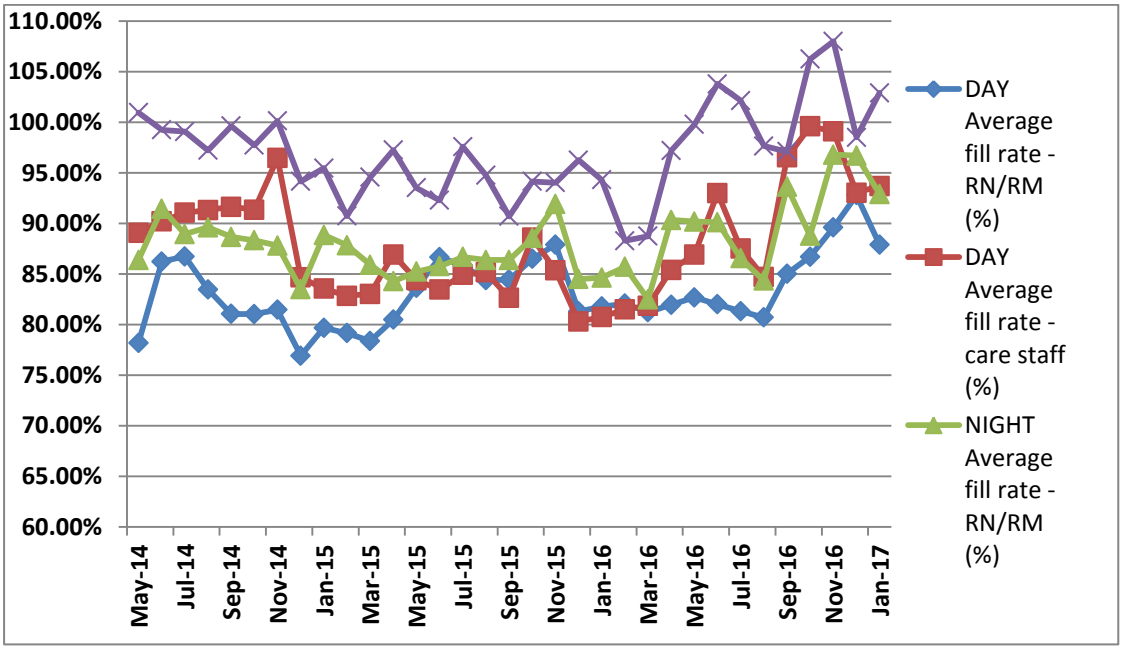


Fig 2: Castle Hill Hospital

CHH	DAY		NIGHT	
	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
Apr-16	81.96%	85.40%	90.34%	97.19%
May-16	82.68%	86.93%	90.19%	99.79%
Jun-16	82.01%	92.99%	90.12%	103.78%
Jul-16	81.33%	87.53%	86.56%	102.15%
Aug-16	80.70%	84.70%	84.35%	97.64%
Sep-16	85.02%	96.52%	93.61%	97.09%
Oct-16	86.70%	99.59%	88.79%	106.24%
Nov-16	89.60%	99.10%	96.80%	108.00%
Dec-16	92.79%	93.03%	96.70%	98.50%
Jan-17	87.90%	93.70%	92.90%	102.90%



The Trust has seen significant improvements in both the registered nurse and care staff (unregistered) fill rates over recent months, especially as more of the newly registered nurses receive their full registration status from the Nursing and Midwifery Council (NMC). The differences between the two sites in December reflect the need to move staff over to HRI in response to non-elective pressures.

Also, some wards exceed 100% of planned fill rates. This is usually explained as a result of needing to provide 1:1 care for specific patients over and above that which is planned or where additional staff are drafted in e..g specialist nurses, to meet patient need.

Some pressures remain in recruiting to optimal staffing levels in some areas and recruitment efforts continue. The Trust has interviewed and successfully appointed a 115 of the adult nursing branch students and 20 of the children's nursing branch students to date, that are due to qualify from the University of Hull in September 2017. A significant amount of effort is also been made with regards to attracting additional candidates from other universities, with Trust representation at recent and

future Career Fairs at Salford University and Leeds University. In addition, the Trust is currently exploring with the University of Hull the possibility of increasing the number of student placements in September 2017 by a further 50 places.

With regards to international recruitment, following a successful promotion and advertising campaign within the Philippines, the Trust is currently considering 50 long-listed CV's. Interviews will be arranged and employment offers will be made following NMC clearance and employment checks. Applicants are expected to commence in July and August, 2017 due to UK visa waiting times. The Trust expects to have 40 overseas nurses working for the Trust before September, 2017.

4. ENSURING SAFE STAFFING

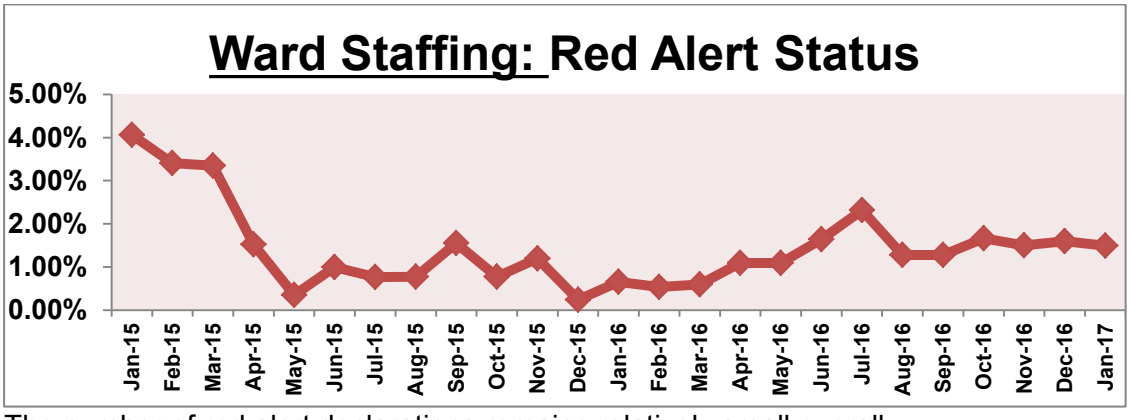
The twice-daily safety brief reviews continue each day, led by a Health Group Nurse Director (or Site Matron at weekends) in order to ensure at least minimum safe staffing in all areas. This is always achieved. The Trust is still able to sustain its minimum standard, whereby no ward is ever left with fewer than two registered nurses/midwives on any shift. However, as the Trust is running a winter ward (H10) and supporting extra beds on C8 and H30, there are still some challenges on some shifts.

Other factors that are taken into consideration before determining if a ward is safe or not, include:

- The numbers, skill mix, capability and levels of experience of the staff on duty
- Harm rates (falls, pressure ulcers, etc.) and activity levels
- The self-declaration by the shift leader on each ward as to their view on the safety and staffing levels that day
- the physical layout of the ward
- The availability of other staff – e.g. bank/pool, matron, specialist nurses, speciality co-ordinators and allied health professionals.
- The balance of risk across the organisation

The Trust will be moving to a more automated safety brief in the near future, which will be fed directly from the e-rostering system. Staff are being trained on the use of the new software (SafeCare) and it is anticipated that this will go-live during Q1.

The following table provides information on the number of occasions staff have declared their wards unsafe (Red Alert), ahead of a safety brief. These are the times over each month that this rating has been allocated represented as a percentage of the total number of assessments in that month.



The number of red alert declarations remains relatively small overall.

The key areas that remain particularly tight in terms of meeting their full establishments currently are:

- The adult intensive care units continue to experience very high demand, which has continued across the winter. These units are established fully for nursing staff. However, as the numbers of level 3 (maximum intensive care level) patients remain higher than planned. Staff are working additional hours to help manage this.
- Wards H70 (Diabetes and Endocrine) and H500 (Respiratory) are improving the fill rates but some challenges remain.

Staffing levels across a number of clinical areas have been compounded further by the high levels of sickness in both the registered and non-registered nursing workforce as illustrated in the following table. This is of particular significance when considered in relation to the Trust's overall sickness percentage of 3.64%.

Table to illustrate the current Attendance Levels for both Registered and Non Registered Nursing Staff as at 31/01/17

Health Group	Target %16/17	% Sickness	% Long Term Sickness	% Short Term Sickness
Medicine: Registered Nurses	**3.90**	**4.20**	**2.51**	**1.69**
Medicine: Non – Registered Nurses	**3.90**	**4.63**	**1.95**	**2.68**
Surgery: Registered Nurses	**3.90**	**4.84**	**3.11**	**1.73**
Surgery: Non – Registered Nurses	**3.90**	**5.45**	**3.36**	**2.09**
Clinical Support:: Registered Nurses	**3.90**	**3.42**	**1.87**	**1.55**
Clinical Support: Non – Registered Nurses	**3.90**	**6.59**	**4.42**	**2.17**
F&WHG: Registered Nurses	**3.90**	**4.76**	**3.27**	**1.49**
F&WGH: Non – Registered Nurses	**3.90**	**4.54**	**2.99**	**1.55**

The Chief Nurse is concerned about these levels of absence and has commissioned a focused piece of work to understand this further and what is driving these rates. This work will look primarily at how attendance is being managed in accordance with the Trust's Policies and Procedures and, secondly, to gain a greater understanding of the reasons underpinning the high sickness levels across each of the Health Groups.

5. NURSE ASSOCIATE – FAST FOLLOWER PILOT SITE

The Trust has successfully recruited 19 Nurse Associate Trainees. Their training programme will commence on 28th April 2017. Work is being undertaken in conjunction with the University of Hull to develop bespoke practice placements for each of the trainees. In addition, work has commenced with the Charge Nurse/Ward Sisters to look at how the role and course will be evaluated going forward.

6. SUMMARY

Nursing and Midwifery staffing establishments are set and financed at good levels in the Trust and these are managed very closely on a daily basis. The next establishment reviews are due to be completed by the end of March 2017. However, the challenges remain around recruitment and risks remain in terms of the available supply of registered nurses, although this position has improved in the short-term.

7. RECOMMENDATION

The Trust Board is requested to:

- Receive this report
- Decide if any if any further actions and/or information are required.

Mike Wright
Chief Nurse
March 2017

Appendix 1: HEY Safer Staffing Report – January 2017

APPENDIX 1

HEY SAFER STAFFING REPORT JANUARY 2017

NURSE STAFFING

HIGH LEVEL QUALITY INDICATORS *[which may or maynot be linked to nurse staffing]*

HEALTH GROUP	WARD	SPECIALITY	BEDS [ESTAB.]	MONTHLY AVERAGE	DAY		NIGHT		PATIENT TO RN RATIO		RN & AN	ACUITY MONITORING [AVERAGE]					HIGH LEVEL			FALLS				HOSPITAL ACQUIRED PRESSURE DAMAGE						QUALITY INDICATOR TOTAL
				Nurse Staffing Red Alert Status	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	EARLY SHIFT [8:1]	LATE SHIFT [8:1]	NIGHT SHIFT [10:1]	0	1a	1b	2	3	REPORTED STAFFING INCIDENT [DATIX]	OFFICIAL COMPLAINT	DRUG ERROR [ADMIN]	MINOR	MODERATE	SEVERE / DEATH	FALLS TOTAL	GRADE 2 (12 UNAVOIDABLE; 5 AVOIDABLE)	GRADE 3	GRADE 4	DEEP TISSUE INJURY (5 UNAVOIDABLE ; 3 AVOIDABLE)	UNSTAGEABLE (2 AVOIDABLE; 2 UNAVOIDABLE)	PRESSURE SORE TOTAL	
MEDICINE	ED	ACUTE MEDICINE	NA	6%													3	9				2	2						0	14
	AMU	ACUTE MEDICINE	45	0%	85%	127%	98%	89%	7 : 1	7 : 1	6 : 1	39%	15%	45%	1%	0%		1	3	3			3				1	1	2	9
	H1	ACUTE MEDICINE	22	0%	83%	99%	102%	89%	8 : 1	10 : 1	7 : 1	41%	24%	36%	0%	0%		1					0	1			1		2	3
	EAU	ELDERLY MEDICINE	21	3%	96%	97%	67%	117%	6 : 1	7 : 1	7 : 1	70%	0%	30%	0%	0%	1	3		3			3						0	7
	H5	RESPIRATORY	20	0%	91%	98%	96%	95%	10 : 1	10 : 1	8 : 1	20%	21%	59%	0%	0%			2	3			3	1					1	6
	RHOB	RESPIRATORY	6	3%	91%	98%	96%	95%	3 : 1	3 : 1	2 : 1	0%	1%	2%	92%	6%							0						0	0
	H50	RENAL MEDICINE	19	6%	94%	106%	100%	100%	7 : 1	10 : 1	6 : 1	45%	0%	53%	0%	2%							0						0	0
	H500	RESPIRATORY	24	0%	94%	90%	99%	98%	8 : 1	9 : 1	8 : 1	41%	3%	56%	1%	0%	1	1	1				0						0	3
	H70	ENDOCRINOLOGY	30	3%	104%	176%	91%	113%	8 : 1	10 : 1	10 : 1	18%	9%	73%	0%	0%	5			1			1				1		1	7
	H8	ELDERLY MEDICINE	27	0%	80%	113%	100%	100%	8 : 1	10 : 1	9 : 1	8%	0%	91%	0%	0%		2		1			1	1					1	4
	H80	ELDERLY MEDICINE	27	0%	80%	106%	101%	102%	9 : 1	10 : 1	9 : 1	13%	2%	85%	0%	0%	1	1	1	1			1	1					1	5
	H9	ELDERLY MEDICINE	31	3%	98%	102%	99%	105%	9 : 1	10 : 1	10 : 1	19%	1%	80%	0%	0%		1		3		2	5	2					2	8
	H90	ELDERLY MEDICINE	29	0%	98%	94%	100%	97%	9 : 1	10 : 1	10 : 1	24%	2%	74%	0%	0%						1	1	1					1	2
	H11	STROKE / NEUROLOGY	28	0%	80%	146%	94%	97%	8 : 1	9 : 1	9 : 1	43%	12%	45%	1%	0%	5			2			2	1					1	8
	H110	STROKE / NEUROLOGY	24	3%	80%	115%	100%	102%	7 : 1	7 : 1	6 : 1	25%	21%	54%	0%	0%	3	2		3			3	1				1	2	10
	CDU	CARDIOLOGY	9	0%	86%	84%	100%		4 : 1	6 : 1	9 : 1	25%	75%	0%	0%	0%							0						0	0
	C26	CARDIOLOGY	26	3%	80%	79%	83%	95%	6 : 1	7 : 1	7 : 1	35%	40%	23%	2%	0%							0				1		1	1
	C28	CARDIOLOGY	17	0%	81%	107%	85%	53%	6 : 1	7 : 1	6 : 1	12%	40%	48%	0%	0%			1	1			1						0	2
	CMU	CARDIOLOGY	10	6%	81%	107%	85%	53%	3 : 1	3 : 1	3 : 1	1%	13%	22%	62%	2%							0						0	0
	H10	WINTER WARD	27	0%	80%	119%	116%	110%	8 : 1	8 : 1	8 : 1	44%	1%	55%	0%	0%	1		2	1	1		2						0	5
SURGERY	H4	NEURO SURGERY	30	0%	92%	110%	99%	112%	8 : 1	9 : 1	9 : 1	24%	0%	75%	0%	0%	1	2	1				0						0	4
	H40	NEURO HOB / TRAUMA	15	0%	80%	102%	86%	96%	5 : 1	5 : 1	4 : 1	0%	47%	49%	4%	0%			1				0	1					1	2
	H6	ACUTE SURGERY	28	0%	93%	92%	85%	193%	8 : 1	9 : 1	8 : 1	36%	20%	44%	0%	0%	2		1				0					1	1	4
	H60	ACUTE SURGERY	28	0%	95%	90%	91%	191%	8 : 1	9 : 1	8 : 1	35%	20%	46%	0%	0%	1	2	1				0						0	4
	H7	VASCULALR SURGERY	30	0%	96%	89%	93%	97%	8 : 1	8 : 1	9 : 1	32%	8%	59%	0%	0%	4	1					0	1					1	6
	H100	GASTROENTEROLOGY	24	0%	91%	103%	104%	105%	7 : 1	8 : 1	8 : 1	52%	1%	47%	0%	0%				4			4				1		1	5
	H12	ORTHOPAEDIC	28	9%	79%	115%	95%	102%	8 : 1	9 : 1	9 : 1	11%	2%	87%	0%	0%	4	1					0	1				1	2	7
	H120	ORTHO / MAXFAX	22	0%	94%	106%	96%	109%	6 : 1	7 : 1	7 : 1	18%	5%	77%	0%	0%			1	2			2						0	3
	HICU	CRITICAL CARE	22	0%	109%	124%	107%	42%	2 : 1	2 : 1	2 : 1	0%	4%	1%	40%	55%			1				0	2			1	1	4	5
	C8	ORTHOPAEDIC	18	0%	105%	74%	93%	88%	8 : 1	8 : 1	8 : 1	63%	3%	35%	0%	0%	1		1				0						0	2
	C9	ORTHOPAEDIC	29	0%	96%	79%	101%	93%	8 : 1	8 : 1	8 : 1	35%	0%	64%	2%	0%							0				1	1	2	2
	C10	COLORECTAL	21	6%	84%	91%	91%	83%	6 : 1	8 : 1	6 : 1	44%	1%	55%	0%	0%							0	1					1	1
	C11	COLORECTAL	22	0%	94%	91%	84%	103%	7 : 1	8 : 1	8 : 1	43%	1%	56%	0%	0%		1	1				0						0	2
	C14	UPPER GI	27	3%	81%	75%	81%	169%	7 : 1	8 : 1	8 : 1	68%	0%	31%	1%	0%		2			1		1				1		1	4
	C15	UROLOGY	26	0%	85%	80%	89%	96%	6 : 1	7 : 1	7 : 1	70%	3%	27%	0%	0%							0						0	0
	C27	CARDIOTHORACIC	26	0%	84%	97%	86%	122%	6 : 1	7 : 1	7 : 1	42%	0%	58%	0%	0%							0						0	0
	CICU	CRITICAL CARE	22	3%	91%	94%	95%	74%	2 : 1	2 : 1	2 : 1	0%	0%	2%	59%	38%	2	1					0						0	3
FAMILY & WOMEN'S	C16	ENT / BREAST	30	3%	95%	109%	123%	80%	8 : 1	8 : 1	9 : 1	51%	30%	15%	4%	0%	1			1			1						0	2
	H130	PAEDS	20	0%	93%	36%	91%	64%	5 : 1	6 : 1	5 : 1	49%	49%	2%	0%	0%				1			1						0	1
	H30 CEDAR	GYNAEOCOLOGY	9	0%	102%	85%	124%		7 : 1	7 : 1	7 : 1	94%	0%	6%	0%	0%	1	2	1				0						0	4
	H31 MAPLE	MATERNITY	20	0%	79%	95%	88%	100%	5 : 1	5 : 1	6 : 1	100%	0%	0%	0%	0%	2	1		1			1						0	4
	H33 ROWAN	MATERNITY	38	0%	103%	92%	103%	84%	7 : 1	7 : 1	9 : 1	95%	5%	0%	0%	0%		1					0						0	1
	H34 ACORN	PAEDS SURGERY	20	0%	106%	81%	101%	92%	5 : 1	5 : 1	7 : 1	82%	17%	1%	0%	0%							0	1					1	1
	H35	OPHTHALMOLOGY	12	0%	90%	79%	107%		6 : 1	6 : 1	6 : 1	60%	7%	32%	0%	0%			1				0						0	1
	LABOUR	MATERNITY	16	3%	111%	80%	108%	79%	3 : 1	4 : 1	3 : 1	81%	8%	7%	4%	0%		4					0						0	4
	NEONATES	CRITICAL CARE	26	0%	96%	128%	97%	109%	3 : 1	3 : 1	3 : 1	0%	32%	5%	41%	23%			3				0						0	3
	PAU	PAEDS	10	0%	100%		102%		5 : 1	5 : 1	5 : 1	35%	60%	5%	0%	0%							0						0	0
	PHDU	CRITICAL CARE	4	0%	101%	77%	102%		2 : 1	2 : 1	2 : 1	41%	18%	7%	35%	0%							0						0	0
CLINICAL SUPPORT	C20	INFECTIOUS DISEASE	19	0%	104%	96%	100%	91%	9 : 1	9 : 1	6 : 1	67%	0%	33%	0%	0%							0	1					1	1
	C29	REHABILITATION	15	6%	99%	110%	100%	290%	6 : 1	7 : 1	5 : 1	32%	1%	67%	0%	0%	1			2			2	1					1	4
	C30	ONCOLOGY	22	0%	93%	103%	98%	99%	8 : 1	9 : 1	7 : 1	24%	15%	61%	0%	0%							0	1					1	1
	C31	ONCOLOGY	27	0%	88%	115%	98%	96%	7 : 1	8 : 1	9 : 1	45%	6%	49%	0%	0%							0				1		1	1
	C32	ONCOLOGY	22	3%	91%	99%	97%	97%	7 : 1	8 : 1	7 : 1	26%	1%	73%	0%	0%				1			1						0	1
	C33	HAEMATOLOGY	28	0%	82%	128%	95%	100%	6 : 1	7 : 1	8 : 1	61%	11%	25%	3%	0%				1			1						0	1
			AVERAGE:	1.3%				AVERAGE:	6 : 1	7 : 1	7 : 1	38%	12%	40%	7%	2%															
																	TOTALS:	40	39	23	35	2	5	42	19	0	0	9	6	34	178

Jan-17	DAY		NIGHT	
SAFER STAFFING OVERALL PERFORMANCE	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)
HRI SITE	93.0%	103.5%	99.1%	101.1%
CHH SITE	87.9%	93.7%	92.9%	102.9%

Hull and East Yorkshire Hospitals NHS Trust

Quality Report

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Date of inspection visit: 9 June, 28 June – 1 July and 11 July 2016
Date of publication: 15/02/2017

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Hull and East Yorkshire Hospitals NHS Trust operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham. The trust provides services for a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. We inspected all eight core services at HRI and five at CHH. We also inspected the minor injuries service operated by the trust at East Riding Community Hospital and outpatient services at the Westbourne NHS Centre. We did not visit outpatient services which operated in other locations. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

We rated the trust overall as 'requires improvement'. We rated safe, effective, responsive and well led as 'requires improvement' and caring as 'good'. The trust had made improvements since our last inspection but these were not significant enough to change the rating for the trust as a whole. Some areas had made considerable improvements, especially the emergency department (ED) which was now rated as 'good'. Medical care, surgery, and children's services had improved. End of life care which was inspected in 2014 remained 'good' across all domains. However, there was deterioration in the ratings overall for critical care (last inspected 2014) maternity and outpatients & diagnostic services from 'good' to 'requires improvement'.

Our key findings were as follows:

- The care of patients within the emergency department had significantly improved since the last inspection. The trust was meeting the locally agreed trajectories for the number of patients seen within four hours (in June 2016, 85.9% of patients were seen within four hours, which was in line with the agreed trajectory of 85.1%), but was still breaching the national standard of 95%.
- The trust reported and investigated incidents appropriately, the previous backlog had reduced. However, staff in some areas could not tell us about lessons learned or changes to practice including within maternity where a never event had occurred.
- The trust had taken effective action when Radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further seven serious incidents regarding specific patients had been reported four of which related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which, if breached, were reported to the medical director.
- A backlog of 30,000 patient episodes/appointments had been identified by the trust prior to the inspection. A cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had implemented a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- We had concerns within the children's services about: the competency of staff to care for patients with mental health needs; that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and; four safeguarding children guidelines were out of date. However, the parents' sitting room facilities on the 13th floor had been improved following receipt of charitable funds.
- Staff were not always assessing and responding appropriately to patient risk. The trust used a National Early Warning Score (NEWS) and the Modified Early Obstetric Warning Score (MEOWS) to identify deterioration in a patient's condition. We saw some examples of when escalation of a deteriorating patient had not happened in a timely way and some staff were unclear about what to do if a patient's score increased (indicating deterioration). The trust was aware of this and was putting actions in place to improve this.

Summary of findings

- Falls risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in some patient records, which may have resulted in a failure to identify patients at risk of malnutrition. We also found poor compliance with the completion of fluid balance charts.
- Nurse staffing shortages were evident across the majority of medical and surgical wards and the trust's safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators. The maternity service did not collect the relevant data and therefore could not provide assurance that women received one to one care in labour.
- There were also some gaps within the medical staffing, especially within critical care and paediatrics.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2 which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016 which was similar to the England ratio (100) of observed deaths and expected deaths.
- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb). This meant that deaths within these areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable, what lessons could be learnt and actions were put in place.
- Although medicines were stored and administered appropriately, we found gaps and errors in the recording of medicines administration and in the monitoring of checks of controlled drugs which had been a concern at our 2015 inspection.
- Leadership had improved. There was a clear vision and strategy for the trust with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork.
- Feedback from patients and relatives was positive. We saw good interactions between staff and patients. Staff maintained patients' privacy and dignity when providing care. Caring within medicine had improved although there were some instances on the acute medical unit at HRI where not all call bells were within reach of patients.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks, if required, during the day.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited.
- There had been a significant improvement in the operating theatre environment at HRI.

We saw several areas of outstanding practice including:

- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award for their training courses and had been asked to write an article for a national nursing journal.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital.
- The responsiveness of the Specialist Palliative Care team (SPCT) in relation to acting on referrals.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones.
- The International Glaucoma Association had awarded the ophthalmology department an innovation award for their glaucoma monitoring work.

Summary of findings

- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology.
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must ensure that:

- Planning and delivering care meets the national standard for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- A review of the process for categorising incidents occurs, including safeguarding incidents, relating to children, to ensure effective investigations and that lessons are learnt.
- Staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- Learning from never events is further disseminated and lessons learnt are embedded.
- Staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment, and; that the escalation procedures are audited for effectiveness.
- Staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- Work continues actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.
- Staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- Staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- Staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/taken by the patient.
- Records of the management of controlled drugs are accurately maintained and audited within A&E.
- Patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- Antenatal consultant clinics have the capacity to meet the needs of women and that there is enough capacity in the scanning department to implement the Growth Assessment Protocol (GAP).
- There is effective use and auditing of best practice guidance such as the "Five steps to safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The critical care risk register is reviewed to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- Ensure outpatient services have timely and effective governance processes in place which identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- Medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient and maternity services.
- At all times there are sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national

Summary of findings

guidance, taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

- Continues to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.
- It takes further steps to improve the facilities for young people on the 13th floor of HRI.

In addition there were areas where the trust should take action and these are reported at the end of the two individual hospital reports.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Hull and East Yorkshire Hospitals NHS Trust

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 as a result of a merger between Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. It operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham.

The trust provides a range of acute services to the residents of Hull and East Riding of Yorkshire area, as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire. Hull Royal Infirmary is a major trauma centre for the region and Castle Hill Hospital has the regional Queen`s Centre for oncology and haematology. The trust also provides clinical services, mainly outpatients at other locations within the Hull and East Riding of Yorkshire area, for example the Freedom Centre in Hull and East Riding Community Hospital in Beverley.

The trust provides services for a population of approximately 602,700 people mainly across two local authority areas. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

Kingston Upon Hull Unitary Authority scored significantly worse than the England averages for 21 of the 32 indicators in the 2015 Area Health Profiles. The city had the highest long term unemployment of any local authority in England. It also scored particularly badly for smoking prevalence; smoking-related deaths; deaths from cancer among under-75s and; female life expectancy. The city scored significantly better than the England average for incidences of malignant melanoma and tuberculosis (TB). The cancer mortality rate in Hull (360.8 per 100,000) is significantly higher than the England average (285.4 per 100,000). By contrast East Riding of Yorkshire Local Authority scored significantly better than the England averages for 14 of the 32 indicators in the area health profiles. The East Riding area scored significantly worse than the national average for three indicators: smoking status of pregnant women at the time of delivery, recorded diabetes and deaths and serious injuries on roads. In the 2015 Indices of Multiple Deprivation, Hull was ranked as the third most deprived of all local authorities in England. The East Riding of Yorkshire was significantly better and was ranked the 195th most deprived local authority in England.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. The trust has been inspected a number of times previously and a summary of the regulatory breaches is provided below.

The inspection in May 2015 was a focused inspection which did not look across the whole service provision; but focused on the areas defined by the information that triggered the need for the focused inspection including the previous inspection in February 2014. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services inspected. The overall rating for the Trust was 'Requires improvement'. The Trust was found in breach of the Health and Social Care Act (Regulated Activities) regulations 2014. These included: Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs), and Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good governance) and Regulation 18 (Staffing).

At the first comprehensive inspection in February 2014, using the Care Quality Commission's (CQC) new methodology, HRI and CHH were found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 22 (staffing) and 23 (staff support). Additionally HRI was also found in breach of regulation 15 (premises).

Hull Royal Infirmary was inspected in June 2012 and October 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication). In December 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

Summary of findings

Castle Hill Hospital was inspected in June 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication) In October 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken: NHS non-executive director and former government lawyer

Head of Hospital Inspections Julie Walton: Care Quality Commission

The inspection team consisted of two inspection managers, 18 CQC Inspectors and 24 specialists including; an A&E doctor and nurse, a critical care doctor and nurse, two end of life nurses, a maternity doctor and midwife, a medical doctor and nurses, an outpatient doctor and nurse, a paediatric doctor and nurse, a surgery doctor and nurse, radiographer, a junior doctor, two student nurses and three trust-wide specialists.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services during the inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of Life Care
- Out patients and Diagnostics

We inspected all eight core services at HRI and the five that were provided at CHH. We also inspected the minor injuries service operated by the trust at the East Riding Community Hospital and outpatient services at the Westbourne NHS Centre. We did not visit any outpatient services which operated in other locations. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

Before visiting, we reviewed a range of information we held about the hospitals and asked other organisations to share what they knew with us. These organisations included the local Clinical Commissioning Groups, NHS England, NHS Improvement, Health Education England, Healthwatch, various medical Royal Colleges and other stakeholders.

We held two public engagement sessions using stalls prior to the inspection to hear people's views about care and treatment received at the trust; one at HRI and the other at CHH. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended these events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists and administration staff. We also

Summary of findings

spoke with staff individually as requested. We talked with patients, families and staff from ward areas. We observed how people were being cared for and reviewed patients' personal care and treatment records.

What people who use the trust's services say

In the Friends and Family Test the percentage of patients who said they would recommend the trust was consistently equal to or higher than the England average.

The trust's own 2015 bereavement survey showed that most (87%) bereaved relatives felt that their relative received a high standard of care; 9% of relatives disagreed with this and 4% did not respond to the question on the survey.

In the national Cancer Patient Experience Survey 2013/14, the trust was in the bottom 20% of trusts for six of the 34 indicators, four of which related to communication. The trust was in the top 20% of trusts for one indicator (which also related to communication): patients being told that they could be given free prescriptions.

The trust performed worse than the England average for three of the four areas in the Patient Led Assessments of the Care Environment 2015. Food was the only area where the trust performed better than the England average.

Facts and data about this trust

The trust had 1,294 beds at the time of the inspection of which: 1,162 were available for general and acute care, 77 for maternity and 40 for critical care. The trust's management structure was based on health groups: surgery, medicine, family and women's health and clinical support along with the corporate functions.

As of 1 April 2016 there were 6,979 whole time equivalent (WTE) staff in post against an establishment of 7,620 WTE. Of these, 956 were medical roles (against an establishment of 1010); 2,778 were nursing roles (against an establishment of 3,066) and; 3,245 were other roles (against an establishment of 3,544).

The medical staff skill mix had similar percentages to the England average with 37% being consultants compared with 39% nationally; 5% were middle career compared with 9% nationally; specialist registrars were 40% compared with 38% nationally and junior doctors were at 18% compared with 15% nationally.

The financial data for 2015/16 included:

- Revenue: £526 million
- Full Cost: £534 million
- Deficit: £8 million

The types of activity at the trust for 2015/16 was:

- Inpatients: 119,751
- Outpatient (total attendances): 694,981
- Accident and emergency attendances: 121,963*
- Attendances to minor injuries unit: 13,414*

*W/c Monday 30 March 2015 to w/c Monday 21 March 2016

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated this trust as 'Requires improvement' for safe in 2015. Whilst there had been improvements in some areas the rating remained as 'Requires improvement' because: • Staff were not always assessing and responding appropriately to patient risk. This included not responding effectively when using early warning score systems to identify deterioration in a patient's condition. The trust was aware of this and was putting actions in place to improve this. • In addition, falls and dementia risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in some patient records, and we also found poor compliance with the completion of fluid balance charts. • From observations the five steps to safer surgery checklist process was not embedded as a routine part of clinical roles. • Nurse staffing shortages were evident across the majority of medical and surgical wards and the trust's safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators. The maternity service did not collect data and therefore could not provide assurance that women received one to one care in labour. There were also some gaps within the medical staffing. • We found gaps and errors in the recording of and signing for medicines administration and in the monitoring of checks of controlled drugs. Since our visit the trust informed us it had taken action to strengthen its audit arrangements for medicines. • Between May 2015 and April 2016 there had been three never events. Staff in some areas, for example maternity, could not tell us about lessons learned or changes to practice following one of the never events. • We had concerns within the children's services that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt. • Four safeguarding children guidelines were out of date. • In addition, a cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had	**Requires improvement** 

their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

However,

- The trust investigated incidents appropriately and the previous backlog had reduced. The trust had taken effective action when radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further seven serious incidents regarding specific patients had been reported, four of which related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited.
- The theatre environment had undergone major improvements at HRI following the 2015 inspection.
- Nurse and medical staffing had improved in the emergency department and in electrocardiography and histopathology.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had in place a policy relating to the duty of candour requirements.
- Incident information reported under the duty of candour requirements was included in the electronic incident reporting system. Senior managers confirmed that the recording and follow up of incidents related to duty of candour had improved significantly since our visit in 2015. Training in duty of candour had increased staff awareness, which was supported by a weekly meeting to discuss reported incidents.
- It was included in the scorecard for the Health Groups' performance meetings which were held monthly with executive directors; the DATIX incident reporting system had been amended to ensure that duty of candour was a mandated field. This allowed for review of compliance against policy.
- Qualified nursing staff that we spoke with were aware of the duty of candour requirements and confirmed that their service

and the wider trust encouraged them to be open and honest following a reported incident and to ensure appropriate verbal and written apologies were provided for patients. However, we found that not all unqualified staff were aware of the duty of candour requirements.
- Our own review of incidents confirmed that duty of candour was applied effectively.

Safeguarding

- There had been a recent change (from the 1 June 2016) with the senior leadership and oversight of children's safeguarding. It had been moved from the Family and Women's Health Group to corporate oversight under the Chief Nurse and assistant Chief Nurse. We were told this was to bring more focus and corporate accountability for child safeguarding.
- The Assistant Chief Nurse was also, and had been for some time, the trust lead for adult safeguarding.
- The trust employed both the local 'Designated doctor for Safeguarding Children' (for both NHS Hull and NHS East Riding Clinical Commissioning Groups) and the 'Named doctor for Safeguarding Children'. However, the latter was on maternity leave at the time of the inspection. We were told the Named doctor role was being covered by the 'Designated doctor' with support from the other trust named professionals (Named nurse and Named midwife) as well as the 'Designated paediatrician' for child deaths who was also an experienced paediatrician in safeguarding children.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situations where abuse or neglect of children is suspected'. However, four other specific guidelines we reviewed on the trust's intranet were out of date including 'Safeguarding children: children and domestic violence' which expired in September 2015. 'Safeguarding children in whom illness is fabricated or induced', expired in June 2015, 'Safeguarding children: managing allegations or concerns against staff', expired in June 2014 and 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.
- The guidance included the local safeguarding pathways and contact details. Staff were aware how to access these on the intranet.

Summary of findings

- Staff we spoke with were clear on their adult safeguarding responsibilities and knew where to seek advice and report concerns. Adult patients with safeguarding concerns were documented as part of the trust daily safety brief.
- We had concerns about recognising, recording and investigating safeguarding incidents within the children's services. We reviewed previous incidents relating to children and these had been correctly identified as requires reporting and had been logged. At least three that we reviewed had been categorised as no or low actual harm, although the potential for harm was significant. No actual harm had occurred to the children but because of the grading of the incidents they had not been fully investigated and lessons had not been learnt. We raised this with the trust at the time of the inspection and they subsequently re-categorised one of them as a serious incident and instigated a root cause analysis investigation. In addition, we were informed that the trust had changed its governance procedures of all incidents from 1 April 2016. There was a tier two review system where reviewers looked at all incidents to check the category given and also assess for any actions required regardless of the grading of the incident. We did not have evidence that this was embedded at the time of the inspection.
- Staff completed safeguarding children level one and vulnerable adults training as part of their mandatory training. Compliance with this training was good at 86.6% for safeguarding children and 88.4% for vulnerable adults training. Both exceeded the trust target of 85%.
- Level two for child safeguarding was also above 80%. Training records showed 88.6% of nursing and midwifery staff and 84.6% of medical staff in the Family and Women's Health Group had completed safeguarding children level two training.
- Overall the trust was at 67% for the completion of level three safeguarding children. Information provided by the trust following the inspection, showed the children's service had achieved 71.3% level three safeguarding children training. They also stated they were on track for delivery of their training target by the end of August 2016. The information had been included on the trust risk register for monitoring purposes.
- Further information provided by the trust showed 100% of nursing and midwifery staff in gynaecology had completed safeguarding children level three training; however 0% of medical staff had completed the training. In obstetrics, 73.6% of nursing and midwifery staff had completed safeguarding level three training, no information was provided for medical staff in obstetrics.

- For the emergency department, 91% of medical and 90% of nursing staff had completed vulnerable adults' level three training. In addition, we found that 89% of medical and 95% of nursing staff had completed safeguarding children level three training.

Incidents

- There were 93 serious incidents reported between May 2015 and April 2016, including three never events. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- There had been two never events declared in radiology at the CHH site since the last inspection, both involving wrong site/ side surgery.
- A new radiology checklist had been introduced following the never events, however no audits had been carried out to confirm staff compliance with its completion. Senior staff said audits were due to start in August 2016. This meant there was no evidence of assurance about the safety of patients undergoing similar procedures in the future. There had been a third never event in Radiology in March 2016.
- The maternity never event was an incident of type "retained foreign object post-procedure". The trust had developed an action plan and recently a training video to highlight learning from this incident. We asked staff about lessons learnt from incidents, only one midwife referred to the never event. We were not assured that learning from the never event had been embedded.
- In addition, we were concerned that not all incidents/'near misses' including some potential safeguarding incidents, had been classified correctly within children's services and therefore not fully investigated or possible lessons learnt.
- Treatment delays were the most common type of serious incident reported (18). This was followed by surgical or invasive procedure incidents (16), slips, trips and falls (11) and pressure ulcers (10).
- Once identified as requiring investigation, the trust investigated incidents appropriately and the previous backlog had reduced. Not all staff were able to give examples of lessons learnt from incidents.
- Radiology had reported a serious incident in December 2015 related to a failure to print up to 50,000 radiology reports. A further seven serious incidents had been reported, four of

which related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.

- A cluster of eight serious incidents had been declared in Outpatients relating to patients that had not had their appointments when they should. Three of these serious incidents were at the HRI site and six at the CHH site; all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

Staffing

- The Chief Nurse presented a monthly report to the board covering the monthly planned and actual staffing levels for nursing, midwifery and health care staff. From July 2015 to June 2016 at HRI the registered nurse (RN) fill rates ranged from 80.25% to 87.14% except for September 2015 when the day fill rate was 79.77%. From July 2015 to June 2016 at CHH the registered nurse (RN) fill rates ranged from 82.06% to 91.91%.
- The turnover of nursing staff was approximately 7% with agency use at 1.3%. The sickness absence rate was consistently below the England average between December 2014 and November 2015.
- There were pressures in recruiting to optimal staffing levels in some areas. From board reports these areas were the Clinical Decision Unit (CDU) at HRI; H70 (Diabetes and endocrine) at HRI; C30, C31 and C33 oncology wards at CHH; critical care units and the neonatal unit. Staffing risks were being managed on a daily basis and some agency staffing were being utilised in these areas.
- At the time of the inspection the Trust has offered 74 jobs to the August/September 2016 student outtake from the local university. There was a proposal to undertake a recruitment initiative for 100 nurses from overseas, which was subject to final confirmation of the funding. The inability to recruit sufficient numbers of registered nurses in order to meet safer staffing requirements was recorded on the risk register.
- There were twice-daily safety briefings, led by a health group nurse director (or site matron at weekends) to ensure at least minimum safe staffing in all areas. The Trust had sustained its minimum standard, whereby no ward was ever left with fewer

than two registered nurses/ midwives on any shift. These briefings covered any staffing issues including acuity of patients, any patients with learning difficulties, patients at risk of falls and safeguarding concerns.

- As part of safety escalation processes staff were able to declare their wards unsafe (red alert), ahead of a safety briefing.
- In the emergency department nurse staffing had improved and was close to meeting planned establishment levels; medical staffing had also significantly improved since our previous inspection in 2015.
- There were staff shortages of nursing and medical staff; these shortages were evident in many areas including surgery and medicine. The trust recognised that nurse staffing was an issue and had introduced new non-registered roles to support nursing staff. Discharge facilitators helped manage patients discharge processes and ward hygienists took the lead in cleaning equipment. This allowed nurses and health care assistants more time for other duties.
- There were shortages of medical staff especially within the division of medical elderly (DME) and acute medicine. For example, there was a planned establishment of ten whole time equivalent (WTE) consultants in DME however, only six WTE were in post.
- The maternity service did not collect data and therefore could not provide assurance that women received one to one care in labour. The service was also not meeting the national benchmarking for midwifery staffing.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff.
- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014 regarding critical care. For example, staffing in the critical care outreach team and the frequency of the consultant on call rota.
- Medical staffing was not in line with guidelines for the Provision of Intensive Care Services (2015) as some patients were not seen by a consultant within 12 hours of admission, twice daily ward rounds did not take place and the out of hours medical staff to patient ratio was higher than recommended.
- The risk register showed in March 2016 the allocation of junior doctors to the general paediatrics and neonatology speciality had resulted in several unfilled posts. Plans had been put in place in an attempt to mitigate against this risk, these included: an attempt to recruit locum trust doctor posts and consultants to work twilight shifts on locum pay in order to support the service. The risk was to be reviewed in June 2016.

Summary of findings

Medicines management

- Trust policies were regularly reviewed and covered most aspects of medicines management. These were accessible via the hospital intranet to all staff. A self-medication policy was also in place, however we saw two examples of patients on medical wards who were looking after their own medicines and no assessment of their ability to do so had been completed.
- The ward-based clinical pharmacy service was available during normal working hours at both sites with a basic dispensary service at the weekends. Pharmacy staff checked (reconciled) patients' medicines on admission to wards and this was audited regularly. Staff also received a daily email about snapshot medicines reconciliation rates to focus on problem areas. The trust had set a target of 80% for medicines reconciliation within 24 hours of admission; audit figures showed the average was 44% between January and March 2016. The pharmacy department had recently recruited a number of new staff which had helped to improve the medicines reconciliation average to 73% between April and June 2016. Although improvements had been made, we found a number of patient records where medicines reconciliation had not been completed in a timely manner.
- Aspects of medicines management were regularly audited across the trust including the safe and secure handling of medicines, antibiotic prescribing, clinical pharmacist activity, delayed and omitted doses, and the management of controlled drugs. Detailed action plans had been developed to drive forward improvements where they were necessary, for example the trial of pharmacy assisted medicines rounds to reduce delayed and omitted doses. This work was supported by the production of an annual report which gave assurances to the trust board quality committee on medicines optimisation.
- At our previous inspection in 2015 we found daily checks of resuscitation equipment and controlled drugs were not being properly completed. Audits carried out by pharmacy staff in quarter three of 2015/16 had identified the same problem, and this remained a concern during this inspection. We found gaps in records of resuscitation equipment checks on eight of the 16 wards we visited. Daily checks of controlled drugs had improved, however we still found a number of gaps in records on the Acute Medical Unit (AMU) and in the emergency department. In addition we saw when checks had identified discrepancies these were not reported as incidents in accordance with the trust policy.
- We checked the storage arrangements for medicines requiring refrigeration and found gaps in temperature records on nine of

the 18 wards we visited. On a number of occasions no action had been taken when temperature readings were outside the recommended range of two to eight degrees Celsius. In some cases, the ward manager did not know there had been a problem with the fridge, and some of the staff we spoke with were unaware of the correct escalation procedure to follow in the event of refrigerator malfunction.

- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust governance arrangements. Staff we spoke with knew how to report incidents involving medicines and we saw examples of learning from errors being shared at ward level. Significant incidents were discussed at the Safe Medication Practice Committee and appropriate actions taken in response to concerns.
- There was a medicines safety officer supported by a dedicated technician, who was involved with medicines safety initiatives in collaboration with other key stakeholders such as the trust medicines management nurse. We observed a trial of a pharmacy-supported medicines round during our inspection and saw how nurses were supported by a member of pharmacy staff to reduce delayed and omitted doses. We also saw that patients' 'take home' medicines were dispensed by pharmacy staff on some of the wards, which helped to reduce waiting times for discharge medicines.
- Patient Group Directions (PGDs) were in use in some areas of the trust and these were prepared and used in a safe way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked PGDs used in the emergency department at Hull Royal Infirmary and saw they were being used effectively to support patient access to medicines in a timely way.
- We saw that nurses did not always follow trust guidance when administering medicines. For example, on both Ward 8 and Ward 9 at HRI we saw nurses sign to confirm the dose had been given prior to administering the medication. Although one nurse said this was not normal practice, the other nurse thought this was normal practice as she had observed this during her supernumerary status. We raised this with the ward managers at the time of inspection.
- During our inspection, we found that staff at Castle Hill Hospital were not completing four hourly checks of the syringe drivers and the infusion sites in line with trust policy. The trust had

taken steps to address our concerns including communication being sent to all wards and a member of the Specialist Palliative Care team told us that they were completing a trust wide audit of this issue.

Assessing and responding to risk

- Risks to all patients in the emergency department were reviewed every two hours by medical and nursing staff working together. Risks were identified and escalated appropriately. However, in other core services the escalation of risk was not always responded to an appropriate or timely way.
- The trust used a national early warning score (NEWS) to identify deterioration in a patient's condition. However, we saw examples of where staff had been unclear about what to do if the score increased / a patient's condition deteriorated in both the general wards and in maternity. We saw examples of a lack of escalation/actions taken, following an escalated score across both sites and a number of wards. The trust was aware of this and was putting actions in place to improve this.
- We saw two patients during our inspection that were referred to critical care requiring level three care that had not been escalated in line with trust policy. When critical care staff reviewed these patients, their assessment found them to be inappropriate for admission to critical care. The critical care outreach team had been involved in work to address this with the resuscitation and deteriorating patient committees and a trial of electronic observations had taken place on some wards.
- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the NEWS respectively to assess the health and wellbeing of women. We reviewed MEOWS charts and found it was unclear from the observation charts when a patient should be escalated and how frequently their observations should be repeated. The observation charts advised staff to "contact a doctor for early intervention if the woman triggers one red or two yellow scores at any one time". However, there was no further guidance on how frequently observations should be repeated. We spoke with five midwives and they all said they would use their clinical judgement to determine how frequently a patient's observations should be repeated, they were not aware of any guidance.
- The trust had introduced daily 'Board rounds' where senior medical staff met with nursing and other clinical staff, usually between 8-9am, to review the care and treatment requirements

of patients. These were multidisciplinary and included both the night and day medical staff. We saw this in operation on some wards, for example, ward 90, but it was not consistent across the trust.

- The critical care outreach team was available 24 hours a day, seven days a week. The team consisted of senior nurses who were supported by a consultant intensivist for one session a week. They supported patients stepped down from critical care and reviewed patients alerted to them through the NEWS referral system. The team also supported patients nursed on wards with tracheostomies, delivered non-invasive ventilation outside of critical care units and were a member of the cardiac arrest and trauma team.
- In 2015, the trust was asked to take action to ensure use of the best practice guidance, such as the five steps to safer surgery checklist. The hospital did undertake the five steps to safer surgery which incorporated the World Health Organisation (WHO) safety checklist. The hospital reviewed compliance with the checklist via audit, with five sets of notes being checked every month, for every theatre. Results we reviewed showed 100% compliance, however an internal audit report provided to us by the trust reported 54% compliance in the reporting period November 2015 to January 2016. The report was completed for 50 patients in most specialities, a recommendation from this report (published in March 2016) was to re-audit one month later and set up a working group to review the form. Post the inspection, the trust confirmed that a working group had not been developed and no further audit had been completed. A new theatre assurance tool had been developed since the internal audit results. The results of this in June 2016, showed 100% compliance for the WHO checklist.
- During the inspection, we reviewed 16 sets of surgical notes containing WHO checklists and we observed 15 occasions when WHO checklists were completed. On the majority of occasions the checklists were completed; however from our observations it was apparent the completion was undertaken without effective involvement of the whole clinical team. For example, sign in and final briefing had no input/involvement from the operating surgeon. No verbal communication was apparent for sign in and final brief on two occasions and on another occasion a band two member of staff had signed for the instrument count. It was unclear whether a registered member of staff oversaw this. We also noted that on five occasions no verbal communication occurred on the appropriate use of antibiotic prophylaxis, pre-operative warming, blood glucose

control or VTE risk assessment, this should occur in the time out step. In addition, in the records we reviewed, we found inconsistencies in the completion of Trust's revised maternity WHO checklist.

- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited. The use of swab counts varied with some staff saying the reason a swab count was not done was because the surgical incision was non-invasive/very small and a swab could not be lost in such a small cavity. Others confirmed they performed a swab count to ensure no swabs were left in a cavity and/or the theatre environment. A process of counting swabs between two members of staff provides assurance that all swabs are accounted for at the end of each surgical procedure.

Environment and equipment

- In 2015, the trust was asked to take action to address concerns identified regarding the flooring and walls within theatres. The trust was also asked to review access and waiting areas for theatres and recovery area. During this inspection, we noted major improvements in the theatre environment. Work was still to be completed; however, the work carried out to date provided an improved environment for patients and staff and improved compliance with infection prevention and control standards.
- In 2015, the trust was also asked to review access and security arrangements for theatres and recovery area at Castle Hill Hospital This work was completed one week after the inspection.

Records

- The wards and departments used risk assessments to determine a variety of care needs. We reviewed a sample of these across the trust. They showed that; documentation for falls and completion of dementia and delirium pathways were not always completed accurately, especially on wards 12 and 120 at HRI. We reviewed twelve sets of notes and found that two had been completed correctly; staff were able to explain the process of falls assessments. On the majority of occasions, staff completed pressure care assessments and intentional rounding documentation accurately.

Summary of findings

- Nutritional assessments were partly completed in some patient records, and we also found poor compliance with the completion of fluid balance charts.
- In critical care, nursing documentation included care bundles and quality and safety checklists. Staff explained how these were used, however, we found numerous occasions where the quality and safety checklists were not completed at night time. We raised concerns about this with senior staff during our inspection.
- On the children's wards the care documentation did not clearly reflect the mental health needs of patients and how those needs would be met.

Are services at this trust effective?

Requires improvement

We rated this trust as 'Requires improvement' for effective in 2015 and this remained unchanged for the 2016 inspection because:

- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb).
- Only twenty five percent of critical care nurses had completed a post registration critical care qualification. This was lower than the national minimum recommendation of 50%.
- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.
- At CHH some staff did not possess specialist competencies required for the medical ward they were on although the trust had put mitigating actions in place.

However,

- Patients' care and treatment followed evidence based guidance and recognised best practice standards which were monitored for consistency.
- Patients' consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act were followed where this was appropriate.
- There was mixed performance outcomes across the data for the national clinical audits. For example, in the National Diabetes Inpatient Audit 2015, the trust was in the top 25% for England for eight of the 18 indicators. However, the trust was in the lowest 25% for England for prescription errors (31.4%). Most patient outcomes in critical care were in line with similar units.
- We observed patient centred multidisciplinary team working.

Evidence based care and treatment

Summary of findings

- Patient care and treatment followed evidence based guidance and recognised best practice standards, including NICE and the Royal Colleges which were monitored for consistency. For example, the emergency department used the College of Emergency Medicine (CEM) guidance with supporting clinical guidelines and patient group directions to ensure the effectiveness of treatment provided for patients.
- The trust participated in national and local clinical audit programmes. There were actions plans in place to further improve the care of patients for most of the audits we reviewed, the main exception being surgery.

Patient outcomes

- Most patient outcomes in critical care were in line with similar units.
- The trust monitored and recorded maternity patient outcomes on a monthly performance dashboard. The trust had started to participate in a Yorkshire and Humber regional performance dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues.
- The percentage of births that were normal vaginal deliveries was slightly above the England average of 60% from January 2015 to March 2016. The percentage of elective caesarean deliveries had increased to 12.9% in January 2016, 12% in February 2016 and 14.1% in March 2016. This was in line with the trust target of 13.9% but above the England average of 11.3%.
- The number of emergency caesarean deliveries between January 2015 and December 2015 was 13.8%; this was lower than the England average of 15.3%. Data from the trust maternity dashboard showed the percentage of emergency caesarean sections had increased above the trust target of 12.1% in January 2016 to 16.2%. The percentage reduced to 10.9% in February 2016 and increased again in March 2016 to 13.6%.
- National audit performance was variable within surgery; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 showed that the trust score was worse than the national average for six out of the 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.

Summary of findings

- In the National Diabetes Inpatient Audit 2015, the trust was in the top 25% for England for eight of the 18 indicators. However, the trust was in the lowest 25% for England for prescription errors (31.4%).
- In the Sentinel Stroke National Audit Programme (SSNAP), the trust scored D for SSNAP for the first three quarters from January to December 2015, but improved to a score of C in the last quarter. The trust's score for the team-centred scanning indicator improved from C in the first two quarters to A in the latter two quarters.
- Hull Royal Infirmary had mixed performance in the Heart Failure Audit 2013/14. The hospital scored better than the England average for two of the four in-hospital care indicators, and four of the seven discharge indicators.
- In the Myocardial Ischaemia National Audit Programme (MINAP) 2013/14, a lower proportion of Hull Royal Infirmary's patients with nSTEMI were seen by a cardiologist or member of their team and a lower proportion were admitted to the cardiac unit or ward.
- The endoscopy service had achieved Joint Advisory Group on gastrointestinal Endoscopy (JAG) accreditation.
- From December 2014 until November 2015 the emergency readmission rate (within two days of discharge) for the under one year of age group was 3.6 patients. This was similar to the England average of 3.3.
- Multiple readmission rates for the one year age group in asthma, diabetes and epilepsy were lower and therefore better than the England average. The multiple readmission rates in the one to17 year old age group was higher than the England average for asthma (19.6% compared to 16.5%) , about the same as the England average for diabetes (13.6% compared to 13.2%) and lower than the England average for epilepsy (26.1% compared with 28.6%).
- There were emergency readmissions among patients in the 1-17 year old age group between November 2014 and October 2015. However, no treatment specialty reported six or more readmissions.
- The National Neonatal Audit Programme 2014 (published in November 2015) identified the percentage of babies less than 33 weeks gestation at birth receiving at least some of their own mother's milk at discharge home was 61%. This was similar to the England average of 60%.

Summary of findings

- All of the pathology departments at the trust were accredited. The United Kingdom Accreditation Service had inspected histopathology in September 2015; the laboratory manager told us this was a surveillance visit and compliance was maintained.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2 which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016 which was similar to the England ratio (100) of observed deaths and expected deaths.
- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb). This meant that deaths within these areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable and what lessons could be learnt.
- The septicaemia (except in labour) outlier meant that there had been a higher number of deaths than expected for patients with sepsis. There were actions in place to improve the outcomes for patients with sepsis. In the trust's quality improvement plan, we saw a project to raise awareness of the Sepsis Six, implement the sepsis care bundle and reduce death from sepsis. Data from the trust indicated that this was improving.
- At the time of the inspection we were awaiting further information on the trust's response regarding the CABG and reduction of fracture of bone (upper and lower limb) mortality outlier alerts.

Multidisciplinary working

- We saw good examples of multidisciplinary team (MDT) working during our inspection.
- A recent development was for wards to carry out multidisciplinary daily board rounds in addition to weekly multidisciplinary meetings. We saw these in operation every two hours in A&E but they were yet to be embedded on all of the wards. Therapists had an individualised activity plan for each patient, this information fed into the MDT meeting.

- An MDT of doctors, nurses, care support workers, physiotherapists, occupational therapists, dieticians and specialist nurses cared for stroke patients on Ward 110. An MDT meeting was held every Tuesday afternoon.
- The vulnerabilities midwife worked closely with community midwives, and there was a process in place for women who did not attend antenatal appointments.
- We saw examples of staff interacting, both formally and informally, to discuss patients' care between teams and seek advice from colleagues.
- We saw paediatricians and nursing teams, along with other allied healthcare professionals (dieticians, physiotherapists, pharmacists, play specialists) working well together.
- The Child and Adolescent Mental Health Service (CAMHS) team telephoned the ward each day to receive an update on their patients. They also visited twice a week if they had patients on the ward.
- The Specialist Palliative Care team (SPCT) held an MDT each week. A member of the chaplaincy team also attended the meeting. All new referrals to the service (both in-patient and outpatient) and ongoing complex patients were discussed at the MDT. In addition to the weekly MDT, the nursing staff from the SPCT also held a daily board round.

Competent staff

- Figures submitted by the trust indicated that the overall appraisal rate for 2015/16 was 78.9% with only the Family and Women's Health Group exceeding the trust's appraisal target of 85%.
- At the time of the inspection the human resources (HR) director indicated that the overall appraisal rates were 87% for medical staff and 81% for most other staff groups.
- Twenty five percent of nurses in the critical care service had completed a post registration critical care qualification. This was lower than the national minimum recommendation of 50%. All staff completed the national competency framework for adult critical care nurses as the first step towards meeting the post registration in critical care qualification recommendation.
- Staff on the paediatric ward may not have had the knowledge to care for children and young people with actual or suspected mental health needs. At the last inspection this was identified and the trust provided an action plan to deliver some bespoke training from the local child and adolescent mental health service (CAMHS). The training had not taken place. Following this inspection, the trust wrote and provided assurance to the

CQC that a training needs analysis to review their competencies had taken place. A meeting had also been arranged with CAMHS services in July 2016 to review staff training needs and determine what other level of support and training could be offered to the staff. Training was identified to start in September 2016 and be delivered by CAMHS.

- At CHH some staff did not possess specialist competencies required for the medical ward they were on although the trust had put mitigating actions in place.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients were consented to surgery in line with trust policy and department of health guidance.
- We observed staff obtaining verbal consent and giving explanations prior to completing a procedure.
- Patients we spoke with also said that staff asked for consent prior to delivering care.
- Staff we spoke with demonstrated an understanding of consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff were more confident with the process as they worked in areas where it was more likely that patients required a DoLS to be put in place.
- The DoLS protocol was on display on some of the wards.
- We looked at the paperwork for two patients with a DoLS in place. This was appropriately completed and reviewed daily for one patient. However, some daily reviews had been missed for the other patient.
- To aid monitoring the Trust's IT system was able to identify any patient that had a DoLS in place.
- There was variable compliance with staff training in the MCA and DoLS across the staff groups, none of which achieved the Trust's 85% target. Overall 79.5% of the nursing and midwifery staff had received training; 14.6% of medical staff; 28% of health care assistants and other support staff; 22.9% of healthcare science staff; 56.5% of scientific, therapeutic and technical staff and; 46% of administration and estates staff.
- Compliance for staff within medical care services for DoLS and MCA training was 86.8% and 87.6% respectively, therefore achieving over the trust target of 85%. The lowest compliance was for health care assistants in chest medicine, who achieved 62.5%.
- Staff we spoke with in children's services understood the Gillick competency requirements regarding consent for children. However, staff within maternity and gynaecology services could not articulate what was meant by Gillick competence and were

unable to provide evidence of how they would ensure a patient had the maturity to make a decision about their care and treatment. The one exception was staff in the pregnancy advisory service that used Gillick competencies as part of their pathway to assess if a patient could make decisions about their treatment.

Are services at this trust caring?

Good

We rated this trust as 'Good' for caring in 2015. In 2016 it was also rated as 'Good' because:

- Feedback from patients and relatives was positive. We saw good interactions between staff and patients.
- Staff maintained patients' privacy and dignity when providing care.
- Patients and relatives told us that staff kept them informed of their treatment and progress and involved them in decision-making.
- There was good emotional support available through the chaplaincy service and there was a multi-faith prayer room within the hospital.
- At the 2015 inspection, we rated medicine at HRI as requires improvement for caring. At the 2016 inspection we found there had been improvements in care and rated it as good.

However:

- Although the availability of call bells to patients was generally good, we saw on the acute medical unit (AMU) that 17 out of 25 patients did not have a call bell within reach.

Compassionate care

- During the unannounced inspection, we carried out a Short Observational Framework for inspections (SOFI) on some wards. We observed positive interactions between staff and patients. Patients responded positively to staff and it was clear from the patients' facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if there was anything they needed.
- In the Friends and Family Test the percentage of patients who said they would recommend the trust was consistently equal to or higher than the England average. However, the response rate was worse than the national average.
- The availability of call bells to patients was generally good during our inspection however; we saw on the Acute Medical Unit that 17 out of 25 patients did not have a call bell within reach.

- Call bell response rates appeared good during the inspection. Patients told us they were normally responded to promptly. It is important for patients to have call bells in reach in order to summon help when needed. On our last inspection, we noticed that this was an issue with many patients' call bells being out of their reach. The trust had carried out monthly call bell audits. We looked at the results of these audits from December 2015 to May 2016 and saw that there was a high compliance rate with call bell availability. Where call bells where identified, as not being within reach there was an action to address this. In some circumstances, there was a documented reason why the call bell was out of reach, for example, it was a choking hazard for a patient with dementia.
- Patients' dignity was maintained, for example, we observed a consultant led ward round and saw that curtains were pulled around the patient to maintain privacy and dignity.
- Staff we observed spoke to patients in a caring and compassionate way. We observed all staff responded to patients' requests in a timely and respectful manner.
- The trust's own 2015 bereavement survey showed that most (87%) bereaved relatives felt that their relative received a high standard of care; 9% of relatives disagreed with this and 4% did not respond to the question on the survey.

Understanding and involvement of patients and those close to them

- In the Cancer Patient Experience Survey 2013/14, the trust was in the bottom 20% of trusts for six indicators, four of which related to communication. The trust was in the top 20% of trusts for one indicator (which also related to communication): patients being told that they could be given free prescriptions.
- The trust performed worse than the England average for two out of 12 selected questions from the CQC Inpatient Survey 2015. These were staff answering questions about the operation or procedure and length of delayed discharge from hospital.
- The trust performed worse than the England average for three of the four areas in the Patient Led Assessments of the Care Environment 2015 (cleanliness; food; privacy and dignity and; facilities). Food was the only area where the trust performed better than the England average. The worst area was the facilities with the trust scoring 80 and the national score was 90.
- Patients told us that their families were involved in their care and informed about treatment plans. We saw involvement in care decisions clearly documented in the medical records we looked at.

Summary of findings

- We heard doctors explaining treatment options and plans to patients and relatives and answering their questions.
- We saw examples of nursing staff involving patients in their care and treatment.

Emotional support

- A psychiatry liaison team from the local mental health trust worked with the hospital and offered support to patients with physical and mental health problems.
- There was a range of clinical nurse specialists who supported patients in different settings, for example, diabetes specialist nurses.
- A chaplaincy service, which consisted of chaplains and volunteers, was available to support patients, their families and carers during their time in hospital. There was a multi-faith prayer room available within the hospital.
- Patients and their relatives who had received emotional support during their time in the emergency department spoke to us appreciatively of the service they had received.
- In the children's emergency department a play specialist was on duty from 6pm to midnight to support children receiving care.

Are services at this trust responsive?

Requires improvement

At the 2015 inspection we rated the trust as 'Inadequate' for responsive. At this inspection we found the trust had improved and rated it 'Requires improvement' for responsive because:

- For an extended period, the trust has failed to meet the constitutional standard to see and treat 95% of emergency patients within four hours of arrival and the referral to treatment times (RTT) indicator.
- There was also a backlog of approximately 30,000 patient appointments at the time of the inspection.
- There were issues with bed capacity which had led to medical patients being cared for on non-speciality or non-medical wards; we found that outlying medical patients were resulting in the cancellation of elective gynaecology procedures.

However,

- Changes had been made to improve the access and flow of patients within medical care services with positive results. There was a reduced length of stay on wards, a reduction in the

number of bed moves for patients especially at night, a reduction in the number of delayed discharge days and a large reduction in the number of patients who were medical outliers being sent to Castle Hill Hospital.
- The trust was meeting the locally agreed trajectories for the constitutional standard for the emergency department and referral to treatment times (RTT) indicator that had been agreed in conjunction with commissioners and NHS Improvement and had done so for three consecutive months. In June 2016, 85% of patients in ED were seen within four hours, which was in line with the agreed trajectory.
- Patients with a learning disability, patients with dementia, and bariatric patients could access emergency services appropriate for them and their needs were supported.
- Patients needing care and treatment for their mental health needs could access services in a joined up way from within the emergency department and most other services.
- Patients with different cultural needs were taken account of in the planning and delivery of services.
- Interpretation and translation services were available and actions were taken to address inequalities.
- Patients knew how to complain, the services followed the NHS complaints policy and staff knew how to deal with complaints they received. Complaints were investigated and learning was shared with staff.

Service planning and delivery to meet the needs of local people

- The majority of the services provided by the trust were commissioned by the two local Clinical Commissioning Groups based on needs assessments of the local populations.
- For example, the needs of patients from the local population had influenced the planning and delivery of the extensively refurbished emergency department. A new frailty team was created to assess the individual needs of specific patients.
- The critical care service was actively involved in the regional critical care network.
- Critical care provision could be flexed to meet the differing needs of level two and three patients; however, at the time of our inspection the provision was limited by nurse staffing levels.
- Other more specialist tertiary services were commissioned through NHS England.
- The major trauma centre facilities had been upgraded since 2015.

- The approach to service delivery within maternity was reactive in relation to how the service had implemented a Growth Assessment Protocol (GAP).
- The trust has set its equality objectives for 2016-2020 with equality and diversity included in the role of the Head of Strategic Planning.

Meeting people's individual needs

- There was a volunteer service which operated at the main entrance to the hospital. The volunteers' role was to meet and greet patients or visitors who had obvious disabilities or appeared not to know where they were going. They also provided support and assistance to patients to use the electronic booking in system.
- Access from the car parks to the main entrance was level and step-free. Parking for disabled people was available near the main entrance.
- We reviewed three sets of patients' notes who had varying needs linked to illness and disability. The patients had been highlighted, along with several others, via the daily hospital safety briefing. Overall the care and treatment of the three patients took into account their disabilities and needs.
- Patients with mental health needs accessed the services of a team from a local mental health NHS trust that was located in the hospital. Medical and nursing staff understood the procedures for reviewing a patient's mental health needs.
- An advocacy service was available for patients needing this support.
- Interpreter services were available, including an on-line service. Staff in the children's emergency department confirmed they used the translation service and had developed a phrase book to help with immediate translation needs.
- Staff used the intranet to access services for patients with specific cultural needs. The cultural needs of patients were included in the initial assessment in A&E and were available in patient records. Staff gave the example of conversations about patient needs that took place during Ramadan.
- The A&E was equipped with trolleys capable of carrying bariatric patients. Bariatric chairs were available for patients' use in the department. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity). Specialised equipment required for bariatric patients was available. Commodes, chairs, and other equipment were stored on the Castle Hill site as this was the site for planned bariatric surgery. If required on the Hull Royal site, staff were aware of how to arrange transport.

Summary of findings

- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available; however, on one area (Ward 40) disabled toilets were not available in the male side of the ward, they were only available within the female section.
- Adults and children were not separated to receive care in the recovery area of main theatres or within both areas of the day surgical unit. The senior management team was aware of this issue, however due to the provision of specialised ventilation within women's and children's theatres, staff were unable to prevent this occurring.
- Relevant information to patients was displayed on the walls of wards we visited, such as discharge information, learning disability services and the butterfly dementia scheme.
- A range of leaflets were available for patients, for example, prevention of pressure ulcers, venous thromboembolism prevention and information for a patient's discharge.
- We observed mixed sex accommodation breaches in the high observation area (HOB) on Ward 40 which admitted both female and male patients. Staff we spoke with said that this was acceptable because the patients were categorised as level two critical care patients. However, the protocol for admission into this area indicated that patients should be level one dependency critical care patients. National guidance indicates that it is acceptable to have level two critical care patients in mixed sex accommodation; however patients who were level one must not be mixed. The trust's policy stated that Level 1 HOBs would be mixed sex but every effort would be made to ensure privacy and dignity was maintained in accordance with guidance. The trust told us that this was in agreement with the local commissioners.
- The maternity service had a vulnerable women's midwife who was responsible for women who: misused substances; had mental health problems; had complex social needs; were refugees; were teenage mothers and; had learning disabilities. This midwife visited clinical areas daily to offer advice and support to staff.
- A vulnerability tool kit was in place for all maternity staff. It outlined what staff could do to address the needs and improve pregnancy outcomes for women with different vulnerabilities including: drug/alcohol misuse, mental health issues, learning difficulties, domestic abuse and women under the age of 16.
- The maternity service had a healthy lifestyle midwife who was responsible for supporting women throughout pregnancy and post-natally to achieve a healthy lifestyle.

- There was a consultant paediatrician with a special interest in mental health and a hospital mental health liaison team. In addition, when children and young people admitted to the service had emotional, behavioural or mental health difficulties they were able to access specialist NHS CAMHS services provided by another NHS trust.
- We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow older children to be cared for by gender. Staff explained that they tried to nurse male and female children and young people in separate bays from eight years of age upwards.
- There were no separate facilities for teenagers, including the use of equipment such as game stations.
- A playroom was available in the paediatric assessment unit (PAU) for children and young people. It was equipped for primary aged children.
- A schoolroom and teacher was available during term time on the ward. Children who were inpatients for five days or more could access this service. Nursing staff gave an example of how the teaching staff at the hospital liaised with invigilators for a young person sitting their GCSEs.
- There was a parents' room available on Ward 130. As there was no parents' room on PHDU, they had access to the facilities on the paediatric medical ward.
- Parents told us they found the facilities to be poor, with uncomfortable seating, and cramped conditions.

Learning disabilities

- We were told that there was a mental health and learning disability draft strategy being developed with local partners.
- On the Trust's intranet there were resources to support staff, such as tool kits, communication aids and patient passports to complete, were available for use.
- Training was provided which varied from a full day's interactive training offered four-six times per year to e-learning packages that were one to two hours long. There were also bespoke sessions offered for service areas that had regular attendances of patients with learning disabilities. However it was not part of mandatory training. We asked for training figures but they were not available at the time of the inspection for how many staff had completed the training.
- The trust had an agreement with another local trust to provide onsite a lead nurse to advise staff and support patients with

learning disabilities. The lead nurse was a member of the wider Learning Disabilities Partnership Board. They had been in post for five years working Monday to Friday and their role was to work with adults or young people in transition to adulthood.

- Staff working within the wards were aware of how to contact the lead nurse. Families of patients with learning disabilities were supported to stay with patients. Staff working within the Surgery Health Group provided examples of when they had used learning disability patient passports and supported patients with a learning disability through their admission, by referral to the Assistant Chief Nurse / Safeguarding Lead and by accommodating relatives to stay with patients.
- Paediatric staff informed us that within their safeguarding training, there was information relating to patients with a learning disability. Additionally, the staff had contact numbers and information leaflets to access specialist groups. For example, 'Downright Special …building a brighter future for children with Downs Syndrome.'
- There was no electronic flagging system in place to alert and manage patients with learning disabilities at the time of the inspection. We were told by the nurse for learning disabilities that this functionality had been set up on the trust's IT system and this would go live at the end of July 2016. There was a manual flagging system in place as part of the routine safety briefs that occurred each day. However, the lead for the trust was unable to tell us how many patients had been flagged within the trust that day when we spoke with them.
- The lead nurse received informal feedback from patients and/or relatives.
- Some elements of the trust's fundamental standards audits (3Gs) of ward areas, such as safeguarding, were reviewed to monitor the care of patients with learning disabilities.
- We were told that any serious incidents relating to learning disability were routinely shared with the lead nurse and they shared an example of a recent incident that was to be used as part of the Trust's lessons learnt newsletter.

Dementia

- A specialist nurse for dementia had recently been appointed. There was also a lead medical consultant. Specific staff in service areas took on a dementia friendly role and felt passionate about this responsibility. This included encouraging others to learn more about dementia.
- The senior management team told us that the specialist nurse was working with the dementia board to produce a dementia strategy.

Summary of findings

- There was a draft dementia strategy in place for 2016-17 to 2018-19 with a vision to provide "safe, high quality, effective care for every person with dementia".
- There was a work-stream within the trust's quality improvement plan to ensure that staff who were involved in caring for patients living with dementia were suitably trained. Dementia training and education was not part of the trust's mandatory training programme.
- There was a dementia and delirium policy available to support staff to care for patients with dementia and a dementia screening tool was in use.
- Patients were routinely assessed for dementia and delirium; however implementation and monitoring of this varied across the hospital services. The assessments were recorded on the trust's IT system.
- In addition, there was a work stream to create a more dementia friendly environment with Wards 8 and 80 at HRI being part of the first phase of this work. The Elderly Assessment Unit (EAU) and elderly care wards had a dementia friendly environment. They had dementia friendly signage and large wall clocks. Red food trays and yellow cutlery was in use for patients with dementia.
- Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This national scheme teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- We saw information regarding dementia displayed on notice boards, which included contact numbers for support.
- Recreational co-ordinators had been introduced on the medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital. We saw that wards had access to activities for patients living with dementia such as twiddle muffs (hand muff with bits and bobs attached inside and out designed to provide a stimulation activity for restless hands for patients with dementia), photo boxes and memory pictures. Ward 9 had a bus stop and bench for dementia patients who were agitated and believed they needed to go somewhere. Nurses told us this had a calming effect.
- The hospital was also trialling the use of twiddle muffs for patients during the application of plasters to use as a

distraction and to reduce the possibility of the cast being interfered with. They also had a board with nuts and screws on for patients to concentrate on when being plastered to avoid disruption.
- Within outpatients at HRI there was a quiet waiting room for patients who had dementia termed the Grey room. This has a bus stop sign for people to wait by, a disabled toilet and local art on the wall with familiar scenes.

Access and flow

- The trust's performance report for June 2016 detailed the following national indicators which had failed to meet the national targets: the 95% four-hour emergency care standard; the 31 day decision to treat (DTT) for subsequent surgery (91.4% against a target of 94%); the 62 day referral to treatment (RTT) cancer standard (80.1% against a national target of 85%); three RTT indicators – admitted, non-admitted and incomplete; and the 52 week breach (two patients breached due to a late identification of data error, and then the patients chose to delay treatment until after their holidays).
- The emergency department had persistently breached the four hour waiting time target between April 2015 and April 2016. In April 2016 there was a marked improvement. The trust had agreed a local performance trajectory with regulators and commissioners to achieve the national four-hour waiting time by March 2017. The emergency department achieved the local trajectory in May 2016, and in June 2016, when it achieved 85.9% of patients seen within four hours, against the national standard of 95%.
- The target for median time to treatment in A&E is 60 minutes. National comparative information showed that the A&E breached the median time to treatment in all but three of the 22 months over the period October 2014 to January 2016. Performance from July 2015 to January 2016 showed a considerable improvement, although the target was still breached in four of these seven months.
- Between April 2015 and March 2016, the trust's referral to treatment (RTT) indicator was consistently worse than the England average and the national standard for incomplete pathways. The operational standard is that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. The trust was performing clinical validation for patients that had breached the 18-week RTT indicator in order to prioritise appointments for those most at risk.
- The trust had an agreed trajectory with the local Clinical Commissioning Groups (CCGs) and NHS Improvement (NHSI) to

meet the RTT indicator by March 2017. The trust was meeting the current individualised local indicator between April and June 2016. However, there was concern from some members of the trust's board and other staff as to whether this was sustainable given the increase in overall attendances.

- Overall, the trust's position relating to the RTT and cancer national standards was improving. The improving cancer position meant the majority of cancer targets were being delivered. The RTT trajectory had improved overall for 2015/16 when compared with 2014/15. There were specific challenges in some areas, and a recovery plan had been agreed for 2016/17.
- The percentage of people waiting more than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between quarter one 2014/2015 and quarter four 2015/2016.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since quarter three 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in quarter one and quarter two in 2015/2016. The breast symptomatic two week wait target was at 92.9% which was just short of the required 93%.
- On 22 June 2016, there was an outpatient follow-up backlog of 29,968 patient episodes. This was the number of patients on an access plan who were overdue a follow-up. The largest individual specialties follow-up backlogs on this date were: ophthalmology 8,117, ear, nose and throat (ENT) 1,032 and plastic surgery 1,369. The trust had put a standard operating procedure in place and was working with local commissioners to address this and agree trajectories to remove the backlog.
- Bed occupancy was consistently above the England average between quarter four of 2013/14 and quarter three of 2015/16 ranging from 92.5 to 99% over this time period.
- The two most common reasons for delayed transfers of care between March 2015 and February 2016 were "Completion of assessment" (44%) and "Awaiting further NHS non-acute care" (28.5%). These were both much more prevalent for the trust than for England as a whole.
- The access and discharge data for critical care was mainly better than the England averages.

- A new frailty model had been piloted since the last inspection which intended to avoid unnecessary admissions to the hospital and, with the support of allied health professionals, ensure safe discharge home from A&E.
- There were issues with bed capacity which had led to medical patients being cared for on non-speciality or non-medical wards. During the inspection, we found several medical patients being cared for on the gynaecology ward. This was affecting services and we found in the divisional report that pressures on the gynaecology ward from outlying medical patients were resulting in the cancellation of elective gynaecology procedures.
- Data provided by the trust showed that in the last six month period from February to July 2016, there had been 25 medical outliers transferred to Castle Hill Hospital from Hull Royal Infirmary. This was a marked improvement on the previous year when up to 100 medical patients were transferred to this site in one month alone.

Learning from complaints and concerns

- We saw evidence that the trust was open and transparent in responding to complaints.
- There was a complaints policy in place and this was also accessible from the website.
- The Trust had seen a 17% reduction in formal complaints received between 2014/15 (769) and 2015/16 (642). During 2015/16, 650 complaints were closed (some overlapping from the previous year). Of these, 207 were not upheld, 161 were partly upheld and 282 upheld. Of the 642 new complaints received 28 were not investigated for the following reasons:

1. they were for another organisation
2. the Trust did not receive consent from the patient for the complaint to be investigated
3. the patient did not want it to be investigated formally

- The trust had a local standard of acknowledging complaints within three working days. This had been met in all complaints during the period April 2015 to March 2016. The standard for a response to a complainant was 40 working days which had a 69.8% achievement rate. The trust's target was to have 90% of complaints closed within 40 days in 2016-17. Although performance had improved from 2014/15, none of the health groups had met this standard in 2015/16 with figures ranging from 64-76%.
- Lessons learned from complaints were shared from the board to wards. We saw evidence of this in board papers and the

health groups fed back actions resulting from complaints at the Patient Experience Forum on a six-weekly basis. Templates had been changed so that the investigation manager could state what the lessons learned had been. Staff used the lessons learned from patient complaints to improve clinical practice.

- In addition, the trust has recently established the CIRCLE group (Clinical Incident Review and Creating a Learning Environment). This group pulled together information from a number of sources, for example, complaints, serious incidents and claims in order to provide an overview of key themes and trends.
- When a complaint response was sent to the complainant, an evaluation form and self-addressed envelope was enclosed. In the period June-Dec 2015, 58 complaints returned a completed evaluation form (12%).
- To improve communication with complainants, staff contacted the complainant on receipt of the complaint to offer a resolution meeting and to confirm the issues for investigation. The agreed issues were stated in the acknowledgement letter. Complainants were made aware of whom they could contact if they required an update or any assistance during the investigation.
- In the month June 2016, 37 complaints were received and 54 closed. Of the closed complaints, 14 were not upheld, 23 were partly upheld and 17 upheld.
- In addition, 244 Patient Advice and Liaison Service (PALS) concerns were received in June 2016; the trust also received 34 compliments, two comments and suggestions and 87 general advice issues. The majority of concerns continued to be regarding delays, waiting times and cancellations. Specifically, these related to follow up appointments and elective waiting list appointments, as well as some patients not being satisfied with their treatment plan or outcome.
- The trust had fourteen cases ongoing with the Parliamentary Health Service Ombudsman.
- As part of the update of the trust's internet website and to make it easier for patients to leave compliments, comments/ suggestions, concerns and complaints, the patient experience team had developed an on-line response form for patients and relatives to use which was being piloted.
- The patient experience hub in the entrance to the main tower block at HRI was being utilised by volunteer support groups and was used by the volunteers to sign-post and reassure patients.

Summary of findings

- Staff were aware of the policy for managing concerns and complaints and how to find it on the intranet. Staff said they tried to resolve minor complaints at source to prevent them escalating to formal complaints.
- We reviewed five complaints in detail and found that they had been investigated appropriately, the tone of the letters was compassionate and responses provided to the complainants included apologies. They had been appropriately risk assessed and the investigations were thorough.

Are services at this trust well-led?

Requires improvement

At the 2015 inspection, we rated the trust as 'Requires improvement' for well led. At this inspection we saw improvements had been made but the rating remained 'Requires improvement' because:

- Whilst there were assurance systems and service performance measures in place which were reported and monitored, not all areas were consistently acted upon or managed in a timely manner. For example, implementation of deteriorating patient processes and completion of risk assessments.
- We identified risks to some services that were not on the health group risk registers.
- The effectiveness of the leadership, governance, culture and support for outpatient services had varied between the four Health Groups and visibility of the leadership was variable. There had been no overarching governance structure or cohesive management oversight in outpatients; this had recently been addressed and was under development.
- The executive team acknowledged that proactive public, patient and stakeholder engagement was an area for further development within the trust.

However,

- There was a clear vision and strategy for the trust with an operational plan on how this would be delivered.
- Governance systems had been reviewed and new systems implemented from April 2015, although these were not yet fully embedded at the time of the inspection.
- The trust was aware of the problems in outpatient services and had plans in place, agreed with commissioners and NHS Improvement to make improvements to achieve the national standards. The lack of an overarching governance structure or management oversight in outpatients had recently started to

be addressed by the weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient transformation project' was also in progress, which was running behind schedule.
- We found an improved staff culture within the trust; staff said it had changed for the better. A programme of professional and cultural transformation training was ongoing for all staff, which included new staff joining the organisation.
- Staff were engaged and told us that there was good teamwork.
- There was a drive for continual change and improvement within the leadership team.

Vision and strategy

- In 2016 the trust had adopted its vision – "great staff, great care, great future" and the linked values of care, honesty and accountability following consultation with staff in 2015. The value statements clearly stated what behaviours were acceptable for staff and which were not.
- Staff in focus groups confirmed they were aware of the trust's vision and there were visible displays throughout the trust of the vision and values.
- The trust's vision was embedded in the services. Most staff were able to articulate priorities and what 'great staff, great care, great future' meant to them.
- At the last inspection there had been no clear long term vision or associated strategy. The vision and the values had informed a trust strategy which was now in place for 2016 to 2021. Staff had been involved in its development and the draft had been sent to key stakeholders for comment.
- There were some views among board members we interviewed that the strategy could have been more ambitious but that this had to be counter-balanced with a pragmatic approach for realistic delivery and the development of the new sustainable transformational plans (STPs) which covered the whole health and social care economy.
- There were strategies and key priorities in place for each of the four Health Groups.
- Mostly staff were able to articulate these priorities, for example, in obstetrics the priorities included reviewing obstetric scanning capacity and the development of the midwifery-led unit on the labour ward. Key priorities for gynaecology services included the development of outpatient procedures and the development of a procedural suite. Senior managers within A&E

told us the development of their strategy was about linking the emergency department plan with hospital wide performance and specialities and to embed resilience and ensure consistency of delivery.
- There was a 'People strategy' that had seven key themes. It had been developed with engagement from staff side trade unions and other partners.
- The trust has set its equality objectives for 2016-2020 with equality and diversity included in the role of the Head of Strategic Planning. These objectives were to: “improve our evidence base for patient equality of access to services; make information more accessible to better meet the needs of people who have a disability, impairment or sensory loss; build an inclusive environment for all staff and; demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)”.
- The implementation of the plan for the relocation of children’s services remained outstanding from the previous inspection in May 2015. This was due to the financial constraints of the organisation and other priorities taking precedent. This has meant there was an inability to give a joined up service due to separation of the paediatric surgical ward from other services; including the paediatric service on the 13th floor.

Governance, risk management and quality measurement

- Overall the leadership understood the improvements that were required to improve safety, quality and activity for the trust. There were assurance systems and service performance measures in place which were reported and monitored. However, not all areas were consistently acted upon or managed in a timely manner. For example, implementation of deteriorating patient processes and completion of risk assessments.
- There was an effective Board Assurance Framework (BAF) in place which articulated key risks and accountabilities. The BAF was reviewed by the Audit Committee and Board.
- At the last inspection we had found the Health Groups had worked autonomously and in isolation of each other with a variation in the approach to governance frameworks. An independent external review of governance arrangements had taken place in December 2015 and the trust had adopted a revised governance framework in April 2016 with standard templates for reporting and streamlined escalation procedures

across the whole trust. The trust had centralised corporate functions to improve consistency and provide services, such as HR and finance, through a 'business partner' model. At the time of the inspection this still required embedding across the trust.

- There was a committee structure in place to manage the board's business. There were four committees: Performance and Finance; Audit; Quality and; Remuneration. We attended the Quality Committee during the inspection where we observed that the clinical performance and governance arrangements were challenged effectively. There was also an executive management committee structure.
- The trust had developed a single 'Quality Improvement Programme' with three objectives, which were: aid in achievement of the trust ` s overall ambition to meet its vision; deliver trust wide quality improvement based on the priorities identified through the programme such as the Quality Accounts, Sign Up to Safety and CQC inspections and; address the 'Must do' and 'Should do' actions identified by the CQC. For each priority there was a detailed plan which was monitored by the board and its committee structure.
- At this inspection there was a corporate risk register in place. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded.
- There was mostly alignment between the recorded risks and what staff said was on their 'worry list'. However, we identified risks to some services that were not on the health group risk registers. For example, within the critical care service, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores. We also saw that there were four safeguarding guidelines which were out of date, including one for review in 2014.
- There had been no overarching governance structure or cohesive management oversight in outpatients, but this had recently been addressed and was under development. Services were split between the four Health Groups, which meant there were different levels of management and clinical support for each service. There was no specific outpatient risk register, however some risks, such as ophthalmology, were on a Health Group risk register. There was limited evidence of outpatient

audits and quality monitoring. An 'outpatient transformation project' was in progress, which was running behind schedule. This project was to improve clinic utilisation, bookings processes and performance against standards.

- There was a systematic programme of clinical and internal audit.
- The trust had changed its governance procedures for all incidents from 1 April 2016. The management of incidents within the trust had improved and the previous backlog had decreased. The decision making process to declare an incident as a serious incident (SI) had generally improved. However we were concerned about the categorisation of some incidents, including safeguarding, relating to children, which had resulted in a lack of investigation and lessons learnt.
- There was now a tier two review system where reviewers looked at all incidents to check the category given and also assess for any actions required regardless of the grading of the incident. As part of the quality improvement programme there was a 'CIRCLE' group which had been in operation for 3-4months. It brought together the reviewing of clinical incidents, complaints and claims to improve triangulation and learning. It produced the Lessons Learnt newsletters that were circulated throughout the trust.
- In addition, a number of staff had participated in human factors training and the trust had recently produced their own human factors learning lessons videos based on recent never events.
- There was a Performance and Access (PandA) operational meeting which met weekly to manage and act on performance issues such as referral to treatment times (RTT).
- The trust had recently developed ward level metrics to monitor the fundamental standards of care. These were to be presented to the board for the first time in July 2016. Outside every ward, compliance with the fundamental standards audit (3Gs) was displayed. This audit measured the ward against standards across a number of areas including nutrition, record keeping and tissue viability. Each area was given a rating then the ward received an overall rating. These effectively identified areas for improvement. However robust action plans were not in place to ensure improvements were made as a result of these audits.
- In 2015 we had concerns that none of the cost improvement plans had a quality impact assessments (QIA) which meant the board could not assure itself how patient care might be affected when changes to services were planned. Although we were told that the QIA process had been strengthened we saw no formal evidence of this or QIAs being reported to the board.

- The trust participated in the national review of the effectiveness and efficiency of use of resources led by Lord Carter and was in the process of implementing some of the recommendations.

Leadership of the trust

- The board level roles were fully appointed to for the first time in over two years with the last appointment starting in April 2016. There was a board development programme in place.
- In addition, the trust had, with the support of NHSI, secured external senior support to further develop the improvement and governance agendas.
- Non-executive and executive board members were linked to specific clinical areas and members were starting to visit these areas to increase feedback from ward to board.
- The leadership team worked well together and had a shared view of the priorities and actions required to improve patient care and outcomes. They had ensured the development of appropriate strategies, procedures and systems in place to deliver this. The leadership acknowledged that they needed to improve holding the Health Groups and staff to account to ensure consistency in following through on the delivery of these. They also commented that because of the recent past history of bullying they were aware that some staff may view holding to account as bullying and they needed to address this.
- Almost all staff we spoke with told us that the executive team, particularly the Chief Executive and Chief Nurse, were visible, visited services and were seen as approachable.
- The trust operated with four Health Groups each of which had a lead medical director, operations director and nurse director. We saw strong leadership at a local level within medicine and maternity services. Staff felt supported and told us that their concerns would be listened to.
- Most of the nursing staff within the Surgery Health Group that we spoke with expressed concern about the response from some of the senior nursing staff working in the site co-ordination team. They provided examples of staff being moved from their substantive ward areas to ease periods of under staffing in other areas. Staff we spoke with said that when they expressed concern about leaving the substantive area with low staffing levels they did not always feel supported and listened to.

Culture within the trust

- The Chief Executive had continued to lead the work on the development of a positive culture within the trust with support from a senior clinician.

- Staff had completed professional and cultural transformation training and all staff who had worked in the trust for a long period told us the culture had improved and they were optimistic about the future.
- Most staff we spoke with told us they were happy in their work, felt supported by their teams and managers, were able to raise concerns and that the culture was open and honest. There were some concerns raised with us about the culture within the cardiothoracic service at CHH which we fed back to the trust at the time of the inspection.
- Senior staff had worked to reduce sickness in the service; information provided by the trust showed registered nurses sickness was 4% and for other staff was 2.6% which was better than the England average.
- Staff had access to a counselling service in the trust.
- Staff awareness courses have been provided for duty of candour and these had been in various forums including: a presentation delivered by the trust's solicitor to approximately 100 attendees; specific training for quality and safety managers in each Health Group; ward manager forums and student nurse forums.

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a policy and standard operating procedure in place for the Fit and Proper Person. This included all executive and non-executive directors.
- We reviewed six personnel files of executive and non-executive director and found they were compliant with the regulation.
- There was an annual declaration of ongoing compliance and clear procedures and checks for new applicants.

Public engagement

- The executive team acknowledged that proactive public, patient and stakeholder engagement was an area for further development within the trust.
- There was a patient story at the start of each board meeting for the members to reflect on and this had been in place for a year.
- In 2015 there had been no patient experience strategy in place. At this inspection we saw a draft strategy dated 2016 – 2019.

The aim of which was to ensure that patients were provided with the opportunity to have a say in the way the trust provided healthcare. It had four work-streams and draft actions outlined with dates yet to be finalised for completion.

- The trust had a patient experience forum and had recently set up a patient and public forum. Following a vote, the forum had appointed a patient representative chair and vice chair and terms of reference were being developed. The group which had 16 members had met on the 27 June 2016 for the first time and decided on how the council would work; their role was to be critical friends – to challenge but be supportive.
- There was a voluntary services team in place for people to give their time to help the patients and staff of the Trust. There was a 'Jolly Volly' support group which was about to have its first meeting.
- There were over fifty young volunteers within the trust across both sites in various departments. The trust was about to start a partnership with the Prince's Trust called the Young Health Champions Project. The project was to offer young people from the age of 16 to 24 the chance to volunteer at the trust.
- The trust participated in national patient surveys, for example the friends and family test, CQC inpatient survey and had initiated some local surveys, such as the 2015 bereavement survey.
- Wards we visited had "You said, we did boards" which highlighted actions taken because of patient feedback, for example, a patient had said they were disturbed at night and the ward had launched a reduced noise at night campaign.
- There were some specific examples of good practice. For example, a patient and spouse had set up a patient support group for critical care; the spouse had attended staff meetings to feedback their experiences, examples of changes introduced from this was for staff to let the patient know if they were leaving the room and changes to some staff's routines on a night shift.

Staff engagement

- Most staff we spoke with had not felt actively engaged in service planning and delivery, but had felt engaged in shaping the values and culture of the trust.
- Representatives from both the Joint Negotiating Consultative Committee (JNCC) and the Local Negotiating Medical Committee (LNC) told us that their meetings functioned well

and they had good relationships with the management of the trust. They provided examples of policies that had been taken through the committees where changes had been made, such as the attendance management policy.

- In the 2015 GMC National Training Scheme Survey the trust performed worse than expected for induction and feedback. It performed within expectations for the remaining 12 survey areas.
- The NHS staff survey results include a score for staff engagement on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged. The trust scored 3.74 for overall engagement in 2015.
- The 2015 NHS staff survey the trust had five negative findings and two positive findings. The trust was within expectations for the remaining 27 questions. The negative findings included the percentage of staff experiencing work-related stress, the percentage of staff witnessing potentially harmful errors, error reporting culture, and staff experiencing harassment, bullying and abuse by other staff (the bullying was significantly worse at 38% which was 12 percentage points above the national average).
- The in house trust survey January to March 2016, showed a slight improvement as the trust scored 3.80 out of 5 for staff engagement.
- There were weekly meetings with the Chief Nurse and various groups of nursing staff. For instance, the Health Groups' nurse directors and band six nurses and above held at CHH and HRI on alternate weeks.
- Across the services, regular staff meetings were held although attendance varied. We saw evidence in the minutes that incidents, training, clinical supervision and equipment were some of the topics discussed.
- There were approximately 11% of the workforce who were from black, minority and ethnic (BME) communities with the percentage being higher within the medical staff. A BME staff network was in the process of being set up; the trust had ten volunteers but it was yet to meet. However, there were no other staff networks such as for staff who had a disability, were LGBT (lesbian, gay, bisexual, and transgender) or carers.
- A Workforce Transformation Committee had been set up which included the Professional and Cultural Transformation (PaCT) work stream and a diversity and inclusion steering group.
- The trust held a yearly 'Golden Hearts' award ceremony to recognise staff contributions to patient care and innovation.

Innovation, improvement and sustainability

Summary of findings

- The trust was actively engaged with the national strategic transformational planning led by NHS England.
- Staff told us the trust had been working with the Improvement Academy to reduce the number of patient falls. New falls assessment documentation had been introduced because of this and falls risks were discussed at safety huddles.
- New roles had been developed within the Medicine Health Group to free up nursing time. Patient discharge assistants had been introduced across medical wards to progress and chase up complex and simple discharges. Recreational co-ordinators had also been introduced to provide patients with stimulating activities and there were plans to introduce nutritional assistants to wards.
- Advanced nurse practitioners (ANPs) worked within the Ambulatory Care Unit (ACU) to provide additional medical / nursing support.
- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care service had successfully recruited and retained advanced critical care practitioners (ACCPs). Feedback from the ACCPs on their role and training was very positive.
- The critical care teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal about their training courses.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.
- The maternity outpatient induction of labour with balloon catheter service had been accepted for publication in the International Journal of Obstetrics and Gynaecology and was presented as an E-poster presentation at the Royal College of Obstetricians and Gynaecologists conference.
- The maternity service had introduced an enhanced recovery pathway following caesarean section. This was implemented in March 2016 and was associated with early discharge home and promoted normality.
- Midwifery staff were undergoing competencies to undertake intravenous antibiotic treatments for neonates to reduce and prevent unnecessary separation of mother and baby.
- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology
- The ultrasound department at HRI was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.

Summary of findings

- The laboratory manager in histopathology told us their digital scanner was about to go live. A digital scanner creates a virtual or digital image of histological slides and provides a digital image for scientific analysis. This digital scanner would enable co-working with histopathology in Sheffield.

Overview of ratings

Our ratings for Hull Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Castle Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Hull and East Yorkshire Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal about their training courses.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health needs.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital.
- The responsiveness of the Specialist Palliative Care team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones
- The International Glaucoma Association had awarded the ophthalmology department an innovation award for their glaucoma monitoring work.
- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology.
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that planning and delivering care meets the national standards for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- The trust must review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt.
- The trust must ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- The trust must ensure learning from never events is further disseminated and lessons learnt are embedded.
- The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- The trust must ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.

Outstanding practice and areas for improvement

- The trust must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- The trust must ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- The trust must ensure that records of the management of controlled drugs are accurately maintained and audited within A&E.
- The trust must ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.
- The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- The trust must ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- The trust must ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement the Growth Assessment Protocol (GAP).
- The trust must ensure the effective use and auditing of best practice guidance such as the "Five steps to safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- The trust must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The trust must review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- The trust must ensure outpatient services have timely and effective governance processes in place which identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient and maternity services.
- The trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitability skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).
- The trust must continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.
- The trust must take further steps to improve the facilities for young people on the 13th floor of HRI.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: There was no policy or protocol in maternity services for staff to assess a young person's (under 16 years of age) understanding using guidance such as Gillick competencies and therefore ability to consent to a proposed treatment. The trust must: 1. ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for patients. The trust must: 1. ensure that planning and delivering care meets the national standards for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits. Regulation 12(1) 2. review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt. Regulation 12(2)(b) 3. ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns. Regulation 12(2)(a) & (b)

This section is primarily information for the provider

Requirement notices

4. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b)

5. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b)

6. ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services. Regulation 12(2)(c)

7. take further steps to improve the facilities for young people on the 13th floor of HRI. Regulation 12(2)(e)

8. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy, especially within A&E. Regulation 12(2)(g)

9. ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient. Regulation 12(2)(g)

10. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)

11. ensure that records of the management of controlled drugs are accurately maintained and audited within A&E. Regulation 12(2)(g)

12. ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services. Regulation 12(2)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

How the regulation was not being met: Some safeguarding guidelines were out of date, not all staff were trained to the required level 3 for safeguarding children, and the computerised record system did not identify adults who may pose a risk to children. The trust must:

1. ensure that systems and process are operated effectively to prevent abuse of service users, specifically in relation to children. Regulation 13(2)&(3)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: Some patients' food diaries and fluid balance chart were not fully completed therefore it is not possible to monitor whether their needs were being met. The trust must: 1. ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The trust must: 1. ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement Growth Assessment Protocol (GAP). Regulation 17(2)(a) 2. ensure that elective orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a)

This section is primarily information for the provider

Requirement notices

3. ensure the effective use and auditing of best practice guidance such as the "Five steps to safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)

4. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).

5. ensure outpatient services have timely and effective governance processes in place which identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.

6. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient and maternity services. Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. The trust must: 1. ensure that there are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically ensure critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012). Regulation 18(1) 2. continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour. Regulation 18(1)

Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust

Hull Royal Infirmary

Quality Report

Anlaby Road,
Hull,
HU3 2JZ
Tel: 01482 875875
Website: www.hey.nhs.uk

Date of inspection visit: 9 June, 28 June – 1 July and 11 July 2016
Date of publication: 15/02/2017

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Good
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Hull and East Yorkshire Hospitals NHS Trust operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham. HRI is the main centre for emergency services including the emergency department (ED). The trust provides services for a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. We inspected all eight core services at HRI. We also inspected the minor injuries service operated by the trust at East Riding Community Hospital and outpatient services at the Westbourne NHS centre. We did not visit any other outpatient services which operated in other locations. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

We rated HRI overall as 'requires improvement'; safe, responsive and well led were rated as 'requires improvement' with effective and caring rated as 'good'. Improvements had been made since our last inspection but these were not significant enough to change the rating for HRI as whole. Some areas had made considerable improvements, especially the emergency department (ED) which was now rated as 'good'. Medical Care, Surgery and Children's Services had improved. End of Life Care remained 'good' across all domains. However, there was deterioration in the ratings overall for Critical Care, Maternity and Outpatients & Diagnostics from 'good' to 'requires improvement'.

Our key findings were as follows:

- The care of patients within the emergency department had significantly improved since the last inspection. The trust was meeting the locally agreed trajectories for the number of patients seen within four hours (in June 2016, 85.9% of patients were seen within four hours, which was in line with the agreed trajectory of 85.1%), it was still breaching the national target of 95%.
- The trust reported and investigated incidents appropriately, the previous backlog had reduced. However, staff in some areas could not tell us about lessons learned or changes to practice, including within maternity where a never event had occurred.
- The trust had effectively responded to a serious incident reported by Radiology in December 2015 related to a failure to print 50,000 radiology reports. A further seven serious incidents regarding specific patients had been reported four of which related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- A backlog of 30,000 patient episodes had been identified by the trust prior to the inspection. A cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- We had concerns within the children's services about: the competency of staff to care for patients with mental health needs; that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and; four safeguarding children guidelines were out of date.
- Staff were not always assessing and responding appropriately to patient risk. The trust used a National early warning score (NEWS) and the Modified Early Obstetric Warning Score (MEOWS) to identify deterioration in a patient's condition. We saw some examples of when escalation of a deteriorating patient had not happened in a timely way and some staff were unclear about what to do if a patient's score increased (indicating deterioration). The trust was aware of this and was putting actions in place to improve this.

Summary of findings

- Falls risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in the patient records, which may have resulted in a failure to identify patients at risk of malnutrition. We also found poor compliance with the completion of fluid balance charts.
- Nurse staffing shortages were evident across the majority of medical and surgical wards and board reports indicated that safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators. The maternity service did not collect the relevant data and therefore could not provide assurance that women received one to one care in labour.
- There were also some gaps within the medical staffing, especially within critical care.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2 which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016 which was similar to the England ratio (100) of observed deaths and expected deaths.
- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb). This meant that deaths within these areas had been outside of the expected range. The Trust had untaken a case note review to determine if any of the deaths were avoidable, what lessons could be learnt and actions were then put in place.
- Although medicines were stored and administered appropriately, we found gaps and errors in the recording of medicines administration and in the monitoring of checks of controlled drugs which had been a concern at our 2015 inspection.
- Leadership had improved. There was a clear vision and strategy for the trust with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork.
- Feedback from patients and relatives was positive. We saw good interactions between staff and patients. Staff maintained patients' privacy and dignity when providing care. Caring within medicine had improved although there were some instances on the acute medical unit at HRI where not all call bells were within reach of patients.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks, if required, during the day.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited. There had been a significant improvement in the operating theatre environment at HRI.

We saw several areas of outstanding practice including:

- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award for their training courses and had been asked to write an article for a national nursing journal.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital.
- The responsiveness of the Specialist Palliative Care team (SPCT) in relation to acting on referrals.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones
- The International Glaucoma Association had awarded the ophthalmology department an innovation award for their glaucoma monitoring work.
- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology.

Summary of findings

- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.

However, there were also areas of poor practice where the trust needs to make improvements. Importantly, the trust must ensure that:

- Planning and delivering care meets the national standards for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- A review of the process for categorising incidents is carried out, including safeguarding incidents relating to children, to ensure effective investigation and lessons learnt.
- Staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- Learning from never events is further disseminated and lessons learnt are embedded.
- Staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- Staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- It continues to work actively with other professionals, internally and externally, to make sure that care and treatment remains safe for children with mental health needs using the services.
- Staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- Staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- Staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- Records of the management of controlled drugs are accurately maintained and audited within A&E.
- Patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- Antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol).
- There is effective use and auditing of best practice guidance such as the "Five steps for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The critical care risk register is reviewed so that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- Outpatient services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- Medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient and maternity services.
- At all times there are sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).
- It continues to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.

Summary of findings

In addition there were areas where the trust should take action and these are reported at the end of the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	At our previous inspection in May 2015, the service was rated as 'Requires improvement' overall. In June 2016 we rated this core service as 'Good' because:

- The service was meeting a locally agreed trajectory to see and treat patients within four hours of arrival, and had done so for three consecutive months.
- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nursing staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Patients care and treatment followed evidence based guidance and recognised best practice standards that were monitored for consistency. Care was delivered with compassion and staff treated patients with dignity and respect.
- Risks to the delivery of care and treatment for patients were appropriately managed. The governance of the department had become more embedded
- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this. The executive team and senior staff in the emergency department were recognised and respected.

However:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival.
- We found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.
- No formal arrangements or protocols were in place for liaison with other specialties.

Summary of findings

Medical care (including older people's care)

Requires improvement

In May 2015 Hull Royal Infirmary Medical Care services were inspected we rated them as 'Requires Improvement' overall. In 2016 the rating remained as 'Requires improvement' because:

- Staff were not always assessing and responding appropriately to patient risk. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care; however, some staff were unclear about what to do if a patient's score increased.
- Falls risk assessments were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment. We found poor compliance with the completion of food charts and fluid balance charts.
- Fridge temperature checks were not always performed and we found that when recorded as out of range, no corrective action had been taken. Controlled drugs were appropriately stored with access restricted to authorised staff however, on most wards; we found daily and weekly checks were not consistent with trust standard operating procedures.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients.
- The trust was not meeting the 18 week referral to treatment standard for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed. There were still issues with bed capacity and medical outliers were affecting other services.

However;

Summary of findings

- Leadership had improved. There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork. There was a drive for continual change and improvement within the Medicine Health Group. Further work was needed to embed the changes and to continue to improve standards.
- Staff were caring. Feedback from patients and relatives was positive. We saw good interactions between staff and patients and staff maintained patients' privacy and dignity when providing care. Patients and relatives felt well informed and involved in decision making about their care. We found that patients' access to call bells had improved and the trust was auditing this regularly.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years where compliance had been 68.7% and 74.9%. There were mixed results in national audits; however, action plans were in place to improve areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.

Surgery

Requires improvement

In 2015 we rated surgical services at HRI as 'Inadequate'. At the 2016 inspection the services had improved and were rated 'Requires improvement' overall because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated for medical review, but this had not always occurred.
- We had concerns over the effectiveness of the five steps to safer surgery checklist, from our observations it was apparent this process was not embedded as a routine part of clinical roles.

Summary of findings

- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff at both sites.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. The trust recognised this was an issue and had twice daily safety briefings to minimise the risks to patients.
- Within medical staffing there were gaps in the junior doctors' rota, especially overnight; this was highlighted on the risk register.
- Nursing staff did not always complete accurately the falls and dementia risk assessments.
- National audit performance was variable; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.
- Due to the environment in the day surgical unit it was difficult to maintain privacy and dignity.
- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance standards for treatment and cancer standards.
- The senior management team had appointed substantive roles within the Surgical Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

However,

- We noted major improvements from the 2015 inspection to the theatre environment.
- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.

Summary of findings

- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI), we carried out showed that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust's values and strategy.

Critical care

Requires improvement

We had not inspected critical care services at HRI since February 2014 when they were rated as 'Good'. During this inspection we rated critical care as 'Requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% national standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified that controls for some of the risks on the risk register were limited and unsustainable. There was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action of some of the risks on the risk register.
- There was no documented evidence that some patients were seen by a consultant within 12 hours of admission or that twice daily ward rounds took place. The medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015)
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care

Summary of findings

services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.

- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts. Some patients were not seen by a consultant within 12 hours of admission; twice daily ward rounds did not take place and medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015).
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. This member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- We saw evidence during our inspection of patients who were referred to critical care requiring level three care that had not been escalated in line with trust policy.
- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015).
- Patients did not have access to formal psychology input following critical care. The service had limited mechanisms of collecting patient or relative feedback.

However, we also found:

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence-based guidance, standards, best practice and legislation.

Summary of findings

- There was clear nursing and medical leadership on the units and in the critical care outreach team and staff had confidence in the units' leadership.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- We observed patient centred multidisciplinary team working.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

Maternity and gynaecology

Requires improvement

At the comprehensive inspection in 2014 we rated Maternity and gynaecology services as 'Good'. In 2016 the services were rated as 'Requires improvement' overall because:

- We found process for recognising deteriorating patients were not always reliable. It was not clear from observation charts how frequently observations should be repeated if a patient was unwell.
- The service did not meet the national benchmarking for midwifery staffing. Data was not collected on the number of women who received 1:1 care in labour to provide assurance about midwifery staffing levels.
- We found that some governance arrangements did not always allow for identification of risk.
- Lessons learnt following a recent never event were not embedded.
- We found that in some areas the approach to service delivery was reactive especially in relation to how the service had implemented the Growth Assessment Protocol (GAP).

However:

- Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
- Patient outcomes were in line with national averages when compared to similar services.
- Women spoke positively about their experience and said they felt well supported and cared for.
- The trust had engaged with the public and sought their views over the development of the midwifery lead birthing unit.

Summary of findings

- We saw strong leadership at a local level. Staff felt supported and felt their concerns would be listened to.

Services for children and young people

Good

At the 2015 inspection, we rated the services for children and young people as 'Requires improvement'.
At the 2016 inspection we saw improvements had been made and rated the services overall as 'Good' because:

- Nurse staffing was appropriate and was planned using an acuity tool. Multidisciplinary working took place and staff worked well as a cohesive team. Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Requirements around the duty of candour were being met.
- The service performed positively in infection prevention and control audits.
- Policies were based on national and local guidelines. Consent to care and treatment was obtained in line with legislation and guidance.
- Staff treated children, young people and their relatives/carers with kindness, compassion, dignity and respect. Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- We saw children and young people being assessed and treated in a timely way. A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- Playrooms and a schoolroom were available to meet the learning needs of patients.
- Following our inspection, the trust informed us they had decided to commission an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's needs.

Summary of findings

- Staff spoke positively about their managers and the culture of the trust and were able to articulate the trust's vision and values.

However,

- Not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patients and how those needs would be met.
- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.
- Records concerning the administration of medications were not appropriately completed.

End of life care

Good

At the comprehensive inspection of end of life care services in February 2014 we found the service to be 'Good' overall. In 2016 the rating remained 'Good' overall because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and managers shared the learning from incidents.
- Mandatory training across most services was above the trust targets and medicines were prescribed and administered safely in line with policy. Staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multi-disciplinary working across all teams. The trust had recently

Summary of findings

employed more resources to provide seven-day specialist palliative care nursing availability. Consent to care and treatment was obtained in line with legislation and guidance.

- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and patients' choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the Specialist Palliative Care Team (SPCT) were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

Summary of findings

Outpatients and diagnostic imaging

Requires improvement

At the inspection in 2015 we rated outpatients and diagnostic imaging services as 'Good' overall. The effective domain was inspected but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the services overall as 'Requires improvement' because.

- The trust was not meeting the national referral to treatment (RTT) standards for incomplete pathways. This meant patients were not always able to access outpatient services when they needed to. There were appointment backlogs and waiting lists in the majority of outpatient specialties, which totalled over 30,000 patient episodes at the time of the inspection.
- A cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery since the 2015 inspection and a previous never event in March 2015.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies in some outpatient specialties, and in radiology, there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.

Summary of findings

- The facilities and premises used to deliver services were of variable quality. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair.
- We found there was a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.
- There was inconsistency in the governance and management oversight in outpatients due to the clinics being split across the four Health Groups. The trust had recognised this and it was being addressed with a weekly Performance and Access (PandA) group, which reviewed all waiting lists, by speciality and an 'outpatient transformation project', which was running behind schedule. This project was to improve clinic utilisation, booking processes and performance against national standards. We were also told that an overarching management post was to be developed.

However,

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway. Standard operating procedures and clinical validation had been agreed in early June 2016 and was ongoing at the time of the inspection. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action.
- At the last inspection, patients undergoing hysteroscopy within gynaecology outpatients were not completing consent forms. We found these patients were now completing consent forms as required.

Summary of findings

- Outpatients and radiology had increased their capacity by running clinics out of hours and at the weekends, to cope with the increased demand and to make sure patients had their appointments in a timely manner.
- Staff providing care and treatment to people in outpatients and radiology were very caring. Patients gave positive feedback about the care they received, and staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing deficiencies or those who needed an interpreter.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching risk register for outpatients which meant there was a lack of cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- The trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.

Summary of findings

- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced. The trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Staff and managers in Radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Hull Royal Infirmary

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging.

Detailed findings

Contents

Background to Hull Royal Infirmary

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 as a result of a merger between Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. The trust operates from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital in Cottingham.

The trust provides a range of acute services to the residents of Hull and East Riding of Yorkshire area, as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire, and Hull Royal Infirmary is a major trauma centre for the region. The trust also provides other clinical services, mainly outpatients at other locations within the Hull and East Riding of Yorkshire area, for example the Freedom Centre in Hull and East Riding Community Hospital in Beverley.

The trust provides services for a population of approximately 602,700 people mainly across two local authority areas. Life expectancy for those in East Riding of Yorkshire is better than average, but worse than average for those in Hull. Kingston Upon Hull Unitary Authority scored significantly worse than the England averages for 21 of the 32 indicators in the 2015 Area Health Profiles. The city had the highest long term unemployment of any local authority in England. It also scored particularly badly for smoking prevalence, smoking-related deaths, deaths from cancer among under-75s and female life expectancy. The city scored significantly better than the England average for incidences of malignant melanoma and TB. The cancer mortality rate in Hull (360.8 per 100,000) is significantly higher than the England average (285.4 per 100,000). By contrast East Riding of Yorkshire Local Authority scored significantly better than the England averages for 14 of the 32 indicators in the area health profiles. The area scored significantly worse than the averages for three indicators: smoking status of pregnant women at the time of delivery, recorded diabetes and deaths and serious injuries on roads. In the 2015 Indices of Multiple Deprivation, Hull was ranked the third most deprived of all local authorities in England. East Riding of Yorkshire was ranked the 195th most deprived local authority in England.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. We also carried out unannounced inspections on 9 June and 11 July 2016. The trust had been inspected a number of times previously and a summary of the regulatory breaches is provided below.

The inspection in May 2015 was a focused inspection which did not look across the whole service provision; but focused on the areas defined by the information that triggered the need for the focused inspection including the previous inspection in April 2014. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services inspected. The overall rating for the Trust was 'Requires improvement'. The Trust was found in breach of the

Detailed findings

Health and Social Care Act (Regulated Activities) regulations 2014. These included: Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs), and Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good governance) and Regulation 18 (Staffing).

At the first comprehensive inspection in February 2014, using the Care Quality Commission's (CQC) new methodology, HRI and CHH were found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 22 (staffing) and 23 (staff support). Additionally HRI was also found in breach of regulation 15 (premises).

Hull Royal Infirmary was inspected in June 2012 and October 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication). In December 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

Castle Hill Hospital was inspected in June 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication) In October 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

The Trust had developed a Quality Improvement Programme in response with three objectives, which were;

- Aid in achievement of the Trust`s overall ambition to meet its vision; Great Staff, Great Care, Great Future
- Deliver Trust wide quality improvement based on the priorities identified through the programme such as the Quality Accounts, Sign Up to Safety and CQC inspections
- Address MUST and SHOULD do actions identified by the CQC.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, former government lawyer and NHS non-executive director

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The inspection team consisted of two inspection managers, 18 CQC Inspectors and 24 specialists including; an A&E doctor and nurse, a critical care doctor and nurse, two end of life nurses, a maternity doctor and midwife, a medical doctor and nurses, an outpatient doctor and nurse, a paediatric doctor and nurse, a surgery doctor and nurse, a radiographer, a junior doctor, two student nurses and three Trust wide specialists.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services during the inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology

Detailed findings

• Services for children and young people

• End of Life Care

• Outpatients and Diagnostics

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations included the local Clinical Commissioning Groups, NHS England, NHS Improvement, Health Education England, Healthwatch, various medical Royal Colleges and other stakeholders.

We held two public engagement sessions using stalls prior to the inspection to hear people's views about care and treatment received at the trust; one at HRI and the other at CHH. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended these events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and

midwives, junior doctors, consultants, allied health professionals including physiotherapists and

occupational therapists and administration staff. We also spoke with staff individually as requested.

We talked with patients, families and staff from ward areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

Facts and data about Hull Royal Infirmary

Hull Royal Infirmary is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust.

The trust had 1,294 beds at the time of the inspection of which: 1,162 were available for general and acute care, 77 for maternity and 40 for critical care. The trust's management structure was based on Health Groups: Surgery, Medicine, Family and Women's Health and Clinical Support along with the corporate functions.

As of 1 April 2016 there were 6,979 whole time equivalent (WTE) staff in post against an establishment of 7,620 WTE. Of these, 956 were medical (against an establishment of 1010); 2,778 were nursing (against an establishment of 3,066) and; 3,245 were other (against an establishment of 3,544).

The medical staff skill mix had similar percentages to the England average with 37% being consultants compared with 39% nationally; 5% were middle career compared with 9% nationally; specialist registrars were 40% compared with 38% nationally and junior doctors were at 18% compared with 15% nationally.

The financial data for 2015/16 included:

- Revenue: £526 million
- Full Cost: £534 million
- Deficit: £8 million

The types of activity at the trust for 2015/16 was:

- Inpatients: 119,751
- Outpatient (total attendances): 694,981
- Accident and emergency attendances: 121,963*
- Attendances to minor injuries unit: 13,414*

*W/c Monday 30 March 2015 to w/c Monday 21 March 2016

Hull Royal Infirmary had over 700 beds and was the main centre for emergency work. The beds were primarily for acute medical and surgical services. The main accident and emergency (A&E) services were on this site. The A&E services were seeing year-on-year increases in attendance, and treated over 132,195 attendances in 2014-15. The Women and Children's Hospital was located at HRI and housed the maternity and children's services, including neonatology with a 26-cot neonatal intensive care unit. The obstetrics department provided maternity services to women of Hull and East Yorkshire. The trust was accredited as an Endometriosis Centre in the North East of England.

In addition, the hospital provided critical care services, with 24 beds available for intensive care and high dependency, close to the main theatre complex. There was also an ophthalmology (eye) hospital on site.

By April 2015 the majority of the medical beds at Castle Hill Hospital had moved to the HRI to bring together acute medicine and care of the elderly onto the one site.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Hull Royal Infirmary emergency department received 132,195 attendances in 2014-15, which excluded patients attending the Beverley Minor Injuries Unit (MIU) and represented more than 360 patients attending the department each day. Of the total number of patients attending, 29.2% of these resulted in an admission to hospital, which was above the England average of 22.2%.

The redeveloped and extended emergency department opened in April 2015. The department comprised of two linked areas accessed by separate entrances, one for adults and one for children's emergencies. The adult emergency department was open 24 hours a day, seven days a week. The children's department was open from 8.30am until midnight each day.

The adults' emergency department included a major's area, eight initial assessment bays and 24 cubicles. The children's emergency department had eight cubicles, two assessment rooms, one paediatric resuscitation area, one neonate's resuscitation cubicle and a waiting area. The minor's area consisted of a rapid self-check-in for patients, supported by a staffed reception area. Ten cubicles were available in the minor's area. A waiting area behind the nurse's station was used for vulnerable patients.

The further phase of building work had been completed since 2015. A relatives' area consisted of three family rooms and a relatives and viewing room. A trolley bay for trolley and equipment cleaning and separate storage had also been completed since our visit in 2015.

The Beverley MIU, operated as part of the emergency department, was located within the East Riding Community Hospital which opened in July 2013. The MIU consisted of an adult waiting area, four treatment rooms and a separate children's waiting area. Patients had the use of an adjacent radiology department.

At our previous inspection in May 2015, the service was rated as Requires Improvement overall. The responsive domain was rated Inadequate and the safe and well-led domains were rated Requires Improvement. This was because:

- Performance against the four-hour target to see and treat patients had deteriorated over a considerable period.
- Shortages of consultants and other medical and nursing staff had an impact on assessment of patients, access and flow and major trauma preparedness.
- Governance structures had recently changed and the revised arrangements were still to become embedded.

During one announced and two unannounced visits in June and July 2016 we spoke with 40 patients and their relatives, and 50 members of staff of different disciplines which included visiting healthcare professionals, for example ambulance staff. We observed the care and treatment of patients and reviewed electronic records and other documents provided by the trust prior to our inspection.

Urgent and emergency services

Summary of findings

At our previous inspection in May 2015, the service was rated as 'Requires improvement' overall. In June 2016 we rated this core service as 'Good' because:

- The service was meeting a locally agreed trajectory to see and treat patients within four hours of arrival, and had done so for three consecutive months.
- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nurse staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Patient`s care and treatment followed evidence based guidance and recognised best practice standards that were monitored for consistency. Care was delivered with compassion and staff treated patients with dignity and respect.
- Risks to the delivery of care and treatment for patients were appropriately managed. The governance of the department had become more embedded
- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this. The executive team and senior staff in the emergency department were recognised and respected.

However:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival.
- We found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.
- No formal arrangements or protocols were in place for liaison with other specialties.

Are urgent and emergency services safe?

Good

At our previous inspection in May 2015, safe was rated as 'Requires improvement. In June 2016 we rated safe as 'Good' because:

- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nursing staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Risks to all patients in the department were reviewed every two hours by medical and nursing staff working together. Arrangements were in place to respond to major emergencies.
- Safeguarding procedures were in place and records in the emergency department were fully maintained and audited.

However:

- Although medicines were stored and administered appropriately, we found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.

Incidents

- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event. Fourteen serious incidents were reported between May 2015 and April 2016. None of these were never events. There were no overdue incident investigations pending, which represented a significantly improved position from 2015.
- No falls with harm or urinary tract infections in patients with a catheter were reported to the patient safety thermometer between March 2015 and March 2016. Over the same period, three new pressure ulcers were reported. Action was taken to reduce falls risk, for

example, yellow socks and yellow wristbands were worn by patients identified as at a higher risk of falls. A weekly safer care audit which included a check for compliance of falls risk assessments was undertaken.

- The service had taken action to identify learning from the investigation of incidents. Investigation reports included documented actions and shared learning. We found evidence that practice in the emergency department changed because of the investigation of incidents. Quality and safety bulletins and lessons learned newsletters used examples from the investigation of incidents and were published regularly.
- Actions taken after our 2015 inspection included the lessons learned newsletters (available through the staff intranet), the use of safety bulletins and the sharing of serious incident investigation findings to clinical and leadership teams. Actions taken to support lessons learned in 2016 has included briefing and discussion events for staff and strengthened audit arrangements following a serious incident.
- The service had also prepared a learning video for staff based on an actual incident in the hospital and human factors training was available to staff. Human Factors principles are applied to health care training to enhance safety through changes in clinical practice.
- The divisional nurse manager held a weekly meeting to review reported incidents and to focus on themes and lessons learned. Face to face feedback following a reported incident was available to staff from a specialist teaching practitioner dedicated to working with staff within the emergency department. Medical staff were supported with learning from incidents through the emergency department governance lead.
- Posters displayed in the department were changed regularly to share current learning from incidents. Staff we spoke with confirmed that they received feedback from the investigation of incidents, but said that this could be slow and said they did not always see changes because of the investigation of incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain "notifiable safety incidents" and to provide reasonable support to that person. The trust had in place a policy relating to the duty of candour requirements.
- Incident information reported under the duty of candour requirements was included in the electronic incident reporting system. Senior managers confirmed that the recording and follow up of incidents related to duty of candour had improved significantly since our visit in 2015. Training in duty of candour had increased staff awareness, which was supported by the weekly meeting to discuss reported incidents. Our own review of incidents confirmed that duty of candour was applied effectively.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and we found infection control and hygiene standards were maintained to a consistently high level. A weekly cleaning schedule was followed by the housekeeping team, supported by a hygienist. Cleaning rotas were dated and signed.
- Following use, the majors and resuscitation rooms were closed for cleaning and restocking before the arrival of the next patient. A colour co-ordinated lighting system was used for each resuscitation room, which showed green if the room was ready to use, and red if it required cleaning. Equipment, including trolleys that were ready to use were labelled with an "Hey I'm clean" sticker.
- The central area of majors used by staff was clean and clutter free. Disposable curtains were used throughout the department. Two sluices were located in the initial assessment and majors areas. Dirty commodes and bed pans were washed in the dirty sluice then labelled and moved to the clean sluice. "Hey I'm clean" labels were used on commodes and bed pans. Entry to the clean utility area was restricted by swipe access. The clean utility area was clutter free.
- A cleaning area for trolleys had opened since our visit in 2015, with separate designated dirty and clean trolley areas for porters to use. Porters cleaned trolleys after each patient use, and also weekly, in the dirty trolley area. Trolleys were labelled as ready for use and stored in the clean area.
- We observed that staff followed the bare below the elbow policy in clinical areas, and personal protective equipment was used. We observed that medical and nursing staff undertook effective hand washing between patients. Hand gel was not readily available in some areas of the department, although staff carried a small gel dispenser on their person. Following the inspection the trust informed us that action had been taken to

provide additional hand gel dispensers. Sharps boxes were provided in each cubicle, although we observed these were opened and stored at waist level, meaning they were accessible to members of the public.

- Cleanliness and hygiene was maintained and a checklist was used in each cubicle that indicated areas that needed cleaning. Cubicles were taken out of action until they were cleaned and restocked. Two rooms in the major's area were fitted with ventilation to isolate patients. Alerts in the computer display indicated patients with MRSA.
- The environment and equipment in each area of the department was cleaned following a regular schedule and this was recorded. Environmental and infection control standards were reviewed for each area of the emergency department each month and an overall score awarded for compliance. We saw evidence that action was taken where cleaning failures were identified from audit.
- The audit confirmed, for example, that mandatory safety training in infection control was compliant. Over 85% of staff were up to date with infection control training. We found evidence of compliance with infection control policies, for example, hand audits achieved 95% compliance and patient-led assessments of the care environment (PLACE) audit achieved 98%.
- The emergency department cleaning standard used in the children's emergency department was supported by nursing staff. The play specialist undertook cleaning of toys and we saw that this was recorded. The department was reviewing its cleaning policies with input from infection control.
- When we visited the Beverley Minor Injuries Unit (MIU) we observed that public areas and rooms were clean and tidy. Evidence that cleaning was done was signed and checked daily. Staff used personal protective equipment. We observed that staff washed their hands after giving treatments to patients. Toys were cleaned daily and this was recorded. Trolley cleaning and checking was undertaken by domestic staff. The sluice area was clean although we found five bed pans that were not labelled "Hey I'm clean." No hand gel was available in the unit.

Environment and equipment

- The hospital's extended and refurbished emergency department opened in April 2015. The major's area consisted of 24 enclosed cubicles. Visibility was maintained through the use of extensive glazed panels with curtains for privacy. Each cubicle included suction facilities and 11 cubicles were fitted with telemetry equipment for cardiac monitoring. Two of the cubicles were lead-lined for X-ray use. Two of the major's cubicles had en-suite facilities and were fitted with moveable partitions, which were used for scenario training. The monitoring and observation area in majors was located centrally in the line of sight for staff, with 12 cubicles on each side. The reception for the major's area was opened since our visit in 2015.
- The initial assessment area consisted of eight cubicles. A separate, supervised room was used for mental health patients.
- The resuscitation area comprised of 10 cubicles as we reported in 2015. The resuscitation cubicles were fitted with trolleys and equipment to support resuscitation intervention.
- The separate, linked children's emergency department had also been recently refurbished. The children's area consisted of eight main cubicles, two triage or initial assessment rooms, one paediatric resuscitation cubicle, one neonate's resuscitation cubicle and a waiting area for children.
- The further phase of building work that was still to be completed when we visited in 2015 was now finished. Since 2015 the minor's area (now known as the "emergency department") had been completed. The emergency department patient self-check-in was supported by a staffed reception area. Ten cubicles (six of these were opened in 2015) were used to see and treat patients. One cubicle with two exits was alarmed and was available to support patients experiencing mental health issues. Other cubicles were designated as a plaster room, an eye room and a physiotherapy room.
- The relatives' area consisted of three family rooms and a relatives' viewing room. A trolley bay for trolley and equipment cleaning and separate storage had also been completed since our visit in 2015. A computed tomography (CT scan) area was located next to the main emergency department.
- The clinical decision unit (CDU), which operated within the emergency division, opened in December 2015. The CDU provided for an extended short stay for up to six male and six female patients who had attended the

emergency department and required further observation or treatment. These patients may not be ambulant and may need a period of observation of up to eight hours.

- The adult major trauma ward facility located in Ward 40 within the Hull Royal Infirmary tower block was opened in December 2015. The major trauma ward consisted of 10 beds. There was no dedicated provision for paediatric intensive care although some facilities were available in neurosurgery.
- The Beverley MIU, operated as part of the emergency department, was located within the East Riding Community Hospital which opened in July 2013. The MIU consisted of an adult waiting area with magazines provided, four treatment rooms and a separate children's waiting area with toys and TV. Patients had the use of an adjacent radiology department.
- The medical physics department undertook the maintenance of medical devices and equipment checks were reported through an on-line system. We reviewed the planned and actual maintenance for the period from 1 April 2015 to 31 March 2016 and for the period from 1 April 2016 to the date of our inspection, which provided assurance that maintenance was up to date.
- We found there was a shortage of observation equipment available in the children's department. Staff told us that equipment shortages particularly happened in the morning as equipment could be moved to the adult department overnight.
- Equipment checklists were used throughout the department and equipment labels we checked were in date. Resuscitation trolleys were checked and signed daily, although we identified three days in June 2016, which were not signed as checked. Bins were provided in the emergency department mental health room and we queried this with staff as it presented a potential hazard.
- At the Beverley MIU the resuscitation trolley was checked daily, although on six days in March 2016 the defibrillator had not been signed and checked.

Medicines

- Medicines and intravenous fluids were stored safely and securely, and access was restricted to authorised staff. Controlled drugs were appropriately stored and accurate records were maintained, however we found daily balance checks were not always performed as per the trust policy. For example, in the resuscitation area checks had not been carried out on six days within the last three months. In the paediatric area checks had not been performed on 10 days within the last four months.
- Emergency medicines and equipment were readily available throughout the emergency department; however checks of resuscitation trolleys had not always been performed regularly in accordance with the trust policy. For example, daily checks had not been performed on 15 occasions within the last four months in the major's area and on eight occasions within the last three months in the minor's area.
- We checked medicines requiring cold storage and found they were not always managed in accordance with the trust policy and national guidance. Records of fridge temperatures had not been completed on 11 occasions within the last four months in majors and on eight occasions in minors. In addition, records showed the fridge temperatures in majors had been outside of the recommended range on six occasions and no action had been recorded in response to this. We raised this with the ward sister who was unaware the fridge had been out of range. We also found temperature records in the paediatrics area showed the fridge had been outside of the recommended range on nine occasions and again no mitigating action had been recorded. The staff nurse we spoke with was unaware of the correct procedure to follow when the fridge temperature was not within the correct range.
- Patient Group Directions (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately. PGDs are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked a PGD used by the nursing team in minors and saw this was being used effectively to support patient access to medicines in a timely way.
- Hospital prescription pads were appropriately managed and were stored securely throughout the department.
- At our unannounced inspection in July 2016 we again found some gaps in the checks undertaken in the major's area (six omissions). The minors area (three omissions) and in paediatric resuscitation (five omissions). In the paediatric area the process for checking was not clear and was dependent on staff remembering the checks needed to be done and remembering to escalate to the sisters if the staff had

been too busy to do the checks. The sister we spoke with said they checked the logs weekly and emailed or spoke with staff that had missed the checks and not escalated and this would be dealt with in line with any performance issues. Fridge temperatures were not checked on two days in July 2016. In the major's area, an incident report had been completed for a controlled drugs error in July 2016.

- Following our inspection the trust informed us it was introducing weekly returns for each department to confirm compliance with the monitoring of daily checks of controlled drugs, resuscitation trolleys and fridge temperatures. The medicines management elements of these checks were to be augmented by a monthly medicines management audit and action plan undertaken jointly by nursing and pharmacy staff.
- At the Beverley MIU we found evidence of daily fridge temperature checks. Medicines were stored in locked cupboards in the clean utility. Spare drugs for the resuscitation trolley and emergency drugs for patients who may experience a fit were available.

Records

- The emergency department used an electronic patient record system widely used in the NHS. Nursing and medical documentation was electronic within the trust. The department and the trust had implemented revised nursing documentation since our 2015 visit.
- We reviewed the recording of patient information for a selection of the records of 10 patients who had arrived in the emergency department. We found that overall the patient information was very well documented. We also reviewed a selection of records at our unannounced inspection, which confirmed that records were generally well maintained.
- We reviewed the documentation checks that the department undertook as part of its safety audit for the week of our inspection and a compliance level of 82.2% was achieved against a minimum expected standard of 70%.
- Following our inspection the trust informed us that senior nurses had been requested to undertake spot checks of record keeping standards.
- The Beverley MIU had also implemented the new system of electronic recording. We found that patient records for the MIU were well maintained.

Safeguarding

- Information provided to CQC by the local authority confirmed there were clear communication channels in place with the hospital's safeguarding specialist practitioner. All safeguarding adult concerns raised by hospital staff were checked by the trust safeguarding practitioners for accuracy before being referred to the local authority safeguarding team.
- Medical and nursing staff we spoke with were aware of their responsibilities relating to safeguarding adults and children and were aware of procedures to follow. For the emergency department, 91% of medical and 90% of nursing staff had completed vulnerable adults' training. In addition, we found that 89% of medical and 95% of nursing staff had completed safeguarding children level 3 training. Staff we spoke with in the emergency department confirmed they were up to date with safeguarding training.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situations where abuse or neglect of children is suspected'. However, four other specific guidelines we reviewed on the trust's intranet were out of date including 'Safeguarding children: children and domestic violence' which expired in September 2015. 'Safeguarding children in whom illness is fabricated or induced', expired in June 2015 and 'Safeguarding children: managing allegations or concerns against staff', expired in June 2014 and 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.
- Following a safeguarding incident in 2016, the department had reviewed its chaperone guidance and we saw that notices about the availability of chaperones were displayed in the emergency department, which included each cubicle. Medical staff we spoke with confirmed they were aware, and complied with, the chaperone guidance. We found the chaperone guidelines were discussed with all temporary staff. The patient's choice of whether to use a chaperone or not was documented.
- The child safeguarding team was available to provide support for the children's emergency department. For children or young people presenting with emotional, behavioural or substance use issues, the department liaised with the Child and Adolescent Mental Health Service (CAMHS).

- Following the inspection, the trust confirmed that each emergency department referral was screened each morning (Monday to Friday) for each child under the age of 18 years. Following a weekend or bank holiday, patient information was screened on the next working day by the safeguarding children's team.
- At the Beverley MIU we observed that notices were displayed about the chaperone policy, which stated that chaperones were available for all medical examinations. Staff confirmed they had received safeguarding training.

Mandatory training

- For the emergency department overall, 84% of medical staff and 83% of nursing staff had completed their mandatory and statutory training in the last 12 months, against the trust's target compliance level of 85%.
- The trust was assured that the numbers of nursing staff trained in the care of children enabled the emergency department to provide sufficient numbers of competent staff to manage paediatric emergency admissions out of hours. The department had an ongoing training plan in place to support nursing staff to manage paediatric admissions.
- We found three of the five nursing coordinators (band 7) in the majors department were RSCN (Registered Sick Children's Nurse) trained. In addition, 11 adult nursing staff had completed EPLS (European Paediatric Life Support) training and a further four staff were due to attend this training. Paediatric immediate life support training had been completed by 24 adult nursing staff. A further 22 adult nursing staff had completed Embrace (Emergency Department Staff Recognition of Critical Illness, Spotting the Sick Child) training. Also, one senior nurse had completed a university course in care of the child in A&E.
- We reviewed separate evidence of advanced trauma life support training and resuscitation training completed by medical and nursing staff. For non-qualified staff, basic life support training was mandatory.
- Protected time was allocated to members of staff who required training. The specialist teaching practitioner followed up members of staff by email when their training was due.
- Staff we spoke with had completed their mandatory training, some of which was completed on line. Staff were able to view the status of their training on the trust intranet. We confirmed from the intranet that staff were fully compliant with their mandatory training.
- At the Beverley MIU staff confirmed they had completed their mandatory training and that allocated time was available for this.

Assessing and responding to patient risk

- Between April 2015 and March 2016 the department experienced 1,081 black breaches. In February 2016 there were 156 breaches and 144 occurred in March 2016. There were black breaches on 42% of days over the year (152 days) and on 39 days there were 10 or more black breaches. Black breaches are defined as the time between an ambulance arriving at the hospital to the patient being formally handed over to the emergency department, which is longer than 60 minutes.
- During the week of our 2016 inspection, ambulance handovers occurred in an average time of 36 minutes. For patients arriving by ambulance, nursing staff completed a handover with ambulance staff and then undertook an initial clinical assessment. Since our visit in 2015 the emergency department had reviewed the patient pathway through the department and revised escalation procedures had been agreed with the ambulance service. Senior managers told us the trust was reviewing the approach of other trusts to ambulance handover in order to compare practice in reducing ambulance handover times.
- The rapid assessment and treatment (RAT) system which had been discontinued in 2015 because of staff shortages we found was now resumed. We observed consultant and middle grade staff as they undertook RAT. Staff told us they felt initial assessment ran more smoothly when RAT was operated.
- The self-registration system for the emergency department (minor's area) was supported by nursing reception staff who helped patients who were unsure as to how to use the system. The check in system prioritised how quickly a patient was seen, based on the information they submitted. The department had taken steps to identify patients who entered exaggerated data to be seen more quickly. The patient was red flagged on the system if they needed pain relief or were

experiencing acute illness. If a patient was triaged as "Red" they were seen by a triage nurse within 15 minutes of arrival (escalation policy states within 30 minutes).

- Following an audit of self-registration six weeks prior to our visit, the system was changed to include a question to the patient as to whether they had a referral letter. The trust confirmed it was auditing the use of the self-registration system at the time of our visit.
- In the resuscitation area we observed the progress of a major trauma incident. We spoke with external staff involved with the response to the incident who confirmed that patients involved in major trauma within a radius of 35 miles could arrive at the hospital within one hour. We were informed that pathways at the hospital were recognised as better for major trauma.
- Every two hours, as indicated by a digital clock at the staff base, the progress and developing risks for each patient in the department were reviewed. A designated member of senior medical staff acting as emergency physician in charge (EPIC) facilitated a ward round with medical and nursing staff supported by screen displays for each area of the department. Each patient was reviewed according to their room number and time critical cases were identified. The patient care plan was discussed and concerns were welcomed. Decisions from the previous board round were followed up and new actions were documented. The ward round typically took 15 minutes to complete. The ward rounds at 8am, 4pm and midnight were handovers.
- We visited the department in the evening and found the ward round had not taken place for five hours 25 minutes. The EPIC role had been transferred to a locum consultant. When we discussed this with senior managers we were informed there had been an exception because of pressure on workload, but the frequency of ward rounds may be varied at night. After discussion, managers acknowledged that maintaining the ward round was essential to support the safety of patients particularly when the department was very busy. Managers stated that if necessary a focused ward round could take place within a 10 minute turnaround and need only involve the senior doctor and senior nurse. Managers confirmed that currently 80% of daily ward rounds were audited. Bringing the whole staff group together was recognised as important to share learning and maintain safety in rapidly changing situations.
- In the children's emergency department, ward rounds took place three-hourly, at 9am, 12noon, 3pm and 6pm. Escalation arrangements were in place for a medically sick child. Paediatric consultants or specialist registrars could be called on to provide support and advice. A dedicated internal telephone number (2222) was used for a paediatric "crash" call.
- Escalation criteria were used for deteriorating patients. The National Early Warning Score (NEWS) observation chart was completed, supplemented by a local assessment. The trust provided evidence to CQC of the completion and auditing of the NEWS score in the emergency department for the last 12 months. A standard operating procedure (SOP) was used with escalation triggers for staff to follow. We discussed with senior staff the operation of the escalation mechanism. Staff acknowledged the importance of maintaining the review of patients through regular (two hourly) board rounds including at night and when the department was particularly busy.
- Medical staff in a focus group confirmed that rising NEWS scores were documented, but stated that they were not always referred, which resulted in patients being missed. They expressed concerns there was no system to identify the deteriorating patient.
- We saw the arrival of adult patients by ambulance and through self-check in. We also observed the arrival and initial assessment of patients in the children's department. A fast track system for arriving children to move to the nurse-led paediatric assessment unit was introduced in 2015 following our previous visit. We observed that triage and streaming of patients took place appropriately.
- Following our inspection the trust informed us it was introducing weekly returns for each department to confirm compliance with the monitoring of daily checks of early warning scores and risk assessments.
- At the Beverley MIU patients were booked in by a receptionist and allocated to a waiting room. There were separate waiting rooms for adults and children. Nursing staff relied on the receptionist to report any change in a patient's condition. We found nurse practitioners prioritised patients by their illness symptoms rather than according to the time they had waited. However, we found there was no standard operating procedure for escalation in place for when the MIU was busy and faced likely breaches. Nursing staff

were not able to explain clearly the escalation procedure they would follow, although they told us support was available from the main emergency department.

Nursing staffing

- We found the trust had made significant progress in its emergency department nursing staffing compared with our 2015 visit.
- The trust confirmed that the emergency department nursing establishment was in line with published guidance and the staffing rota was devised to meet demand. The safer nursing care tool was also used and staffing concerns were escalated to and discussed at the twice daily safety brief. The nursing establishment for the emergency department was 79.4 WTE and the department was carrying four vacancies for qualified nurses at the time of our visit, which were due to be filled during 2016. Seven student nurses working in the department were due to be qualified in September 2016 when they were to be offered permanent posts. This represented a substantially improved staffing complement compared with 2015, and also included the recruitment of advanced nurse practitioners (ANP), as anticipated at our 2015 visit.
- We found the nursing staffing rota was planned to provide for staggered start times which reflected the demands of the department over the 24 hour period. We observed in the emergency department that the EPIC, working with the nurse in charge, allocated staff from the current rota to the various areas of the department, dependent of the assessed need. The allocation of resources was reviewed during the progress of the shift.
- The paediatric emergency department was staffed with RSCN trained nurses between 8.30am and midnight. When the children's emergency department was closed, out of hours staffing was provided by adult nurses, with the paediatric ward coordinator attending for resuscitation calls. We were informed that emergency department staff had access to paediatric trained staff 24 hours per day should this be needed. We observed that during busy periods, nursing staff were moved between the adult and children's areas. Adult trained nurses were rotated to the paediatric area on a six-weekly basis. Staff we spoke with and staff side representatives expressed some concerns as to the availability of suitably competent staff deployed to each area of the department.
- The department used temporary or agency staff only rarely. All staff received an induction before working in the department. The specialist teacher practitioner was not rostered into the staff rota, but was available to work in the department if there were staff shortages.
- At the Beverley MIU, nurse practitioners were used to provide a nurse led service, supported by qualified and unqualified nursing staff. Staff numbers were planned using an acuity tool.

Medical staffing

- Our 2014 inspection report referred to the Royal College of Emergency medicine (CEM) 2011 operational handbook which stated that every emergency department that had over 100,000 attendances per year should have a minimum of 16 consultants. At this visit the trust confirmed the consultant establishment in the emergency department was 17.00 WTE. Of these, 11.35 WTE were substantive in post. Of the 5.65 WTE vacancies, 1.45 WTE was provided by internal long term locum cover and 2.36 WTE by regular agency cover. The emergency consultant shortfall was therefore 1.84 WTE.
- As in 2015, the trust was actively recruiting to the consultant posts and we were informed that the trust expected four further substantive emergency department consultants to be in post during 2016. This meant the trust was significantly ahead of its trajectory of three-year consultant recruitment which we reported in 2015.
- Following our inspection the trust confirmed that trainee vacancies and establishment for emergency medicine were 86% filled effective July 2016. The proportion of junior doctors was higher than the national average and the proportion of consultants was higher than average.
- The EPIC on duty explained to us how medical staffing numbers were deployed in the majors, resuscitation and paediatric areas of the department, according to patient need and flow. There was a recognised shortage of medical staff at night. We discussed with senior managers the deployment of medical staff resources for the two hourly ward rounds in the emergency department. Although the medical resource was recognised as significant, the advantages of ensuring patient safety and of potentially more effective use of other staff resources were felt to outweigh any resourcing implications.

- We also expressed concern as to the long hours worked by some consultant staff to provide night cover. One consultant had worked from midnight to 8am the previous evening and returned to work at 4pm to work until midnight. During the evening medical staff were attending to a high acuity patient in the department in addition to six patients in the resuscitation area. We found there was no guidance related to shift turnaround for medical staff and we discussed our concerns with senior managers as to the safety aspects of this arrangement.
- The trust informed us there were three consultants in the emergency department who were paediatric trained. Consultants provided cover for the children's department Monday to Friday 8am to midnight and 8am to 5pm on Saturday and Sunday. Locum consultant cover was provided from 5pm to midnight on Saturday and Sunday. Overnight cover was provided by consultants on Wednesday and Thursday. Registrars (ST4 and above) provided overnight cover on Monday, Tuesday, Friday, Saturday and Sunday. Providing adequate consultant cover was recognised as challenging.
- The hospital was designated as a major trauma centre. Regulators had identified there was not a consultant trauma team leader always available within five minutes, 24 hours per day which was the national requirement for co-ordinating care to trauma patients. In addition, there was no evidence to demonstrate that times when the department was not covered by a consultant trauma leader there were minimal number of trauma calls received. The trust had reviewed six months' data which indicated that each patient triggering a trauma call was seen by a consultant within five minutes and a policy was in place to support this. The department was to explore the feasibility of a tiered trauma alert system. An external peer review visit was planned for October 2016.
- At the Beverley Minor Injuries Unit MIU, the emergency nurse practitioners accessed consultants on duty in the main emergency department if they needed medical advice.

Major incident awareness and training

- The trust had a major incident plan accessed through the staff intranet. The document identified the role of the hospital major incident plan in the escalation pathway in the event of a major incident. The previous alert took place during 2016. We reviewed the major incident plan and discussed with staff their awareness of the plan and the actions they would take in the event of a major incident. Alert forms and supporting documentation were available in the staff base area. Staff undertook CBR (Chemical, Biological, and Radiological) training weekly and were familiar with procedures to follow in the event of a major incident alert.
- Staff at the Beverley MIU had not received major incident awareness training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

At our previous inspection in May 2015, we rated effective as 'Good'. In June 2016 we rated effective as 'Good' because:

- Patient care and treatment followed evidence based guidance and recognised best practice standards.
- The service supported the learning and development of both medical and nursing staff. All staff new to the department received an induction and all staff received an annual appraisal.
- Medical and nursing staff worked closely with other disciplines in the hospital to coordinate care pathways for patients. Patients being discharged or referred to another service were supported with information which followed their pathway of care.
- Patients' pain was assessed and controlled and they were provided with appropriate nutrition and hydration. Outcomes for patients were audited.
- Patients' consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act were followed where this was appropriate.
- The department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme, measured its performance against other trusts, and performed well in some of these audits, for example, initial management of the fitting child.

However:

- The trust's performance against some standards measured through audit, for example, cognitive impairment in older people, was poor. Action plans were in place for these audits.

Evidence-based care and treatment

- The emergency department used National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) with supporting clinical guidelines and patient group directions to ensure the effectiveness of treatment provided for patients.
- As examples we reviewed the clinical guidance cards for emergency department head injury which included the NICE head injury guidelines and the Canadian C-spine rules; we also reviewed the clinical guidance cards for minor side ankle foot which included the Ottawa ankle rules and the Ottawa knee rules. The guidance was part of mainstream practice followed by all staff in the department. Guidance was accessed through the staff intranet.
- Use of the sepsis care bundle was a College of Emergency Medicine recommendation. We found it was used in the emergency department. The trust presented evidence which showed the percentage of patients who met the criteria for the local protocol who were screened for sepsis correctly in the emergency department had risen from 25% to 92% in the period from August 2015 to May 2016.
- The emergency department participated in the Royal College of Emergency Medicine's national programme of clinical audit. For 2014-15, the department performed well in the initial management of the fitting child audit, meeting all five standards. In the assessing for cognitive impairment in older people audit, the department failed to meet the fundamental standard for all patients to have their early warning score documented. Although one of the two developmental standards was technically met, only one case was audited against this standard. Performance against the remaining standards was poor. In the audit of mental health in the emergency department, the department was in the lower England quartile for four indicators, but it was in the upper England quartile for two developmental standards, one of which was met. The trust provided evidence it was taking action in response to these audit results.
- In support of the development of the major trauma centre, we found systems were in place for recording and collecting trauma audit and research network (TARN) data. This enabled comparative information relating to trauma care in the department to be shared externally and provided evidence based measures of meeting NICE guidance.
- The local audit programme in the emergency department in the last 12 months included an audit of asthma, a record keeping audit and an audit of minimising missed antibiotic doses. We did not review the results of these audits.
- At the Beverley Minor Injuries Unit (MIU), nurse practitioners confirmed they followed NICE guidelines as for the main emergency department.

Pain relief

- In their initial assessment the patient was asked about whether they were experiencing pain and whether they required pain relief. The record of the assessment showed that checks were undertaken and medication administered to provide pain relief for the patient.
- We spoke with 14 patients in the initial assessment, minor injuries, majors and paediatric areas of the department about whether they were offered pain control medicine if they were in pain. With two exceptions, which were for clinical reasons, patients were asked about their pain. Three patients had declined pain relief. Although we observed patients were asked to score their pain, we did not see that this was always recorded.
- Patients using the self-registration screen were asked to complete a pain score, to answer whether they required pain relief, and to identify the area the pain was located.
- We observed that staff were prompt in following up patients' pain symptoms and administering pain relief. Patients we spoke with who had required pain relief spoke positively about the way staff had handled their request. Patients who declined pain relief said they were satisfied with the care they received.
- At the Beverley MIU, patients we spoke with confirmed they were offered pain relief.

Nutrition and hydration

- Food and drink was offered to patients in the department if clinically appropriate. In addition to meals being offered three times a day, sandwiches and drinks and cultural and special diets were available on request throughout the day and monitored using the fluid balance chart.

- We saw there were water fountains and juice provided in the initial assessment and major's areas of the department. When we visited the department unannounced, we observed as a nurse gave priority to getting a drink for a patient.
- Checks included in the initial assessment included the patient's needs for food and drink, their need for assistance if required, and the need for intravenous fluids.
- We reviewed the clinical observation and hydration checks that the department undertook as part of its safety audit for the week of our inspection and a compliance level of 95.4% was achieved against a minimum expected standard of 70%.
- Patients we spoke with had mainly been offered a drink and could order food during their time in the department. A patient who had been in the department more than three hours had taken drinks but declined food. They told us they were satisfied with their care.
- When we visited the major's area in the evening, we spoke with one patient who had not been offered any food or given an explanation why. They said it was an hour since they had a glass of water.
- We discussed with senior managers our concerns about a patient who had no food or drink for more than two hours and staff had not informed the patient they were nil by mouth for clinical reasons.
- At the Beverley MIU, we observed that a water dispenser was available in the main area of the department. No facilities were available for snacks.

Patient outcomes

- The percentage of patients leaving the emergency department before being seen was higher than the England average between June 2015 and January 2016.
- Unplanned re-attendances to the emergency department within seven days of discharge were consistently worse than the 5% standard for England between February 2015 and January 2016.
- The emergency department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme and measured its performance against other trusts through taking part in these audits. Action plans to take forward the results of national audits were completed and ongoing actions were monitored through the trust's quality improvement programme action plan and progress report (QIP).
- For 2014-15, the department performed well in the RCEM initial management of the fitting child audit, meeting all five standards, including the fundamental standard. However only one case was audited against the fundamental standard (blood glucose is recorded in all children actively fitting on arrival) and the standard that children actively fitting on arrival are managed according to the APLS or EPLS algorithm. Furthermore only two cases were audited against the standard that patients' parents or carers should be provided with written safety information.
- In the RCEM audit of assessment of cognitive impairment in older people 2014/15, the department failed to meet the fundamental standard for all patients to have their early warning score documented. Although one of the two developmental standards was technically met, only one case was audited against this standard. Performance against the remaining standards was poor.
- The department failed to meet either of the two fundamental standards in the RCEM audit of mental health in the ED 2014/15. The department was in the lower England quartile for four indicators (including three developmental standards). On the other hand it was in the upper England quartile for two developmental standards, one of which was met.

Competent staff

- The proportion of nursing staff in the emergency department who had received an appraisal as at May 2016 was 78.4%. The proportion of administrative and clerical staff in the emergency department who had received an appraisal, as at May 2016 was 90%, and for ancillary staff, 100%. For other clinical services staff it was 75%. The proportion of medical staff in the emergency department, who had received an appraisal as at April 2016, was 80%. This represented a significant improvement from our 2015 visit.
- A specialist practitioner (band 7) provided a teaching role for the emergency department. Staff new to the department attended an eight-day induction programme and worked for a supernumerary period, usually one month. Student nurses were oriented to the department. Staff new to the department worked in the major's area for six to twelve months, before working in the resuscitation area. Staff needed to complete competencies before moving to other areas of the department, for example initial assessment. All staff rotated to the children's department for six weeks to

support their competency development. Newly qualified staff were supported by preceptorships. Qualified staff we spoke with said they felt well supported with their development.

- Nursing staff from the children's department may work in the adult area during their shift. Staff working in the children's department and staff side representatives, expressed concern as to the deployment of adult trained nurses in the children's area, and of children's nurses in the adult area, who may not have relevant skills and competence for the role.
- Following our inspection we asked the trust to provide assurance as to the competencies of staff to care for children 24 hours a day. The trust provided evidence that specialist support from children's trained nurses and paediatricians was available 24 hours a day. Also, the department rotated nursing staff into paediatrics for six weeks so that adult staff could be assessed for competency in the care of children and 15 adult nursing staff had undertaken this assessment.
- The trust confirmed that advanced trauma nursing course (ATNC) trained nurses were available on all emergency department shifts, which was verified during our inspection. A major trauma coordinator (band 7) was in post from December 2015 and we reviewed evidence of the coordinator's training plan for the centre. Trauma intermediate life support (TILS) training and other specialist training was planned to support staff working in the major trauma ward.
- The General Medical Council (GMC) reported in 2016 that doctors in training received a good level of supervision but work intensity remained an area of focus. The GMC reported that it continued to support the trust with enhanced monitoring to ensure changes were sustainable. The GMC provided evidence of the revalidation decisions and deferral rates for medical staff in the trust.
- Doctors in training that we spoke with confirmed they received protected time for their regular and mandatory training activities. Medical grades CT1 to CT3 attended morning teaching sessions. Consultant staff we spoke with confirmed the trust provided developmental support through coaching and mentoring.
- At the Beverley MIU, emergency nurse practitioners we spoke with had received an appraisal and developmental training. Clinical supervision included informal support from consultant medical staff. Clinical support staff confirmed they had received an appraisal; they told us they were well supported through mentoring and were encouraged to develop their skills.

Multidisciplinary working

- We observed effective multidisciplinary working within the department between medical and nursing staff of all levels of seniority, and with other clinical services and administrative staff. Effective cross-team working was observed particularly in the two-hourly ward round. Information was shared by the whole team, which supported learning.
- During or following the ward round, emergency department staff engaged with other disciplines, for example physiotherapists and mental health nurses, to coordinate patient care. Managers we spoke with identified the need to develop more effective links with the medical wards as the area which most needed development.
- The children's emergency department worked jointly with the paediatric ward. The paediatric ward provided medical and nursing support for the emergency department.
- The emergency mental health liaison team based at the hospital supported patients who arrived with symptoms of mental illness. The children's emergency department worked with the child and adolescent mental health services team to support patients.
- Multidisciplinary meetings identified major trauma patients across the hospital and coordinated the care and movements of patients within the trauma network. We observed a trauma patient in the CT suite and the effective working of the multidisciplinary team. The ambulance service attended monthly meetings.
- In the Beverley MIU, X-ray facilities were on site and staff liaised effectively with radiographers on duty.

Seven-day services

- The emergency department, including the major's reception area, was open 24 hours a day, seven days a week. Patients with symptoms of mental illness were supported 24 hours a day.
- The children's emergency department was open from 8.30am to midnight. We were informed the children's emergency department could be kept open after midnight in emergency situations. The children's waiting area remained open and patients who arrived

after midnight were cared for in the major's emergency department. From September 2016, the children's emergency department was to stay open until 2am for a trial period.
- Diagnostic tests for patients including X-rays, blood tests and CT scans were available 24 hours a day. A second CT scanner was located on the second floor of the Hull Royal infirmary building which was open from 9am to 5pm.
- The Beverley MIU was open Monday to Friday, from 9am to 5.15pm. At weekends and bank holidays it was open from 9am to 6pm. Another NHS organisation operated a GP out of hour's service from the MIU location from 6pm until 8am.

Access to information

- The computer information system used in the department was widely used in the NHS and had been implemented since our last visit in 2015.
- In the central staff area of the majors department large information screens displayed real time information about patients in each area of the department, in each cubicle. For example, information displayed included arrival time in the department, medications, and any abnormalities with blood results, highlighted with an exclamation. Three hours from arrival patients were marked in purple, and after four hours, in red. Information screens were sited to support patient confidentiality.
- Clinical Information and guidance was available through the staff intranet. Information also included operational policies and procedures for the department. The front page of the staff intranet showed the latest operational performance information for the emergency department. The emergency department operational performance was also displayed on a whiteboard, titled, "How are we doing?"
- The executive team used a recently devised management information report with key operational management information also displayed in graphical format which was produced daily. Some senior staff used a mobile app which showed current average waiting times and the number of patients in attendance in the department.
- A whiteboard was used to record tasks for portering staff. We observed that portering staff used the computer displays to track the whereabouts of patients.
- A picture archiving and communication system (PACS) was used to access radiology images on line.
- Each member of staff had access to their own email account.
- Posters located on notice boards were also used in the common area and in cubicles to display useful information for patients and staff. Each major's cubicle displayed named nurse information outside of the room, with "Things to do" documented and marked when done. In the emergency department (minors) coordinating area we observed a whiteboard was used to show the status of patients in each of the 10 cubicles. A handwritten whiteboard was used to display patient information in the resuscitation area.
- We found after discussion that there was currently no system of checking that patients' blood results had been checked before they were discharged.
- In the Beverley MIU, a display board in the waiting area informed patients of staff on duty and waiting times. The computer displays in the emergency department also showed the situation at the Beverley MIU.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were requested for their consent to treatment and we found evidence this was discussed with them so that consent was obtained appropriately. For most patients who arrived in the department, interventions required informal or verbal consent.
- The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were included in mandatory training. Nursing and medical staff we spoke with had completed their training.
- Staff we spoke with, including junior medical staff, demonstrated a clear understanding of the MCA, of their responsibilities and of DoLS procedures. The emergency department's specialist practitioner supported staff who may not have had previous experience of using the procedures.

Are urgent and emergency services caring?

Good

At our previous inspection in May 2015, we rated caring as 'Good'. In June 2016 we rated caring as 'Good' because:

- Care was delivered with compassion and staff treated patients with dignity and respect.
- Staff responded promptly and empathically when patients needed help and support to meet their basic personal needs and staff anticipated these needs in a caring way.
- Information from patients about their experience of using the service reflected a relatively high level of patient satisfaction. The cultural needs of patients were understood and their individual needs were taken into account in the way patients received care.
- Patients received emotional support as part of their care.
- Patients were consulted and involved in decisions about their care and treatment.

However:

- When the department was very busy we found patients were not always kept consistently informed about progress with their care and treatment.

Compassionate care

- The performance in the friends and family test between March 2015 and February 2016 was positive, although the emergency department's performance was mostly worse than the England average. Despite this, the percentage of patients likely to recommend the emergency department had doubled, to 78.1%, over the six months to January 2016. During the week of our visit the friends and family response rate was 89%.
- In 2015 we reported on the emergency department survey 2014, in which the trust performed worse than other trusts for 11 of the questions relevant to the caring domain, and “About the same” for the remaining 13 questions. No formal local patient survey information for the emergency department was available to inform this inspection.
- Ahead of this visit, we undertook an unannounced inspection of the emergency department on 9 June 2016, specifically to review the caring domain. We spoke with patients and their relatives to seek their opinions of care in the department, and observed care being delivered. We also reviewed a selection of the “I want great care” forms completed by patients in the emergency department, and a selection of letters written to the trust by patients about their care. In addition to the patients we spoke with at the CQC stall in the hospital ahead of the inspection, we spoke with 20 patients in the emergency department and observed the care of a further five patients. We also spoke with five relatives.
- The overall theme of the 2016 evidence we reviewed was positive, which represented a continuing improvement from 2015. Patients we spoke with were generally very happy with the care they received and spoke positively as to their treatment in the department, as to staff respecting their dignity and as to their privacy and confidentiality being maintained. Patients said all grades of staff treated them with compassion.
- Relatives we spoke with said they were impressed with the speed with which their relatives were seen and how they were treated. We spoke with relatives of children being seen in the paediatric area who told us their children had good experiences of attending the department.
- We observed that staff interacted with patients empathetically and responses to their needs were usually prompt. In the majors area we observed that respect was shown to patients and their dignity was upheld. Staff assisted patients who were unsteady on their feet with their personal needs. A call button was also positioned near the patient so they could summon help, except in one instance we observed. At our unannounced visit we observed the transfer of one patient through the department where their dignity was not maintained. We also observed that although the doors of adjacent cubicles were closed during the ward round, this was only partially effective in maintaining confidentiality.
- In the children’s department we observed that doctors and nurses spoke in an appropriate way to children and asked relevant questions in a way that the child understood. We observed that curtains were drawn to preserve privacy and dignity in the paediatric area. We observed one patient who went to the X-ray department by hopping or being carried by their parents, although there was a wheelchair nearby.
- The letters written to the trust by patients about their care included examples of compassionate care being given.
- Staff in a focus group told us that no member of staff would be concerned about a family member being treated in the emergency department.
- At the Beverley Minor Injuries Unit (MIU), we spoke with two patients and their relatives and observed as staff

interacted with a number of other patients. Patients spoke positively about the convenience of the service and the relevance of the diagnosis they received. Patients visited the MIU from preference. The "I want great care" forms completed by patients at the MIU commented on the efficiency, friendliness and helpfulness of the advice given. They commented positively about the professionalism of staff and the excellence of the care they received.

Understanding and involvement of patients and those close to them

- In the majors area patients told us they felt generally well informed about their care and treatment by doctors and nursing staff. However, when we visited the major's department in the evening we spoke with one patient who felt they had not particularly been kept informed, although they stated that the staff themselves were fine. When the department was very busy we found patients were not always kept consistently informed about progress with their care and treatment.
- In the emergency department (minors) we observed that nursing staff explained to patients about their care and treatment so that they knew what to expect. Patients told us that nurses had explained what was happening all the way through their visit.
- In the children's department we observed that clear explanations were given at each stage of the patients' pathway through the department, which included reporting to reception, initial assessment and consultation. For example, we observed as staff spoke with patients and their relatives about a patient who required admission and gave a clear explanation to the patient who required admission as to the reasons why and the likely length of stay. For another patient who had had an X-ray staff explained what was to happen next, what the follow up actions were going to be which involved a clinic visit, and about self-management of pain when at home.
- Relatives told us they had been kept informed of what was happening next to their child and of what follow up actions were going to be. Relatives said they were happy with the explanations they had been given.
- In the major trauma ward, we saw that staff shared an information leaflet with patients who transferred to the trauma unit as a reference and confirmation of information they were given verbally on arrival in the unit.
- At the Beverley MIU we observed that at discharge, advice leaflets were given to patients about their illness and treatment which supplemented information given verbally to the patient about their condition and pathway of care after discharge.

Emotional support

- A bereavement service was available for the relatives of patients who died in the department. The chaplaincy service was available to support relatives who had lost loved ones.
- Patients and their relatives who had received emotional support during their time in the emergency department spoke to us appreciatively of the service they had received.
- In the children's department a play specialist was on duty from 6pm to midnight. We observed that the play specialist provided emotional support to children and their families visiting the department.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement

At our previous inspection in May 2015, responsive was rated as 'Inadequate'. In June 2016 we rated responsive as 'Requires improvement` because:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival
- No formal arrangements or protocols were in place for liaison with other specialties. When the department was very busy we found senior medical and nursing staff time taken up unduly with arrangements for the transfer of patients, while their care and treatment could be delayed.

However,

- The trust was meeting a locally agreed trajectory which had been agreed in conjunction with regulators and had done so for three consecutive months. In June 2016, 85.9% of patients were seen within four hours, which was in line with the agreed trajectory of 85.1%.

- The needs of the local population had influenced the planning and delivery of the extensively refurbished emergency department. A new frailty team was used to assess the individual needs of this group of patients. The major trauma centre facilities had been upgraded since 2015.
- Patients with a learning disability, patients with dementia, and bariatric patients could access emergency services appropriate for them and their needs were supported. Patients needing care and treatment for their mental health needs could access services in a joined up way from within the department.
- Patients with different cultural needs were taken account of in the planning and delivery of services and actions were taken to address inequalities.
- Patients knew how to complain and staff knew how to deal with complaints they received. Complaints were investigated and learning was shared with staff.

Service planning and delivery to meet the needs of local people

- We reported in 2015 that the refurbished emergency department which opened in April 2015 was planned and designed in consultation with patients and staff following feedback received from patients and their relatives about their experiences in the department. A separate children's emergency department had been refurbished within the previous two years, also following feedback received from patients and their relatives.
- Since our 2015 visit the refurbished relatives' rooms had reopened which provided a suitable environment for bereavement support and a viewing area. The four family rooms included one with a link to a viewing room which could be accessed independently to the other rooms, which meant families' emotional needs were respected.
- Since 2015 the service had taken significant steps in developing its major trauma centre facilities. The trust had responded to serious concerns identified by regulators in achieving compliance with its major trauma centre accreditation requirements. A further external peer review visit was planned for October 2016.
- The trust had completed a business case for the development of the major trauma centre which was submitted to the executive team in May 2016. A major trauma ward for adults was operational from December 2015. The service did not include a paediatric major trauma centre. The longer term development of rehabilitation facilities was being progressed in conjunction with the trust's trauma network and health economy partners.
- We were informed of plans to introduce a frailty service during 2016 as a further phase of development of the urgent and emergency services for the trust.
- We also commented in our 2015 report on the trust's longer term development of its emergency medical service pathways. The development of emergency services within the sustainability and transformation plans was in development and consultation with commissioners and neighbouring providers of care.
- The Minor Injuries Unit (MIU) emergency service operated from the East Riding Community Hospital was subject to review by commissioners at the time of our visit.

Meeting people's individual needs

- At our unannounced inspection we observed staff in the major's area as they provided care and interacted with a patient's relative who was elderly and was living with dementia. We saw staff were skilled at re-orientating the relative to his surroundings and keeping him safe. Staff provided both the partner and the patient with sandwiches and a cup of tea. Staff showed concern and compassion and involved social care services in a timely way. The elderly man had been referred to the emergency duty team in social services who visited while we were still in the department. Emergency respite care was to be arranged.
- The needs of patients with complex needs who attended the emergency department were under review at the time of our inspection. The identification of patients at initial assessment suitable to be supported by a frailty service was planned for introduction during 2016.
- Patients with mental health needs accessed the services of a specialist mental health trust that was located in the hospital. From July 2016 an integrated care arrangement was used and services were available from an in-house mental health team 24 hours a day. Medical and nursing staff understood the procedures for reviewing a patient's mental health needs. An advocacy service was available for patients needing this support.

- Interpreter services were available, including an on-line service. Staff used the intranet to access services for patients with specific cultural needs. A chaplaincy service was available 24 hours a day.
- Staff in the children's emergency department confirmed they used the translation service and had developed a phrase book to help with immediate translation needs. .
- The cultural needs of patients were included in the initial assessment and available in the patient record. Staff gave the example of conversations about patient needs that took place during Ramadan.
- Patient passports for patients with a learning disability may be completed by care providers prior to admission. The learning disabilities nurse received details of patients with a learning disability and was available to support patients and carers when a patient required admission to hospital. The service was available Monday to Friday 9am to 5pm. Groups representing carers had requested additional support.
- Patients with dementia were identified by a butterfly sticker on their ID bracelet and a butterfly on their notes, which highlighted to staff the need for additional support for the patient. Dementia awareness was included in mandatory training for staff, supported by dementia awareness sessions. Aids were available to support patients with dementia.
- The emergency department was equipped with trolleys capable of carrying bariatric patients. Bariatric chairs were available for patients' use in the department. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity).
- The emergency department presented an extensive area for staff and visitors. Direction signage on the flooring helped people to find their way between areas.
- At Beverley MIU, we found there were no facilities designated for mental health patients, although on request a room could be set aside until the mental health crisis team took over the patient's care.

Access and flow

- At the 2015 inspection, the trust informed us that operational issues had affected the trust's ability to move patients through the emergency care pathway in a timely manner, leading to crowding in the emergency department. This affected the trust's ability to take a timely handover of patients from the ambulance service, leading to black breaches. Staff identified patients who were likely to exceed the four hour wait after three hours, but actions required to support the care and treatment of these patients frequently involved liaison with other departments, including the identification of a bed for the patient to be admitted, or tests to be completed prior to discharge. Arrangements were followed to escalate long waits to on-call managers and to include the bed manager.
- At this inspection the care pathway had been changed to improve patient flow. The acute medical pathway was revised so that stable, ambulant patients were managed in the ambulatory care unit. The acute medical unit was used for patients with complex needs unable to be managed outside of hospital. A clinical decision unit (CDU) provided for the extended short stay of patients who required a period of observation or treatment of between four and eight hours. Only the emergency department consultant or senior clinician had direct admitting rights to the CDU.
- Ahead of this inspection we were informed that within the first two months of 2016 there had been an 11% increase in patients attending the emergency department. During June 2016 the actual daily attendance averaged 418 patients and on one day during our visit 470 patients presented to the department. This level of attendance substantially exceeded the average contracted number of patients, which were 372 in June 2016. We were informed flow had increased most at night between 8pm and 8am and we observed the department during this period which confirmed this.
- To address this challenge the service further reviewed patient flow, the transfer of patients into and out of hospital and access to beds linked to discharging patients, and including secondary care. Escalation plans were revised to include provision for heightened escalation to maintain patient flow. The trust agreed an "Acute and emergency care plan" with commissioners, with a time line for delivery of March 2017.
- We found the initial assessment area handled 100 to 120 patients daily, and handover from ambulance staff had been streamlined and rapid assessment and treatment (RAT) reintroduced. The RAT consultant worked with support from band 6 nursing staff. Patient flow support staff ("progress chasers") were used to facilitate the flow of identified streams of patients, for example, failed discharges or surgical referral. Frail elderly patients were admitted directly to the elderly admission unit between 8am and 6pm wherever possible.

- Patients who could walk arrived through the emergency department (minors) area. We observed as patients used the self-registration screen. They were supported if they needed help and assisted if their responses indicated certain conditions, for example chest pain. Patients were assessed to determine if they needed to go to the major's area. On one day of our inspection 203 patients arrived in the emergency department through the minor's area. Progress chasers were used in minors for the first time during the week of our inspection.
- Paediatric patients were seen in a timely way. In the children's emergency department we observed as five patients arrived at the paediatric reception desk. They were each seen quickly and their initial assessment was prompt.
- Major's trauma coordinators oversaw admissions to the major trauma ward. We found the number of trauma calls had increased since 2015. The department handled 700 to 800 major trauma patients per year.
- The percentage of emergency admissions through A&E waiting four to 12 hours from the decision to admit until being admitted was consistently worse than the England average between February 2015 and February 2016. Between February 2015 and February 2016 8,976 patients waited four to 12 hours, and eight people waited over 12 hours, from the decision to admit to admission.
- The emergency department persistently breached the four hour A&E waiting time target between April 2015 and April 2016. Apart from April, performance was also consistently worse than the England average. In April 2016 there was a marked improvement, which was sustained in May and June. The department achieved 85.9% of patients seen within four hours in June 2016. This compared with only approximately 60% being achieved at the 2015 inspection. At 85% the performance was in line with the local trajectory and comparable with the England average.
- Patients who arrived in the department needed to be triaged within 15 minutes of arrival. The trust's median time to initial assessment was worse than the England median from October 2014 to January 2016.
- The standard for median time to treatment is 60 minutes. National comparative information showed that the emergency department breached the median time to treatment standard in all but three of the 22 months over the period October 2014 to January 2016. Performance from July 2015 to January 2016 showed a considerable improvement, although the standard was still breached in four of these seven months.
- The total time patients spent in the emergency department was longer than the England average in all but one of the 12 months from February 2015 to January 2016.
- The number of ambulance handovers delayed over 30 minutes at the emergency department during the winter of 2014/15 was the sixth highest of any department in England, with 3,535 delays. We commented on the trust's response to this in our 2015 report.
- The percentage of ambulance journeys with turnaround times over 30 minutes ranged between 65% and 72% between April 2015 and March 2016. The number of ambulance journeys with turnaround times over 60 minutes varied between 139 and 620. During the week of our 2016 inspection, ambulance handovers to the department occurred in an average time of 36 minutes.
- For the Beverley MIU, the percentage of patients admitted, transferred or discharged within four hours was consistently high between May 2015 and April 2016. Performance was higher than the England average in 10 out of these 12 months. In five months performance was 100%.
- We found there was no standard operating procedure in place for when the MIU was busy and had impending breaches; Practitioners redirected patients to other facilities nearby if capacity became unmanageable.

Learning from complaints and concerns

- The patient experience team responded to complainants and progressed the investigation of complaints. Responses to complainants following an investigation were signed off by a director. Actions in response to complaints were progressed by emergency department senior staff.
- A system was in place to follow up actions from complaint investigations to check these were completed. A quarterly complaints report was prepared by the department's governance lead with a clinical summary and learning points. Learning was shared in team meetings and through the department's governance arrangements.
- The trust identified themes and trends from the investigation of complaints it received. A&E was the

most complained about service; complaints related to lack of treatment, for example missed fractures. The department had not received any recent complaints which were the result of a serious incident.
- The emergency department had no formal registry of compliments it received, or analysis of themes and trends.
- For Beverley MIU, complaints were infrequent. We found no evidence of lessons learned as a result of complaints.

Are urgent and emergency services well-led?

Good

At our previous inspection in May 2015, well-led was rated as 'Requires improvement'. In June 2016 we rated well-led as 'Good' because:

- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this.
- The executive team, particularly the Chief Executive were visible to staff and were seen as approachable. The leadership roles of senior staff in the emergency department, including clinical leadership, were recognised and respected by most staff.
- Risks to the delivery of care and treatment for patients were identified, managed and action taken appropriately to mitigate them.
- Arrangements for the governance of the emergency department had become more embedded and were linked with governance arrangements in the wider Health Group and the trust.
- Patient experience in the emergency department was audited and results were cascaded to staff.

However:

- Performance and outcome measures from governance processes were not shared consistently, particularly with more junior staff.
- The vision and strategy for emergency services required development, linked to the vision and strategy for the trust.

Vision and strategy for this service

- In 2016 the trust had adopted its vision – great staff, great care, great future and had adopted the linked values of care, honesty and accountability following consultation with staff. These informed the vision and goals and the trust strategy for 2016 to 2021. Staff in a focus group confirmed they were aware of the trust's vision.
- The vision and strategy for the emergency department was included in the operational plan for the Medicine Health Group. The delivery of emergency department targets was a recognised outcome for the trust. However, senior staff in the department told us the plan lacked a formal vision for the emergency department.
- A plan to implement change in the urgent and emergency care pathway which took account of system and hospital wide challenges to delivery was presented to the executive in March 2016. The urgent and emergency care plan for the department to March 2017 was agreed with regulators and commissioners. The trust agreed a local performance trajectory with regulators and commissioners to achieve the national four-hour waiting time standard by March 2017.
- Senior managers told us the development of the strategy linking the emergency department plan with hospital wide performance and specialities was involved in the next stage of the department's plans for five years to embed resilience and ensure consistency of delivery.

Governance, risk management and quality measurement

- An independent external review of governance arrangements by regulators had taken place in December 2015 and the trust had adopted a revised governance framework with standard templates for reporting and streamlined escalation procedures. We attended a board committee quality meeting during the inspection where we observed that the performance and governance arrangements for the department were challenged effectively. An automated daily performance report for the executive and senior managers had been developed since our 2015 visit. The department's daily performance was reviewed by the trust's senior executive team.
- We spoke with senior managers and staff and the governance lead for the department about governance and quality. Governance arrangements for the department had become more embedded since our

visit in 2015, with a pattern of regular meetings with actions recorded. An emergency department speciality governance meeting took place monthly. A clinical excellence meeting was held informally each month. A senior staff forum attended by senior medical and nursing staff was held weekly for sharing of clinical information. An emergency department consultants' meeting was held weekly to review the weekly performance dashboard and the consultants' rota. An emergency department senior nursing staff meeting was held monthly and actions were recorded. A clinical governance meeting took place monthly to which all staff were invited. The meeting was minuted.

- A quarterly governance committee for acute medicine and an integrated governance committee for the Medicine Health Group provided upward feedback to the Medicine Health Group board. An emergency division report and presentation for the board was prepared in March and April 2016 with performance, quality, safety and risk issues and set out what was being done to address these.
- The emergency department risk register identified the current risks for the department which included for example the recruitment of medical and nursing staff, the response to crowding in the department, and the delivery of waiting time targets. Each risk was identified with a named risk handler. The risk register was reviewed and risks were discussed at a monthly risk meeting for the emergency department which reflected both adult and paediatric risks. As well as consultants, registrars were invited to the risk meeting. Risk was also reviewed at clinical governance and Health Group governance meetings held monthly.
- Senior medical staff told us global themes and trends about the department's performance and outcomes needed to be shared more consistently with junior staff.
- Governance, risk and quality measurement for the Beverley Minor Injuries Unit (MIU) was managed through the divisional nurse manager and a monthly sister's meeting was held at the MIU.

Leadership of service

- A clinical director for acute and emergency medicine provided oversight for the department. The clinical director was seen as getting things done. A divisional manager for emergency medicine had also recently been appointed. A divisional nurse manager (band 8b) provided oversight for the department's nursing staff. The clinical lead for the department was held jointly by two members of the consultant staff. Another emergency department consultant was governance lead. Three lead sisters (band 7) were allocated to the emergency department (minors), the children's department, and majors. Staff told us the leadership within the emergency department was better and the management team had brought more confidence in the emergency medicine speciality.
- Staff we spoke with commented positively on the visibility and approachability of the Chief Executive and other members of the executive team. Staff in a focus group told us they received trust wide updates at monthly meetings and gave examples of the Chief Executive attending their local meetings. Staff told us the Chief Executive visited the emergency department and we observed this. Staff said they had seen quite a lot of the Chief Executive and he seemed very grounded and normal.
- The structure and composition of the Trust's executive management team had changed since 2015 and staff spoke positively of this development. Members of the executive team were approachable and would sort things out. Staff told us they appreciated that the trust was slowly turning round. Staff in a focus group told us they thought the new trust board was introducing positive change. They said they felt more supported now and there was a feeling of mutual trust. Staff were enthusiastic and conveyed positivity and optimism.
- The recently introduced role of the emergency physician in charge (EPIC) for the emergency department was seen as having helped other staff to be clear about their roles and for tasks to be allocated effectively. We observed that the EPIC role functioned effectively during the day and we saw the importance of the EPIC functioning effectively at night. Staff had mixed views about the effectiveness of the role of site team matrons overnight.
- A small minority of junior staff told us they did not feel well supported. Managers recognised the challenge for them was to support staff with change.
- Staff at the Beverley MIU said they had met the Chief Executive and he had visited the unit. Staff told us the management team was very visible. Nurse practitioner staff in the unit reported to the divisional nurse manager. Staff felt well supported.

Culture within the service

- The culture of the organisation had changed positively since our 2014 visit. In 2015 we reported on actions taken to address previous allegations of bullying which had been followed up in the department and action taken. At this inspection staff we spoke with, with one exception, said they did not feel bullied.
- The trust had appointed staff as anti-bullying champions and provided training to support these members of staff in their support role. Most staff in a focus group stated the culture had changed substantially for the better. Staff were more aware of each other. Staff with concerns could go to a champion in another department for impartial advice. Staff talked about the trust charter and what were and were not acceptable behaviours. People felt more confident and supported to address issues and expectations of staff were clearer.
- We found an improved and largely positive culture in the emergency department at this inspection. The attitude and behaviour of staff was positive. Staff had a better perception of the organisation and of the emergency department. Senior managers in the department described the department as having achieved reputational change. There was no longer a blame culture. Positive changes in the culture of the department were noticed in staff survey responses. An improved culture had resulted in better staff retention.
- Qualified nursing staff that we spoke with were aware of the duty of candour requirements and confirmed that the department and the wider trust encouraged them to be open and honest following a reported incident and to ensure appropriate verbal and written apologies were provided for patients. However, we found that not all unqualified staff were aware of the duty of candour requirements.
- One member of nursing staff told us they did not feel able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes, although they said they had not experienced this behaviour personally.
- At the Beverley MIU, staff told us they enjoyed working in the unit and felt the staff team worked well together.

Public engagement

- We found patient experience in the emergency department was audited weekly and the results of audit were shared with staff. At our inspection, the patient experience score for May 2016 was 92.3%.
- The development of the recently completed relatives' area had followed consultation with a relatives' forum and followed their recommendations.
- Comments from patients and the public were also received through the local Healthwatch organisations. Healthwatch had visited the emergency department in 2015 and 2016 and shared its survey responses and recommendations to the trust.
- For the Beverley MIU, the responses of patients and relatives were consistently positive. We observed in the reception that the family and friends card was visible but staff were not aware of feedback from the survey. We were unable to ascertain that the friends and family test was completed consistently at the unit.

Staff engagement

- The trust's strategy for 2016-2021 was developed in consultation with staff as well as partners and other stakeholders.
- Staff we spoke with said they felt more involved and improvements in communication with staff had made the difference. Staff had been involved in how to change things for the recently redesigned emergency department.
- Staff in a focus group told us that all staff had been consulted about the trust values through an online survey. Support staff in a focus group said there were no forums for administrative and clerical staff. Nursing staff in a focus group said they had not been consulted directly and there had been short notice for staff events related to this. Staff engagement required further development at trust level.
- Managers in the department told us staff were consulted about changes to the department through staff meetings, the staff forum and staff surveys. Managers also recognised that mechanisms to consult with particularly more junior staff required development.

Innovation, improvement and sustainability

- The recently redeveloped emergency department represented a significant improvement in the facilities for the hospital which meant emergency care being provided in a suitable environment for patients and staff. Following the opening of the extended department in April 2015 we reported in 2015 on further phases of work which were planned to complete. At our 2016 visit we found these were completed.

Urgent and emergency services

- The trust used its golden hearts awards scheme to reward staff initiative. In 2015 the emergency team won a golden hearts award for its partnership working.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

Hull Royal Infirmary is part of Hull and East Yorkshire Hospitals NHS Trust and provides acute medical services for NHS patients. Medical care is provided across two sites in the trust with Hull Royal Infirmary providing acute medical services including older people's care and Castle Hill Hospital providing cardiology, oncology and haematology services.

Between January and December 2015, there were approximately 65,000 medical episodes of care carried out in this trust with approximately 38,000 at this hospital. Day cases accounted for 28% of all episodes, emergency admissions 71% and elective admissions 1%.

In 2015, there had been a reconfiguration of acute medical care and three medical wards from Castle Hill Hospital had transferred to the Hull Royal Infirmary site. A new respiratory ward (Ward 500) had been added. The elderly care pathway had been redesigned.

Medical services were managed within the Medicine Health Group, which was made up of four divisions, emergency medicine, general medicine, elderly medicine and specialist medicine. Hull Royal Infirmary provided medical care in 14 medical wards, and covered a number of different specialties, which included general medicine, care of the elderly, respiratory medicine, diabetes/ endocrinology, gastroenterology, neurology and stroke care.

During the inspection, we looked at 25 patient records and 16 prescription charts. We spoke with 30 patients and relatives, and approximately 50 staff including doctors, nurses, therapists, health care assistants, ward managers, matrons, administrative assistants and student nurses. We visited Ward 1 (short stay ward), Ward 5 and Ward 500 (respiratory), Ward 50 (nephrology), Ward 70 (diabetes/ endocrinology), Wards 9 and 90 (elderly care), Ward 11 and Ward 110 (stroke/neurology), Ward 100 (Gastroenterology), the Elderly Short Stay Unit on Wards 8 and 80, the Elderly Assessment Unit on Ward 200, the Acute Medical Unit (AMU), the Ambulatory Care Unit (ACU) and the Endoscopy Unit.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust.

A focussed inspection of Hull Royal Infirmary was carried out in May 2015. All five domains were inspected for medical care services. Safe, effective, caring and well led were rated as 'Requires improvement' and responsive was rated as 'Inadequate'. The service was rated overall as 'Requires improvement'.

The main issues of concern from the last inspection were; incident reporting policies were not being followed, medicines management and checking of resuscitation equipment was not in line with trust policy and guidance, and call bells were not in reach of patients on elderly care wards. There were delays to patients being discharged, a high number of patient bed moves out of hours and

Medical care (including older people's care)

patients being cared for on non-speciality wards. A previous inspection had identified a bullying culture and although most staff thought there had been an improvement, there was still further work to do.

Summary of findings

At the 2015 inspection we rated medical care services as 'Requires improvement' overall. This rating was the same in 2016 because:

- Staff were not always assessing and responding appropriately to patient risk. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care; however, some staff were unclear about what to do if a patient's score increased.
- Falls risk assessments were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment. We found poor compliance with the completion food charts and fluid balance charts.
- Fridge temperature checks were not always performed and we found that when recorded as out of range, no corrective action had been taken. Controlled drugs were appropriately stored with access restricted to authorised staff however, on most wards; we found daily and weekly checks were not consistent with trust standard operating procedures.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients, as well as new ward support roles, such as discharge facilitators.
- The trust was not meeting the 18 week referral to treatment standard for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed. There were still issues with bed capacity and medical outliers were affecting other services. During the inspection, we found several medical patients being cared for on the gynaecology ward.

Medical care (including older people's care)

However;

- Leadership had improved. There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork. There was a drive for continual change and improvement within the Medicine Health Group although further work was needed to embed the changes and to continue to improve standards.
- Staff were caring. Feedback from patients and relatives was positive. We saw good interactions between staff and patients and staff maintained patients' privacy and dignity when providing care. Patients and relatives felt well informed and involved in decision making about their care. We found that patients' access to call bells had improved and the trust were auditing this regularly.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years were compliance had been 68.7% and 74.9%. There were mixed results in national audits; however, action plans were in place to improve areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.
- We found good practice in order to meet the individual needs of patients. The environment on elderly wards had been adapted for patients living with dementia. Recreational co-ordinators had been introduced in medical elderly wards to provide patients with activities. A learning disability liaison nurse supported patients with a learning disability.

Are medical care services safe?

Requires improvement

At the previous inspection in 2015, we rated safe as 'Requires improvement'. At this inspection we also rated safe as 'Requires improvement' because:

- Staff were not always assessing and responding to patient risk appropriately. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care. We found examples of patients with high scores indicating they should have been escalated but had not been. Some staff were unclear about what to do if a patient's score increased.
- We found that risk assessments for falls were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment.
- We had concerns about the completion of nutritional risk assessments and fluid balance charts in patient records.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients as well as new ward support roles, such as discharge facilitators.
- We observed on several medical wards, that fridge temperature checks had not always been performed. We also found many examples of when the fridge had been recorded as out of range and no corrective action had been taken.
- Controlled drugs were appropriately stored with access restricted to authorised staff. However, on most wards, we found daily and weekly checks were not consistent with trust standard operating procedures.

However;

- Incident reporting was good and there was good sharing and learning from incidents.
- We observed good infection prevention and control practice and ward areas were clean, tidy and well organised.

- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- Compliance with mandatory training for staff in medical care services was generally good at this hospital with most clinical areas in medical care exceeding the trust target of 85%.

Incidents

- There were no never events reported in medical care services between May 2015 and April 2016. Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Between April 2015 and April 2016, there were 5180 incidents reported for the Medicine Health Group across the trust. The Medicine Health Group included emergency medicine, general medicine, elderly medicine and specialist medicine divisions. The majority of these incidents resulted in no harm or low harm however, 78 caused moderate harm, 18 caused severe harm and four resulted in patient death.
- Twenty-seven incidents had been reported as serious incidents for medicine between May 2015 and April 2016. Serious incidents are incidents that require further investigation and reporting. The most prevalent incident types were slips, trips and falls (nine), pressure ulcers (seven) and sub-optimal care of the deteriorating patient (six).
- Serious incidents were all investigated. We looked at examples of incidents, which had been investigated and found that staff had completed thorough root cause analyses and action plans. The trust held meetings to review the serious incidents reports.
- Incidents were investigated at ward level and fed back to staff individually and at ward meetings. Most staff received feedback about incidents and could give us examples of incidents and changes that had occurred as a result.
- The trust produced a monthly lessons learnt bulletin, which was circulated to staff electronically and was available on the intranet for sharing with the ward teams. Staff commented positively on this during the inspection.
- Staff told us about action and learning from incidents. For example, in response to a serious incident related to a pressure ulcer on Ward 8, staff had attended meetings with the ward manager and tissue viability nurse. They also received additional tissue viability training both at the bedside and online.
- Staff understood how to report incidents using the electronic reporting system and identified a positive incident reporting culture. However, they told us that they would not routinely report concerns when they were short staffed as this was highlighted within the daily safety brief completed by the trust.
- Mortality and morbidity meetings were held monthly. We saw minutes of the renal department mortality and morbidity meetings, which showed discussion of each case with learning points and actions identified to prevent reoccurrence.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had a 'Being Open when Patients are Harmed Policy' which set out the process for duty of candour.
- Most staff we spoke with understood the principles of duty of candour however; some junior members of staff such as health care assistants were not as knowledgeable.
- The incident reporting system had a mandatory field for duty of candour. We reviewed a root cause analysis following a serious incident, which resulted in patient harm and saw that staff had followed the policy correctly.
- A relative we spoke with told us they had been provided with a duty of candour letter following their relative's fall. The letter said the incident would be investigated, although there was no information about who would contact them following this.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis

(blood clots), and catheter and urinary tract infections (CUTIs). Between March 2015 and March 2016, staff reported 50 pressure ulcers, 22 falls with harm and 20 CUTIs in medical services across both hospital sites.

- Patient safety thermometer data showed that between March 2015 and October 2015 there was an upward trend in the prevalence of new pressure ulcers reported. There was then a downward trend in prevalence from January 2016 to March 2016. There was also a downward trend in the prevalence of falls from April 2015 to March 2016. The prevalence of urinary tract infections in patients with a catheter fell in April 2015 and May 2015, since then the rate has been stable. Overall, this showed an improving picture for harm free care.
- On inspection, we observed safety thermometer information displayed on all wards. For example, Ward 50 displayed data showing there had been five patient falls, no pressure ulcers, no MRSA and no Clostridium difficile infections in May 2016.
- The trust produced a monthly safety bulletin, which was circulated to all staff.

Cleanliness, infection control and hygiene

- The areas we visited were clean and ward cleanliness scores were displayed in public areas.
- Hand washing facilities were available at the entrance to and throughout the wards we visited with signage to remind people the importance of handwashing. Personal protective equipment including aprons and gloves, and sanitising hand gel were also available.
- We observed good infection prevention and control practice on all wards we visited. Staff used appropriate personal protective equipment when completing clinical tasks. They complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- Each ward had an infection control link practitioner who attended infection control study days and cascaded information to the ward manager and the team.
- Monthly infection control audits were carried out to identify gaps in practice. Handwashing and ward cleanliness audit findings were displayed on Ward 50 and showed 100% and 99.8% compliance in May 2016.
- Staff completed infection prevention and control training as part of their mandatory training programme. The overall compliance with this training for medical care staff at this hospital was 72.9%, however most staff groups exceeded the trust target of 85%. The staff group with the lowest compliance with this training was the administration and clerical staff group, who did not meet with trust target in many clinical areas.
- We observed clinical waste and domestic waste were appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited. Sharps were correctly disposed of.
- Equipment we inspected appeared clean and was identified as being clean using cleaning assurance stickers. However, we observed a health care assistant using a reusable blood pressure cuff on several patients without cleaning it in between. We mentioned this to the member of staff and found they were not aware this was required.

Environment and equipment

- Most areas we visited were clean, tidy and well organised.
- The endoscopy unit had a waiting room, assessment room and separate changing rooms and sub-waiting area for male and female patients. There were three procedure rooms and separate recovery areas for male and female patients.
- Arrangements for the decontamination of equipment in the endoscopy unit were being upgraded in line with recommendations by the Joint Advisory Group (JAG). Work was ongoing to refit a designated area with new decontamination equipment; this was planned to open in October 2016.
- On all wards we visited, staff had signed to confirm they had carried out daily checks on resuscitation trollies. The trollies we checked were all in order and ready for use.
- The equipment we checked had been serviced correctly and dates recorded. Electrical equipment had been safety tested.
- The trust carried out an environmental review of clinical areas. The review rated each ward and outlined areas for improvement if it fell below standard. We saw that for areas identified as needing rechecking or a weekly check, this was carried out and documented.
- Ward 8 had a folder to identify daily which patients required glucose blood monitoring and at what time. We checked the monitoring machine to ensure it was working correctly however, we found the testing solution was out of date.

Medical care (including older people's care)

Medicines

- All patients had a drug administration record. Within the record, it allowed the prescriber to identify the patient's allergies and venous thromboembolism (VTE) assessment. There was also a record of any omitted medication and a numbered scale to identify the reason why the medication was omitted.
- We looked at 16 prescription charts and found they had been fully completed and were legibly written. Allergies were recorded and VTE prophylaxis was documented. Start and stop dates were recorded and where medicines were omitted, a corresponding code was entered detailing the reason for this.
- We saw antibiotics had been prescribed as per trust guidelines in the prescription charts we reviewed. Start dates were recorded and the rationale for why antibiotics were needed was recorded on most charts. Antibiotic prescribing was reviewed at least every three days and there was an automatic end after five days requiring the chart to be rewritten if required.
- We saw that nurses did not always follow trust guidance when administering medicines. For example, on both Ward 8 and Ward 9 we saw nurses sign to confirm the dose had been given prior to administering the medication. Although one nurse said this was not normal practice, the other nurse thought this was normal practice as she had observed this during her supernumerary status. We raised this with the ward managers at the time of inspection.
- We observed on several medical wards that fridge temperature checks had not always been performed and there were many examples of were the fridge had been recorded as out of range and no corrective action had been taken. For example, Ward 5 had recorded the fridge being out of range 26 times in April, May and June and no appropriate action was taken. The fridge on Ward 8 had three checks missed in April and was recorded as being out of range seven times in May with no action taken. This meant that drugs might not have been stored at the correct temperature required.
- The pharmacy team completed audits on the wards to measure compliance with fridge monitoring, 24 hours controlled drug checks and resus trolley checks to ensure patient safety was maintained. The audits showed most wards achieved 100% compliance with fridge checks. This did not reflect our observations during the inspection.
- We found some vacutainer butterflies (used for venepuncture) in the peritoneal dialysis room were out-of-date which were removed on our request.
- Controlled drugs were appropriately stored with access restricted to authorised staff. However, on most wards we found daily checks were not consistent with trust standard operating procedures. For example, the Acute Medical Unit (AMU) missed five checks in March, one in April, and four in June. On Ward 9, we found that the weekly checks had only been completed five times in a six month period. This issue was raised with the ward manager at the time.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked cabinets. Expiry dates were checked and the stock was rotated appropriately.
- We found the appropriate risk assessment and patient agreement had been completed for patients who were self-medicating.
- National Institute of Clinical Excellence (NICE) guidance recommends in an acute setting, medicines reconciliation should be carried out within 24 hours. The trust submitted a trust wide medicines reconciliation audit for three months from April 2016. In April, 66% of medicines were reconciliated within 24 hours, this increased to 77% in May and 76% in June. This fell short of the trust target of 80%.

Records

- Care plans were divided into care bundles, which related to certain risks such as falls, nutrition, pressure areas, and venous thromboembolism. The care bundles were generic assessments with an area for individualised care to be added for each patient.
- Intentional rounding documentation was in place. Regular checks and scheduled tasks or observations such as pain, positioning and comfort, were carried out at set intervals. We saw that apart from two, these were appropriately completed.
- We reviewed 25 sets of patient records, which represented a sample of the services we visited. Most of records we reviewed were completed appropriately in line with professional standards, with relevant risk assessments and descriptions of staff interaction with the patient. However, we had concerns about the completion of nutritional risk assessments and fluid balance charts.

- Nutritional assessments were partly completed on the patient records that we observed. The trust used a validated nutritional screening tool on the wards. The daily food chart identified how much food had been consumed at each mealtime, and a rag rating was given to the amount of food eaten. For example, if none or only a quarter of the meal was eaten, a red indicator was given or if the whole meal was eaten, a green indicator was given. Daily totals were added up to identify the overall malnutrition risk to the patient and whether the patient needed referring to a dietitian. We observed six records where this part of the food chart was not fully completed.
- We saw during our unannounced visit and our inspection that there was poor compliance with completion of fluid balance charts. We saw at least 10 records where fluid balance charts had either not been completed at all, were partially completed or had not been totalled up.
- Most medical and nursing notes were paper records and were stored securely on each ward in a lockable trolley. Each ward had access to an electronic display board, which held patient information such as admission details, discharge planning, acuity, nursing and medical history and risk assessment details.
- We saw on two occasions, patients records left unattended at the nurses' station on the Elderly Assessment Unit.
- Documentation standards on each ward were audited as part of the safer care weekly audits.
- There was good compliance with information governance training. Overall compliance for staff in medical care services at this hospital was 85.5%, which exceeded the trust target of 85%. The lowest compliance was for medical staff in neurophysiology, which achieved 50%.

Safeguarding

- The trust had policies and procedures for safeguarding children and adults at risk. Both policies were in date and required to be reviewed in December 2016. This included guidance on the local safeguarding pathways and contact details. Staff were aware how to access these on the intranet.
- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- Patients with safeguarding concerns were documented as part of the trust's daily safety brief.
- Staff completed safeguarding children level one and vulnerable adults training as part of their mandatory training. Compliance with this training was good at 86.6% for safeguarding children and 88.4% for vulnerable adults training. Both exceeded the trust target of 85%.

Mandatory training

- The trust's mandatory training programme included: information governance, moving and handling, major incident training, safeguarding children, vulnerable adults, infection control, conflict resolution training and resuscitation. The trust target for mandatory training was above 85%. Training could be completed either face to face or online. Staff were also required to complete statutory training such as fire safety and safety training.
- Compliance with mandatory training for staff in medical care services was generally good at this hospital with most clinical areas in medical care exceeding the trust target of 85%. Compliance in nursing staff was particularly high with many areas achieving 100%. However, we were concerned that resuscitation training had the lowest compliance at 64.5%.
- Ward managers monitored mandatory training. They told us that compliance was improving but staffing numbers affected their ability to achieve better compliance. Some staff told us they were completing on-line training from home.

Assessing and responding to patient risk

- The trust used a National Early Warning Score (NEWS) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care.

Nurses and care support workers recorded patient observations in each patient's notes, which enabled their NEWS to be calculated. NEWS was mainly recorded in patients' paper records however; Wards 11 and 110 had been trialling an electronic system for the last year, which automatically alerted when a patient's NEWS was high and needed escalating. Staff told us this system worked well.

- We had concerns about the correct escalation of patients when their NEWS was high. On our unannounced inspection on 11 July 2016, we visited

Ward 5 and 500 and found four patients out of eight were recorded with a high NEWS, however, no action or escalation plan was documented in the patient's notes. For example, one patient on Ward 5 had a NEWS of 11 recorded at 6pm and this had not been escalated as per the trust guidelines. A doctor did not see the patient until 9.30am the following day.

- Three nurses we spoke with were not clear about when a patient's NEWS indicated that they should escalate the patient. One patient had a NEWS of seven and the nurse did not know if this was of concern or not. Two nurses we spoke to said they used their professional judgement to decide whether to escalate a patient.
- Patients with chronic conditions were given a higher baseline NEWS. We saw this documented in patients' notes.
- The trust audited compliance with NEWS. We looked at audit data provided by the trust for three months from April to June 2016. The audits measured whether patient observations had been completed, whether patients' NEWS had been correctly calculated and whether appropriate action had been taken and documented in response to the NEWS. Twenty patients' notes were audited per month. The audit showed good compliance for most medical wards at 100%, although in June 2016 the Acute Medical Unit (AMU), Ward 500, Ward 110 and Ward 8 dropped below 100%. Ward 110 was the lowest was at 83%.
- Patient risk assessment documentation for falls, pressure areas, nutrition and venous thromboembolism were included in care records. The trust used a falls risk assessment tool for patients over the age of 65 years or those identified at risk of falling. We found these assessments were not completed or not fully completed in eight records out of 25. This was particularly noted on the acute medical wards where four patients over 65 years of age did not have a completed falls assessment.
- If a patient required assistance to mobilise or transfer, this should trigger a multifactorial assessment. We found on four occasions that although this section was ticked, there was no evidence that a falls multifactorial assessment had been carried out. We requested falls audit information from the trust but this was not supplied.
- We saw that patients had falls bundles in place. This included a bed rail assessment, footwear assessment, moving and handling assessment and intentional rounding.
- Patients identified as being at high risk of falling were discussed at the daily safety huddle. The ward sister for Ward 9 told us that all patients were considered as a high falls risk for the first 24 hours after admission. Patients at high risk of falling were cohorted into bays nearest to the nurse's station. Falls sensors were available and patients were given yellow socks and a yellow wristband to wear to signify they were at high risk of falling.
- We saw good use of the SSKIN care bundle, which included five simple steps to prevent pressure ulcers.
- The critical care outreach team covered both hospital sites, providing care 24 hours a day seven days a week. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them through the NEWS referral system. The team supported patients nursed on wards with tracheostomies and delivered Non-invasive Ventilation (NIV) outside of critical care.

Nursing staffing

- Information submitted by the trust showed the Medical Health Group had 42.3 whole-time equivalent (WTE) nursing vacancies from their 772.69 WTE establishment.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the trust's risk register. Controls put in place by the trust to reduce the risk included, a clear escalation process and discussion at the safety brief meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and retention of staff.
- There was an ongoing campaign to recruit additional qualified nurses. The trust recruited overseas nurses and had made 72 job offers to student nurses due to qualify in Autumn 2016.
- Staff on the wards often completed extra shifts to reach the required staffing levels and ward managers commented how good staff were at covering the extra shifts. Whenever possible, the same bank staff were used to provide continuity to the patients and bank staff.
- The trust recognised that nurse staffing was an issue and had introduced new non-registered roles to support nursing staff. Discharge facilitators helped manage patients discharge processes and ward hygienists took the lead in cleaning equipment. This allowed nurses and health care assistants more time for other duties.

Medical care (including older people's care)

- The trust was introducing the 'safer nursing care tool' as recommended by the National Institute for Health and Care Excellence (NICE). This tool calculates safe nurse staffing levels based on patients' level of sickness and dependency. At the time of the inspection, this was being piloted on the Elderly Assessment Unit (EAU) and Wards 8, 80 and 90. This informed the safety brief giving the number of patients and their acuity for each ward.
- The trust aimed for staffing ratios of 1:8 on general medical wards; however, this was often not met. Nurse staffing was reviewed twice daily at the safety brief in line with acuity. The safety brief meetings were held at 10am and 3pm and were chaired by a nurse director (on a rota) and attended by a representative from each zone. Staffing levels and patient acuity were discussed as well as patient falls, safeguarding and infection control issues. Each ward was discussed and given a risk status of red, amber or green. If necessary, staff would be moved from one ward to another to ensure staffing levels were as safe as possible.
- The trust produced a monthly safer staffing report that identified average registered nurse fill rates for all wards. In these reports, we saw that in March, six out of 14 medical wards had a fill rate of below 80%. The lowest fill rate was for Ward 90, which was 64%. There was a similar pattern for the April, May and June however, for these months the Acute Medical Unit (AMU) had the lowest average fill rate of 58%. AMU had a high turnover of patients with acute conditions therefore; we were concerned by the low fill rate for this unit.
- Staff shortages were evident across the majority of medical wards and safer staffing levels were not met. Staff were aware how to escalate their concerns regarding staffing.
- The ward manager was often expected to work in the planned numbers of staff more than their allocated allowance due to the staff shortages. This was confirmed in the safe staffing report where the supervisory charge nurse capacity was regularly below 10% for most medical wards and dropped to 0% for Ward 50 in April and May and Ward 70 in April. Ward sisters told us they found it impossible to fulfil their role as they were often covering the ward.
- Planned and actual nurse staffing numbers were displayed on large whiteboards on each ward. This included registered nurse to patient ratios.
- Ward 500 had five whole-time equivalent (WTE) registered nurse vacancies. The ward sister told us these posts had been filled with newly qualified staff who would start later in the year however, it would be months before they were able to undertake their full duties. On the day of our visit, there were two registered nurses, one of which was the ward sister, to care for 24 patients.
- On Ward 50, planned staffing levels were met on the day of our visit. Nurse to staff ratios were 1:6 in the morning, 1:9 in the afternoon and 1:9 overnight.
- There was a six bedded Respiratory High Observation Bay (RHOB) on Ward 5. Patients with a higher acuity were cared for in this bay. Recommended nurse staffing levels were a nurse to patient ratio of 1:3, which took which into account the acuity of the patients. We visited the RHOB on two occasions and found that nurse staffing levels were met. On a third visit to Ward 5, nurse staffing levels were not met. There were four nurses in the morning and three in the afternoon to cover both the RHDU and the 20 bedded ward. The matron had made the decision to transfer three patients from the RHDU to other wards and close these beds. This meant that one nurse would be able to care for the remaining three patients in the RHDU and two nurses to care for 20 patients on the ward.
- Ward 70 had five nurse vacancies and staff on short and long term sickness. Bank and agency staff or borrowed staff from other wards were used to cover vacant shifts.
- The Elderly Assessment Unit (EAU) had 21 beds and seven nurse vacancies. Nurse staffing was not on display on the day we visited. The planned level of registered nurses was four in the morning, four in the afternoon and three at night. The actual level was three in the morning, three in the afternoon and two at night, there was one nurse short on every shift.
- Actual staffing levels were below the planned level during our visit. The matron was covering shifts to make staffing levels safe. Stroke co-ordinators also helped on the ward when available.
- Ward 8 nurse staffing was fully established although staff were moved to support other wards that had low staffing numbers.
- Advanced nurse practitioners (ANPs) worked within the Ambulatory Care Unit (ACU) to provide additional medical / nursing support.
- From information supplied by the trust, bank and agency spend for the months of January, February and March 2016 for the Medicine Health Group for this

hospital, were highest on the Acute Medical Ward (AMU), Ward 1, Ward 70, and Ward 110. The percentage of total pay bill spends for bank and agency staff exceeded 20% on one or more months for these wards.

- Formal handovers took place twice a day. We observed a nurse handover on Ward 500 and found it to be systematic and thorough. Clear information was provided and plans were made for discharge. Staff completed and updated an electronic handover sheet. Staff felt the handover was beneficial for receiving up to date information. Wards had implemented a pre-recorded handover between the day and night staff to ensure maximum staff numbers remained on the ward during a shift transition. This was followed up by a bedside summary when necessary.

AHP staffing

- Planned hours for Allied Health Professional (AHPs) staff in March 2016 for the Medicine Health Group, were 842. However, the actual hours completed was 504.5 leaving a deficit of 337.5 hours.
- Planned hours for unqualified staff were met at 280 hours.
- The physiotherapy team for Ward 500 was fully staffed. There was one band 6, two band 5 therapists, and one assistant.

Medical staffing

- The proportion of consultants was lower than the England average at this trust. The proportion of middle grade doctors was about the same as the England average however, the proportion of junior doctors was higher.
- There was consultant presence on AMU Monday to Friday 8.30am to 10pm. General internal medicine consultants were on call from 5pm to 9am. Junior doctor cover was available over the 24 hour period, seven days a week.
- The Ambulatory Care Unit had medical cover from 8am until 10pm. Medical cover consisted of a consultant with registrar support. Between the hours of 10pm and 1am, staff provided medical assistance from the Acute Medical Unit.
- Day cover on medical wards was provided by junior doctors from 9am to 5pm and middle grade doctors from 9am to 10pm. At night, there were two middle grade doctors and junior doctors with bleep holders. At weekends, one middle grade doctor and junior doctors provided cover. All medical specialities had access to an on call consultant 24 hours a day, seven days a week. The hospital at night team supported the medical staff out of hours.
- There were concerns about gaps in the junior doctor rotas especially for out of hours. When possible, gaps in medical rotas were covered by locums. We saw from data provided by the trust between April 2015 and March 2016 that locum and bank medical staff usage was highest in acute medicine and the department for medical elderly. The highest usage was in March 2016 when the percentage of the total pay bill spend for bank and agency staff was 56.6% for acute medicine and 50.7% for the department for medical elderly.
- The trust had several vacancies for junior doctors and was showing further vacancies from the beginning of August. The main areas for concern at this hospital for medical services were gastroenterology, which was showing a 60% fill rate and had two vacancies, and acute medicine, which had a 76.2% fill rate and five vacancies. The trust's medical staffing team was working hard to fill these posts and informed us that suitable applicants had been sourced for two of the vacant acute medicine posts and were awaiting clearances.
- Long standing vacancies within the consultant establishment in the department of medical elderly was on the Health Group risk register. One vacant consultant post had been used to recruit two Advanced Nurse Practitioners (ANPs) to support the consultant body.
- Medical staff sickness was consistently low with the highest percentage at 1.5% in August 2015.
- Formal ward handovers took place twice a day at 8am and 8pm, with informal handovers occurring during the shift change. We observed an evening medical handover on the Acute Medical Unit. The senior doctor present (specialist registrar) briefly went through the patients on the unit and flagged those triggering concerns. The registrar then discussed how many patients were waiting to be seen and allocated jobs out to the junior doctors. There was no formal recording of which doctors were present, or which patients had raised concern, although this was recorded on the electronic board. We noted the electronic board system had not been completely filled out therefore, there was a potential to miss things.

Major incident awareness and training

Medical care (including older people's care)

- The trust had a major incident and business continuity plan. Medical departments had their own individual business continuity plans. Policies were also accessible for winter plan, escalation plan, severe weather and pandemic flu.
- Staff were required to complete a once only training session in major incident awareness as part of their mandatory training. Overall compliance with this training was good at 94.3% for medical care services.
- Staff explained how to access the major incident and continuity plans on the intranet and had an awareness of their role.

Are medical care services effective?

Good

At the previous inspection in 2015, we rated effective as 'Requires improvement'. At this this inspection we rated effective as 'Good' because:

- We saw examples of good multidisciplinary team working. We thought the weekly ward round on Ward 70, which included a vascular surgeon, podiatrist, endocrinologist and therapists was particularly good practice.
- We observed consistent use of a red tray system to identify patients who needed help with meals or their dietary intake monitoring. Red water jugs were also in use to help staff identify patients who required help with their fluid intake and were at risk of dehydration.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years were compliance had been 68.7% and 74.9%.
- Staff had a good understanding of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff gave good explanations to patients and gained consent prior to completing a procedure.
- There were mixed results in national audits. We saw action plans to improve in areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.

However;

- The trust was a CQC outlier for sepsis. This meant that there had been a higher number of deaths than expected for patients with sepsis. In the trust quality improvement plan, we saw a project to raise awareness of the Sepsis Six, implement the sepsis care bundle and reduce death from sepsis.
- Local audits were carried out and effectively identified areas for improvement, however robust action plans were not in place to ensure improvements were made as a result of these audits.

Evidence-based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. We saw in the minutes of speciality governance meetings that audits measuring adherence to NICE guidance were being undertaken. For example, NICE guideline CG186 Multiple sclerosis in adults: management.
- The trust had an ongoing monthly audit programme for safe care, which included tissue viability, fluids and nutrition, observations and documentation. The results of these audits were displayed on notice boards in wards areas and combined in the trust's Safe Care Summary Report.
- Protocols and policies were available on the intranet and staff knew where to find them. The policies we reviewed all had identified author/owner and all had future review dates.
- The peritoneal dialysis team were involved in the nationwide Peritoneal Dialysis Outcomes Practice Patterns Study (PDOPPS) to support national and local learning.
- Outside every ward, its compliance with the fundamental standards audit (3Gs) was displayed. This audit measured the ward against standards across a number of areas including nutrition, record keeping, infection control and tissue viability. Each area was given a rating then the ward received an overall rating. These effectively identified areas for improvement, however robust action plans were not in place to ensure improvements were made as a result of these audits.

Pain relief

- We saw pain relief was prescribed on prescription charts.

- Nursing staff used and documented an evidence based pain score to assess patients' needs. We saw from patient care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- The trust scored 7.8 out of 10 in the National Inpatients Survey 2015, for the question 'did hospital staff do all they could to help control your pain'. This score was about the same when compared with other trusts.
- Most patients we spoke with said they received pain relief when required, however, the relatives of one patient we spoke with who was being cared for on Ward 90, told us that their relative's pain relief had on occasion been missed. They also told us that when first admitted to the Elderly Assessment Unit (EAU) with severe back pain, their relative had waited for several hours before receiving any pain relief medication.

Nutrition and hydration

- The trust used a validated nutritional screening tool on the wards. We saw in patients' notes that their nutritional needs had been assessed however, food charts and fluid balance charts were not always fully completed by staff.
- The hospital used a red tray system to identify patients who needed help with meals or their dietary intake monitoring. Red water jugs were also in use to help staff identify patients who required help with their fluid intake and were at risk of dehydration.
- Protected meal times were in place and we saw staff assisting patients with their meals. However, one member of staff on Ward 8 told us that protected meal times did not always occur and it was difficult trying to feed all patients who needed assistance. The food would remain on the patient's table and could go cold until a member of staff was available to feed them. The ward manager was aware that mealtimes could be difficult.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks during the day.
- Patients on the Elderly Assessment Unit (EAU) had food and drinks in reach and were eating breakfast independently. The catering assistant gave patients a choice of having their drink in a mug, beaker or cup and saucer.
- Patients we spoke with were happy with their meals. One patient said there was an excellent choice of main courses. One patient thought there were not enough fresh fruit options.
- We saw a notice board in the kitchen on Ward 8, which identified patients requiring a high calorific diet.
- Staff had completed training to support patients who had difficulty in swallowing. The dietitian and speech and language team provided assistance when needed.

Patient outcomes

- In the National Diabetes Inpatient Audit 2015, the trust was in the top 25% for England for eight of the 18 indicators. However, the trust was in the worst 25% for England for having a high percentage of prescription errors (31.4%).
- The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.
- In the Sentinel Stroke National Audit Programme (SSNAP), the trust scored D for SSNAP level for the first three quarters from January to December 2015, but improved to a score of C in the last quarter. The trust's score for the team-centred scanning indicator improved from C in the first two quarters to A in the latter two quarters.
- Hull Royal Infirmary had mixed performance in the Heart Failure Audit 2013/14. The hospital scored better than the England average for two of the four in-hospital care indicators, and four of the seven discharge indicators.
- There was poor performance in the Myocardial Ischaemia National Audit Programme 2013/14. A lower proportion of Hull Royal Infirmary's patients with nSTEMI (non-ST segment elevation myocardial infarction) were seen by a cardiologist or member of their team and a lower proportion were admitted to the cardiac unit or ward. The proportion of patients with nSTEMI that were referred for or had angiography was not available for the hospital. There was no data for the trust for thrombolytic door to needle time. We saw that the trust had plans to increase the quality of data provided to this audit.
- We saw that when performance was below the standard required in national audits, an action plan was formed and clearly documented.

Medical care (including older people's care)

- The risk of readmission at Hull Royal Infirmary from December 2014 to November 2015 was lower than expected for elective and non-elective care overall. Risk of readmission was higher than expected for non-elective geriatric medicine and stroke medicine.
- The trust was a CQC outlier for sepsis. This meant that there had been a higher number of deaths than expected for patients with sepsis. In the trust's quality improvement plan, we saw a project to raise awareness of the Sepsis Six, implement the sepsis care bundle and reduce death from sepsis. Data from the trust indicated that this was improving.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2, which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016, which was similar to the England ratio (100) of observed deaths and expected deaths.
- Wards displayed 'fundamental standards' results which were colour coded against local compliance targets such as care of vulnerable people, medicines management, nutrition and hydration and patient experience.

Competent staff

- There was no specific supervision policy for nurses. Managers told us that they relied on a number of organisational processes to provide assurance on managerial, clinical and professional competency. This included local and trust induction for all new staff, annual appraisals, local preceptorship and Nursing and Midwifery Council (NMC) revalidation.
- We were concerned that an agency nurse working on the Respiratory High Dependency Unit (RHDU) on Ward 5 did not have the skills to provide Non-invasive ventilation (NIV) for these patients. Staff told us that the agency nurse was there to support the experienced nursing staff.
- Staff on Ward 70 were concerned that staff were often moved to other wards to cover for sickness and they did not always have the correct skills.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years when compliance had been 68.7% and 74.9%.
- Preceptorship packages for new members of staff were in place and an allocated amount of supernumerary time in order to progress with competencies. There were two steps to this package. Step one provided incremental development for newly registered practitioners and step two was designed to develop the capabilities of the practitioner within the specialty in which they work.
- Junior medical staff commented that training was excellent and they felt well supported by consultants. A junior doctor commented how their request to fully experience the stroke pathway was supported by gaining experience during the rotation to experience patient flow from acute through to rehabilitation.
- Nursing staff told us that there was good access to training and development and they were being supported with revalidation.
- New staff on Ward 110 had a stroke training day. We were told this included recognising signs and symptoms and an online training package.
- Physiotherapy staff were required to complete an induction and a six month probationary period. The team carried out peer review sessions using a standard template to improve performance. We saw there were clear objectives set for band five rotational physiotherapists.
- Therapists had developed competencies for ward based rehabilitation staff of all grades to support patient care to complete the care certificate.
- An e-learning package on falls prevention had been developed for staff.
- Medical wards provided placements for student nurses. Trained mentors were allocated to both student nurses and newly qualified nurses to provide support.

Multidisciplinary working

- We saw good examples of multidisciplinary team (MDT) working during our inspection. All wards carried out daily board rounds and weekly multidisciplinary meetings. We saw examples of staff interacting, both formally and informally, to discuss patients' care between teams and seek advice from colleagues. Therapists had an individualised activity plan for each patient, this fed into the MDT meeting.

Medical care (including older people's care)

- A multidisciplinary team (MDT) of doctors, nurses, care support workers, physiotherapists, occupational therapists, dietitians and specialist nurses cared for stroke patients on Ward 110. An MDT meeting was held every Tuesday afternoon.
- On Ward 70, a weekly ward round was held to review patients on the ward. The team comprised of a vascular surgeon, podiatrist, endocrinologist and therapists. We thought this was an example of very good practice.
- Ward 8 held daily MDT meetings, which involved medical and nursing staff, therapists, social workers and mental health staff. Staff from the intermediate care team occasionally attended.
- Patients who were identified at risk of malnutrition were referred to the dietitian. We saw evidence of dietetic input documented in patient's notes.
- Multidisciplinary safety huddle were carried out daily on the wards. We observed a safety huddle on Ward 9, which was attended by nursing, medical, physiotherapy and occupational therapy staff. Patient safety was discussed including patients requiring one to one supervision as they had a high risk of falling.
- Staff spoke positively about close MDT working and felt they had good working relationships between professional groups.

Seven-day services

- The trust was working towards a 24 hour seven day week working. Further work on the acute medical pathways was underway as part of the urgent and emergency care programme. We were informed that changes had been made to junior medical rotas to increase doctor presence at weekends and overnight.
- The Ambulatory Care Unit (ACU) opening hours had recently been extended from 8am to 10pm to 7am to 1am every day including weekends. This was with support from both medical and nursing staff to enable a better patient experience.
- Peritoneal dialysis nurses provided seven day cover between 7am – 7pm. They provided services to in-patients, out-patients and day cases.
- The physiotherapy team offered a seven day service across the wards. Physiotherapists were available at the weekend and were on call out of hours.
- Nurse practitioners worked out of hours and helped support staff on the wards.
- Consultant cover was available over the 24 hour period for patients with a gastrointestinal bleed. Nurses in the endoscopy unit were on call after 6pm and would come into the unit if a bleed occurred out of hours.
- The Hyper Acute Stroke Unit (HASU) was a four bedded area within Ward 110. Thrombolysis was carried out on the HASU by the consultant.
- Pharmacy staff were available seven days a week including bank holidays. The on call pharmacist could be called outside opening hours for any urgent emergency items or advice. Clinical Pharmacy services were provided to the vast majority of wards throughout Monday to Friday with a selected service to key admission areas at a weekend.
- Information provided by the trust, indicated that 11 out of 14 diagnostic services were available seven days a week. Staff on the Acute Medical Unit (AMU) told us that CT head scans were available out of hours.

Access to information

- The trust used the same electronic patient board on each ward; this allowed up to date information to be stored and informed the nursing handover record for staff. Staff could complete electronic referrals and record patient pathways. However, the trust used three different IT systems and some staff found this inefficient and slow to work at times.
- By using the trust's intranet, staff had access to relevant guidance and policies. Staff we spoke with were aware of how to access policies and were advised to look on the intranet for the latest version. All staff had access to an email account.
- Staff were able to access blood results and x-rays using electronic results services.
- Medical and nursing records were accessible on all wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated an understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Some staff were more confident with the process as they worked in areas where it was more likely that patients required a DoLS in place.

- The DoLS protocol was on display on some of the wards. We looked at the paperwork for two patients with a DoLS in place. This was appropriately completed and reviewed daily for one patient however; some daily reviews had been missed for the other patient.
- We observed staff obtaining verbal consent and giving explanation prior to completing a procedure. Patients we spoke with also said that staff asked for consent prior to delivering care.
- The electronic computer system would identify any patient that had a DoLS in place.
- There was good compliance with staff training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Overall compliance for staff within medical care services for DoLS and MCA training was 86.8% and 87.6% respectively. Therefore, both achieved over the trust target of 85%. The lowest compliance was for health care assistants in chest medicine, who achieved 62.5%.

Are medical care services caring?

Good

At the previous inspection in 2015, we rated caring as 'Requires improvement'. At this inspection we rated caring as 'Good' because:

- Feedback from patients and relatives was positive. We saw good interactions between staff and patients.
- Staff maintained patients' privacy and dignity when providing care.
- Patients and relatives told us that staff kept them informed of their treatment and progress and involved them in decision making.
- There was good emotional support available through the chaplaincy service and there was a multi-faith prayer room within the hospital.

However:

- Although the availability of call bells to patients was generally good during our inspection, we saw on the Acute Medical Unit (AMU) that 17 out of 25 patients did not have a call bell within reach.

Compassionate care

- The Friends and Family Test response rate for this hospital was lower than the England average from March 2015 to April 2016. There were good test results across all medical wards for this period with wards consistently scoring between 90 -100%. The exceptions were Ward 80, which scored 50% in June 2015 and 72.7% in October 2015 and Ward 10, which scored 61.5% in September 2015 and 33% in October 2015. Ward 10 was the winter pressures ward and was closed at the time of our visit.
- It is important for patients to have call bells in reach in order to summon help when needed. On our last inspection, we noticed that this was an issue with many patients' call bells being out of their reach. The trust had carried out monthly call bell audits. We looked at the results of these audits from December 2015 to May 2016 and saw that there was a high compliance rate with call bell availability. Where call bells where identified as not being within reach there was an action to address this. In some circumstances, there was a documented reason why the call bell was out of reach, for example, it was a choking hazard for a patient with dementia. The availability of call bells to patients was generally good during our inspection however; we saw on the Acute Medical Unit that 17 out of 25 patients did not have a call bell within reach.
- Call bell response rates appeared good during the inspection. Patients told us they were normally responded to promptly. On the Elderly Assessment Unit (EAU), we heard four call bells ring, three were answered in less than two minutes, and one took longer than two minutes. Two patients we spoke with on Ward 8 were happy with their care and said they did not have to wait long for their call bell to be answered.
- Patients' dignity was maintained. We observed a consultant led ward round and saw that curtains were pulled around the patient to maintain privacy and dignity.
- Staff we observed spoke to patients in a caring and compassionate way. We overheard a student nurse on EAU assisting a patient with washing, care was personalised and they were having a conversation about the patients' family and their individual preferences. We observed a porter arriving to transport a patient and saw that he ensured the patient was comfortable and had a blanket before leaving the ward. A relative told us staff on Ward 8 were very kind.
- During the unannounced inspection, we carried out a Short Observational Framework for Inspections (SOFI) on Ward 80, Ward 90 and Ward 500. We observed good

interactions between staff and patients. Patients responded positively to staff and it was clear from the patients' facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if there was anything they needed.

- One patient on EAU was shouting out and unable to express their needs, staff attended to the patient and offered reassurance. Another patient was wandering at their bedside; the nurse assisted the patient back to the chair, moved any trip hazards, reoriented the patient and reminded them about using their buzzer.
- Most patients and relatives we spoke with were satisfied with their care. They said that some staff on the ward, predominantly health care support workers were not attentive to the needs of patients, particularly those with dementia.

Understanding and involvement of patients and those close to them

- Patients told us that their families were involved in their care and informed about treatment plans. We saw involvement in care decisions clearly documented in the medical records we looked at.
- One patient said, "Staff are brilliant". "They take time to answer our questions and concerns".
- We heard doctors explaining treatment options and plans to patients and relatives and answering their questions.
- We saw examples of nursing staff involving patients. For example, a nurse was assisting a patient to pack their bag. The nurse involved the patient and asked how they would like things packed.
- One patient told us that staff had involved her in discharge plans and had considered the needs of her husband who was unwell when putting her care package together.

Emotional support

- As part of the safety huddle on Ward 9, we heard a doctor request bereavement support for a relative who was not coping with a recent bereavement.
- A psychiatry liaison team from the local mental health trust worked with the hospital and offered support to patients with physical and mental health problems.
- A chaplaincy service, which consisted of chaplains and volunteers, was available to support patients, their families and carers during their time in hospital. There was a multi-faith prayer room available within the hospital.

Are medical care services responsive?

Requires improvement

At the previous inspection in 2015, we rated responsive as 'Inadequate'. At this inspection we rated responsive as 'Requires improvement' because;

- The trust was not meeting the 18 week referral to treatment indicator for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- There were still issues with bed capacity and medical outliers were affecting other services. During the inspection, we found several medical patients being cared for on the gynaecology ward.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed.

However;

- There was some good practice in order to meet the individual needs of patients. The environment on elderly wards had been adapted for patients living with dementia. For example, dementia friendly signage and large wall clocks. Recreational co-ordinators had been introduced in medical elderly wards to provide patients with activities.

Service planning and delivery to meet the needs of local people

- The trust worked closely with local Clinical Commissioning Groups (CCGs), stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- Partnership working was in place with community providers and other agencies to ensure the timely and safe discharge of patients requiring additional support.

There was a multi-agency discharge hub on the hospital site, which arranged services to support patients to be discharged safely to their own homes or to an intermediate care bed in the community.
- The Health Group were engaging with commissioners in a complete re-design and new commissioning approach for services that would enable new integrated models of care with services in the community.
- GPs and patients had been involved in the design of the elderly care pathway.

Access and flow

- In the last 12 months there had been no mix sex breaches reported by the Medicine Health Group.
- Data for the period April 2015 to March 2016 for showed that overall the trust was not meeting the 92% indicator for the percentage of patients receiving treatment within 18 weeks of referral. The percentage achieved by the trust was worse than the England average. By speciality, the worse areas were cardiology at 71.8%, geriatric medicine at 84.6%, thoracic medicine and gastroenterology at 87% and dermatology at 88.9%. General medicine, neurology and rheumatology were achieving the 92% indicator within this period.
- The management team were aware of the failure to deliver the national 18 week referral to treatment time and had agreed an improvement plan with the local CCGs to work towards achieving this. There was an agreed trajectory for improvement and the trust was currently ahead of this trajectory.
- Information regarding bed moves between March 2015 and February 2016, indicated that across medical services for Hull Royal Infirmary, 40% of patients had no moves, 45% were moved once during their stay, 10% were moved twice, 3% three times and 2% of patients were moved four or more times. This showed a slight improvement in the percentage of patients moved three times compared to the previous year.
- Nurses told us that they sometimes felt pressured to move patients to free up beds however, it was very rare to move a patient after 10pm. Information provided by the trust showed that between January and April 2016, 266 medical patients had been internally transferred between 10pm and 8am. This was an improvement compared to last year with 779 bed moves after 10pm.
- Issues with bed capacity led to medical patients being cared for on non-speciality or non-medical wards. During the inspection, we found several medical patients being cared for on the gynaecology ward. This was affecting services and we found in the divisional report that pressures on the gynaecology ward from outlying medical patients were resulting in the cancellation of elective gynaecology procedures.
- The trust had criteria for medical patients outlying on the gynaecology ward. The criteria stated patients should have an agreed discharge plan of 24 to 48 hours. On our unannounced visit, the ward had eight medical outliers. Staff said the medical outliers on the ward were not in line with the criteria. For example, one patient was waiting for an MRI scan and did not have an agreed discharge plan. There was a doctor on the ward reviewing the patients and staff told us appropriate medical staff reviewed the outlying patients daily.
- Staff on Ward 50 told us that beds on the renal ward were sometimes filled with patients from a different speciality. This caused problems when a renal patient needed to be admitted for dialysis. We were also told that patients who were medically fit for discharge from the ward would sometimes be moved to another ward until their care package could be put in place. This was not ideal if the patient needed dialysis as they would need to be transported back to the ward. Staff said this was rare but it did sometimes happen.
- Data provided by the trust showed that in the last six month period from February to July 2016, there had been 25 medical outliers transferred to Castle Hill Hospital from Hull Royal Infirmary. This was a marked improvement on the previous year when up to 100 medical patients were transferred to this site in one month alone.
- There were 21 beds on the Elderly Assessment Unit (EAU). The number of beds had increased from 15 to 21 since the last inspection and chairs previously used for ambulatory care had been removed to accommodate the additional beds. Staffing levels had also been increased in line with the number of beds. The unit no longer accepted patients who needed ambulatory care.
- A consultant on EAU told us there were plans to introduce rapid access clinics for frail elderly patients and these clinics would not be based on EAU.
- At Hull Royal Infirmary, the average length of stay was longer than the England average for elective care but shorter than the average for non-elective care from January to December 2015. Elective gastroenterology and respiratory medicine had longer than average lengths of stay.

Medical care (including older people's care)

- Data from NHS England for May 2016 showed there were 625 days delayed transfers of care for this trust. The main reasons for these delays were related to the completion of assessments and waiting further NHS acute care. This was a reduction compared to a delay of 756 days for the same period in 2015.
- The trust had introduced a new role of discharge co-ordinators onto medical wards. The aim of this role was to ensure the timely discharge of patients and free up time for the registered staff to concentrate on their tasks. This role had been extremely well received; staff said the role was effective in discharge planning.
- We saw evidence that Ward 80 had sustained a reduction in the length of stay by more than two days, over the period December 2015 to July 2016.
- Ward 10 had been the winter surge ward was not in use at the time of our visit. On our last inspection, the winter surge ward had remained open into the spring and was open when we inspected in May 2015.

Meeting people's individual needs

- Face to face interpreters were available and there was access to a language line for rare languages. There was also access to British Sign Language (BSL) interpreters. Staff were not always using an interpretation service. On Ward 110, we observed a relative being used to translate for a patient. This was not good practice as confidentiality may be breached.
- There was a full time dementia lead nurse role. The senior management team told us that the nurse was working with a local dementia board to produce a dementia strategy.
- Dementia training and education was not part of the trust's statutory or mandatory training programme. However, there was a dementia and delirium policy available to support staff to care for patients with dementia and a dementia screening tool was in use.
- Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This national scheme teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- The Elderly Assessment Unit (EAU) and elderly care wards had a dementia friendly environment. They had dementia friendly signage and large wall clocks. Red food trays and yellow cutlery was in use for patients with dementia. We saw information regarding dementia displayed on notice boards, which included contact numbers for support. Specific staff took on a dementia friendly role and felt passionate about this responsibility. This included encouraging others to learn more about dementia.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital. We saw that wards had access to activities for patients living with dementia such twiddle muffs, photo boxes and memory pictures. Ward 9 had a bus stop and bench for dementia patients who were agitated and believed they needed to go somewhere. Nurses told us this had a calming effect.
- Clinical psychologists and the learning disability liaison nurse supported those patients with particular needs. Staff were aware of the learning disability passport and how to access this. Patients with learning disabilities were highlighted as part of the safety brief to identify if further support was required. We observed this element within the safety brief during our inspection.
- A patient with learning disabilities was being cared for on Ward 500. Their carer had been able to stay with them overnight to offer reassurance and provide consistency for the patient.
- The learning disability liaison nurse provided training for staff and the trust was planning to facilitate a mental health and learning disability study day in July 2016. Online training was also available.
- There were a range of clinical nurse specialists who supported patients in a range of different settings, for example, diabetes specialist nurses.
- There was no day room on Ward 50. Patients and relatives could use the seminar room; however, this was not very comfortable or patient friendly.

Learning from complaints and concerns

- Information submitted by the trust showed the trust received 855 formal complaints between April 2015 and April 2016. The average number of days taken to close a complaint was 36. The trust's gold standard for completing complaints was 25 working days; however, complex complaints were assigned a timescale of 40 or 60 days to complete. Forty-six (5.4%) of complaints were re-opened.

Medical care (including older people's care)

- The most common issues complained about were all aspects of clinical treatment, which included, care provided, attitude of staff and management of a patient's condition. The staff group most often complained about was medical staff, which accounted for 83% of complaints involving staff.
- There were 33 complaints specifically relating to the Acute Medical Unit (AMU) and 64 about patients with dementia. These specialties were in the top 10 most complained about.
- Information provided by the trust identified in November 2015 there were a number of complaints that had been open for 40 days. An update was requested and the trust identified this was due to waiting for responses from professionals.
- We reviewed the response to a serious complaint from a patient and found the response to be fair and thorough. A face to face meeting had also taken place to resolve any outstanding issues. The response letter to the complainant included an apology for the distress and upset caused and detailed changes which had been made to prevent the situation reoccurring.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. We saw information displayed in clinical areas (such as posters or leaflets) setting out the complaint process and explaining to patients how they could raise concerns.

Are medical care services well-led?

Good

At the previous inspection in 2015, we rated well led as 'Requires improvement'. At this inspection we rated well led as 'Good' because:

- We found an improved staff culture; staff said it had changed for the better. A programme of professional and cultural transformation training was ongoing for all staff, which included new staff joining the organisation.
- There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered.
- Staff were engaged and told us that there was good teamwork.
- There was a drive for continual change and improvement within the Medicine Health Group.

However;

- Ward sisters/charge nurses were often counted in the nursing numbers providing patient care and did not have dedicated time to carry out their management duties.
- Leadership had improved however further work was needed to embed the changes and to continue to improve standards. Some staff found it difficult to keep up with the pace of change.

Vision and strategy for this service

- The Medicine Health Group had a five-year plan, which clearly set out their overall goals. The plan fitted with the trust's strategy for 2016 to 2021.
- There was a clear programme of change and vision for the Medicine Health Group, which we saw, in the Health Group's operational plan 2016/17 and 2017/18. The group's strategic vision was that "every patient will receive high quality, safe and responsive care irrespective of their age, social status and the time and day of the week that they access our services".
- The operational plan included objectives, which set out the key actions, measurable outcomes and timescales for completion. This included the planned programme of transformation across a number of specialties that would implement integrated pathway redesign.
- Most staff we spoke with were familiar with the trusts organisational goals of 'Great Staff - Great Care - Great Future.'

Governance, risk management and quality measurement

- The senior management team for the Medicine Health Group were clear on their greatest risks and we saw this clearly documented on the risk register. Control measures were put in place to reduce the level of risk. Each speciality service had their own risk register and high risks could be escalated onto the Health Group register. The risk register held most of the issues we had identified such as staffing and delivery of the national 18 week RTT however, the management of the deteriorating patient and the accurate completion of records were not included.
- Within the Medicine Health Group, an integrated governance committee was held monthly. Items discussed at this meeting included incident management, serious incidents, the risk register, current

audit plans and complaints. The meeting was attended by the divisional nurse, quality and safety managers, business manager, pharmacy and governance lead and chaired by the nurse director. We saw from copies of the minutes that actions with completion dates were recorded.

- Monthly governance meetings were held for medical specialities for example, diabetes and endocrinology, neurology and stroke medicine.
- An audit programme was in place for each speciality within medicine. Quality audits such as the fundamental standards audit (3Gs), measured each ward against standards across a number of areas which also included infection control.
- The results were monitored by the Health Group however, they not always completed in the agreed timescales.
- Wards had regular team meetings and staff felt they could raise issues. However, these did not always happen due to staffing constraints.

Leadership of service

- Staff we spoke with told us they were more confident in the current trust board. Some staff said they had seen and spoken to the Chief Executive on a recent walk around.
- A medical director, an operations director and a director of nursing, led the Medicine Health Group. The group was subdivided into four divisions; elderly medicine, emergency medicine, specialist medicine and general medicine. A clinical director, a divisional manager and a divisional nurse managed each division.
- Staff told us that senior managers were visible and approachable. They said they felt well managed and their line managers at ward level were supportive.
- The Health Group leadership team had recognised the need to develop effective leadership at all levels and this was identified on the risk register. Leadership development for service leaders and the introduction of the 'Great Leaders' programme for middle managers were control measures in place. Ensuring charge nurse competency and appropriate training for staff were also identified as control measures.
- Senior managers were proud of their staff and of what they had achieved. They recognised that the pace of change needed to be managed in order for improvements to be sustainable.
- Nurse directors met with the Chief Nurse every Tuesday and would alert the Chief Nurse to any major issues as they arose.
- The matron for Ward 110 visited the ward daily for an update and regularly carried out a walk round to speak to patients.
- There was a lead consultant for dementia and elderly medicine. Ward sisters told us that the consultants provided excellent leadership and support and they has a genuine passion for patient care.
- Ward sisters/charge nurses were often counted in the nursing numbers and were not able to carry out their management duties because they were providing direct patient care.
- A ward sister from Castle Hill Hospital had moved to Ward 110 to provide leadership to the ward. Staff told us this had made a positive difference.

Culture within the service

- There was an ongoing programme of professional and cultural transformation training for all staff. New staff also received this training at induction to understand the expectations of them as staff working at the trust.
- The trust had appointed staff as anti-bullying champions and provided training to support them in their role.
- The majority of staff we spoke with told us the culture had changed for the better and there was no longer a blame culture. They felt they could raise concerns and that these would be listened to and addressed.
- One member of staff told us he had never come across any bullying or harassment but was aware of historic issues. He believed there had been a positive change in culture in recent times.
- Sickness rates for registered nurses between January and April 2016 were similar to the England average.

Public engagement

- The trust's strategy for 2016-2021 was developed in consultation with patients and stakeholders.
- There was a newly established patient and public council, which was chaired by a patient representative.
- A draft patient experience strategy, which included medical care services, was in the process of being reviewed by stakeholders and the public and patient council. The final version of the strategy was due to be presented to the trust board for approval in September 2016.

- Patients were involved in service user groups and patient stories were shared at every board meeting.
- The trust participated in the friends and family test.
- Ward 70 had a communication booklet for patients to provide feedback on the service they had received.

Staff engagement

- We found staff were positive and there was a strong focus on teamwork.
- Ward sisters we spoke with said that staff morale had been low a year ago but had improved since then.
- Staff told us there were strong ward teams with everyone pulling in the same direction. The ward sister and a consultant on the Elderly Assessment Unit (EAU) told us that there was good teamwork on the unit.
- Staff on Ward 70 told us that managers had responded well to a request for improved storage and computer access. Both issues had been resolved efficiently.
- The trust held a yearly 'Golden Hearts' award ceremony to recognise great work from staff. A member of staff we spoke with told us she had received a golden heart in relation to her work on falls prevention.
- Staff had been involved in choosing the new values for the organisation of care, honestly and accountability.
- Staff received a Medicine Health Group newsletter, which was circulated to keep staff up to date with news and changes.
- Ward sisters we spoke with were positive about the senior leadership and the changes taking place. One ward sister said that some staff struggled to keep up with all the changes and recognised the need to support staff with this.
- Two members of staff told us they felt it was difficult to keep up to date with all the changes, especially the new paperwork.

Innovation, improvement and sustainability

- There was a drive for continual change and improvement. The leadership team had taken on board areas requiring improvement identified at the last CQC inspection and had integrated them into their quality improvement plan.
- Senior managers shared with us that they had concentrated their initial efforts on improvements in emergency care, but were now focused on making changes to improve the acute medical pathway and elderly care.
- Staff told us the trust had been involved with the improvement academy to reduce the number of patient falls. New falls assessment documentation had been introduced because of this and falls risks were discussed at safety huddles.
- New roles had been developed within the Medicine Health Group to free up nursing time. Patient discharge assistants had been introduced across medical wards to progress and chase up complex and simple discharges. Recreational co-ordinators had also been introduced to provide patients with stimulating activities and there were plans to introduce nutritional assistants to wards.
- Advanced nurse practitioners (ANPs) worked within the Ambulatory Care Unit (ACU) to provide additional medical / nursing support.

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull Royal infirmary (HRI) is part of the Hull and East Yorkshire Hospitals NHS Trust. The Surgery Health Group provides a range of surgical services for the population of Hull and surrounding areas.

On this site, the Surgery Health Group provided non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, neurosurgery. It also provides elective vascular and neurosurgery.

The surgery service has eight wards surgical wards at HRI with 205 inpatient beds. The hospital has nine theatres in the main tower block, three ophthalmology (eye surgery) theatres, two-day surgery theatres and one clean procedure room.

Between January 2015 and December 2015 the Surgery Health Group carried out 57, 579 surgical spells, this placed the trust in the highest quarter of all NHS hospitals nationally. Fifty-one percent of procedures were carried out as a day case with 38% emergency admissions and 11% elective admission.

During our inspection, we spoke with 60 members of staff including nursing, medical, and allied health professionals as well as 28 patients and three relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 30 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the Surgical Health Group.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust. We also carried out unannounced inspections on 9 June and 11 July 2016.

A comprehensive inspection of HRI was carried out in February 2014; all five domains were inspected for surgical services. Safe and well led were rated as requires improvement and effective, caring and responsive were all rated as good. The service was rated as requires improvement overall.

A focussed inspection was carried out in May 2015. Two domains were inspected, for surgical services. Safe was rated as inadequate and well led was rated as requires improvement. The service was rated overall as inadequate. The main issues at this inspection were:

- A number of Infection Prevention and Control (IPC) concerns in relation to the environment and compliance with specialised ventilation guidance within theatres
- Concerns over the number of suitably skilled and experienced staff working in surgical wards.
- No clinical strategy for the Health Group.
- A backlog of complaints and incidents within the Health Group requiring investigation.
- The trust was not meeting the overall referral to treatment (RTT) performance standards.

Surgery

Summary of findings

Last year we rated surgical services at HRI as 'Inadequate' overall. Following the 2016 inspection we rated surgical services at Hull Royal Infirmary as 'Requires improvement' overall because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated for medical review, but this had not always occurred.
- From our observations the five steps to safer surgery checklist was not embedded as a routine part of clinical roles within the theatres we visited.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff. From information we reviewed and staff we spoke with we saw that only six consultant Orthopaedic ward rounds had taken place in the month of June 2016.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. The trust recognised this was an issue and had twice daily safety briefings to minimise the risks to patients.
- Nursing staff did not always complete accurately the falls and dementia risk assessments.
- Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- National audit performance was variable; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- The trust was a mortality outlier for the reduction of fracture of bone (upper and lower limb).
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.
- Due to the environment in the day surgical unit it was difficult to maintain privacy and dignity.
- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance standards for treatment and cancer standards.
- The senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

However,

- We noted major improvements from the 2015 inspection to the theatre environment.
- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI), we carried out showed that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust's values and strategy.

Surgery

Are surgery services safe?

Requires improvement

Last year we rated surgical services at HRI as 'Inadequate'. Following the 2016, inspection we rated surgical services at Hull Royal Infirmary as 'Requires improvement' for safe because:

- The escalation process for identifying and acting when patients deteriorated was not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated for medical review, but this had not occurred.
- From observations the five steps to safer surgery checklist process was not embedded as a routine part of clinical roles within the theatres we visited.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. The trust recognised this was an issue and had twice daily safety briefings to minimise the risks to patients. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- We found that nursing staff did not always complete accurately the falls and dementia risk assessments.

However,

- We noted the theatre environment had undergone major improvements following the 2015 inspection.
- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.

Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. One never event had been declared within the Surgery Health Group in the reporting period July 2015 to June 2016; the retention of swabs post procedure from a previous episode of surgery. The Health Group had investigated, and a root cause was identified. In the period between the incident occurring and being reported, the trust procedures for swab checking and counting had already changed. No new recommendations were made within the report and staff we spoke with were aware of the incident.
- Serious incidents are incidents that require further investigation and reporting. Twenty-three serious incidents (SI) were reported within the Surgery Health Group during the reporting period May 2015 to April 2016. Themes from serious incidents reported included surgical procedure issues, treatment delays and pressure ulcers. We reviewed four serious incident reports and noted the recording of duty of candour discussions, recommendations and further learning identified as appropriate. One serious incident we reviewed was due to be reviewed six months after completion, to ensure the new practices recommended were embedded.
- The Health Group investigated all reduction of fracture of bone (upper and lower limb) patients who were not able to have an admission to theatre within 36 hours. We reviewed two root cause analysis reports; however, from the reports we reviewed, it was difficult to ascertain lessons learned to prevent the issues from happening again.
- We reviewed incident data supplied to us by the trust that showed surgical wards and departments reported 2,518 incidents from May 2015 to April 2016. Reported incidents we reviewed showed two graded as death, nine graded as severe harm, 57 as moderate harm, 496 graded as low harm and 1,954 graded as no harm/ near miss.
- The Surgery Health Group reported the second largest number of incidents in the trust (23.4%). Reported incidents showed the top three categories of incidents reported was patient accident at 28% (713 reports), access, admission, transfer, discharge (including missing patient) were 13% (329 reports) and treatment and procedure 11% (280 reports). Staff we spoke with were aware of the top three incidents.
- In 2015, the trust was asked to take action to ensure, that all incidents were investigated in a timely manner. Data we received from the trust in February and March 2016 showed a backlog of 168 incidents required review. We discussed this backlog with the senior management

team and they informed us of the work to reduce the backlog, and at the time of the inspection, the Health Group had reduced the backlog to 28 outstanding incidents to review.

- Nursing and medical staff we spoke with were aware of the reporting system and staff, could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. The majority of staff we spoke with said that they received feedback following completion of incident forms, staff investigating incidents were aware of what action needed to be taken to provide staff with feedback.
- Staff we spoke with said that learning from incidents was shared internally through safety briefs during shift handovers, quality and safety bulletins and lessons learned newsletters. Themes within the newsletters and bulletins we reviewed included new medications, changes to radiology results notifications, falls, blood transfusions and incident reporting.
- On Ward 60, we saw a newsletter produced to share all incidents received for that ward on a monthly basis.
- There was evidence of changes in practice from incidents. For example, there had been an incident in another Heath Group with alcohol hand gel; staff we spoke with were aware of this incident and had taken individual ward based actions to identify solutions. On one ward, falls had increased; to manage this staff had placed at risk patients together with a member of staff within the room, to increase observation of at risk patients.
- The senior management team held bi-weekly meetings with ward managers to discuss incidents and actions taken.
- Mortality and Morbidity meetings were held within individual specialities, no specific overall mortality meeting was held for the Health Group. The senior management team spoke with us about the trust mortality committee and the governance group providing information into this group; however, from governance and business minutes we reviewed it was not apparent that mortality discussion was held at the Health Group's governance or speciality business meetings. The lack of a forum to discuss mortality and morbidity within orthopaedics was identified in December 2015 as a risk. In June 2016 the Health Group agreed to remove this from the register; however medical staff had challenged this. Within the Health Group strategy it was recognised that a robust mortality and morbidity team review system was required. The senior management team informed us that a new system of case note review mortality meetings was been introduced. Staff from within the Health Group had received training and the centralised system was due to be implemented from September 2016.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of duty of candour requirements and described it as being open and honest with patients when incidents occurred. They provided examples of when patients were cancelled and having open discussions with the patient about the reasons for cancellation and when patients had acquired pressure area damage whilst in hospital.
- Data we reviewed showed that within the Surgery Health Group, duty of candour requirements had been declared on 16 occasions during 2015/2016. The senior management team provided us with examples about its use, for example an increased incidence of pressure ulcer development within the Health Group. Staff recorded duty of candour discussions on the investigation reports and staff we spoke with said this was also recorded on the incident form and medical notes.
- Response letters to complaints included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots) and catheter and urinary tract infections (CAUTI's).
- Information from the safety thermometer data was displayed in all areas we visited.
- In the Health Group during the reporting period, March 2015 to March 2016 there had been 35 pressure ulcers, six falls with harm and 15 CAUTI's.

- The rate of new pressure ulcers reported was highest in March 2015, following this period rates were variable with no trends identified.
- The Surgery Health Group had reported six falls with harm; these had all been reported from September 2015.
- The rate of urinary tract infections reported in patients with a catheter showed a decreasing trend between October 2015 and February 2016.
- Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed March 2016 showed 77.9% of patients received the appropriate assessment of risk. The trust had implemented a new patient administration system and the trust reported that data capture issues were causing low-level compliance issues.
- Staff on ward 12 had identified in the previous year an increase in pressure ulcers and had developed an educational package, competency-training tool and improved documentation to address this. No avoidable pressure ulcers had been identified since the training had taken place. Following the identification of an avoidable pressure ulcer on Ward 40, staff had undertaken a root cause analysis and had reviewed their own documentation to identify further learning; from this, staff were able to identify specific gaps in documentation.

Cleanliness, infection control and hygiene

- In 2015, the trust was asked to take action to ensure the results of Infection prevention and control (IPC) audits were reviewed especially on wards and theatres. The trust was also asked to ensure compliance with theatre engineering performance measures and annual servicing of ventilation for all theatres. Since the previous inspection, the trust had undertaking a significant refurbishment programme of the theatre suite this included undertaking testing of the specialised ventilation.
- Infection prevention and control information was visible on all wards we visited; this information included the number of days since last hospital acquired clostridium difficile (C.Difficile) infection and methicillin resistant staphylococcus aureus (MRSA) isolate.
- The trust reported zero cases of hospital acquired MRSA from July 2015 to April 2016. The trust reported 46 cases of hospital acquired C.Difficile in the reporting period April 2015 to April 2016 this was lower than the agreed maximum threshold of 53 cases.
- The trust had a policy for screening surgical patients for methicillin resistant staphylococcus aureus (MRSA). Emergency and elective patients undergoing surgical procedures and fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening and noted 75% compliance against a target rate of 100% during the reporting period April 2016 to June 2016
- At the time of the inspection, the trust did not undertake audits of the MRSA and C.Difficile policies.
- Wards and departments were visually clean and we saw ward cleanliness scores displayed in public corridors.
- We saw staff washing their hands, using hand gel between patients and staff and complying with 'bare below the elbows' policies. We also saw staff challenging other staff about whether they had washed their hands.
- Hand hygiene audit data we reviewed showed 94.4% compliance in the reporting period April to June 2016. However, only three wards and three theatres audits submitted data, out of these only two areas submitted data every month. The trust had recognised a reduced compliance with the audit, and from July 2016 had introduced a new five moments audit tool and IPC ownership tool.
- During the inspection, we saw hand hygiene compliance data displayed on the wards and departments we visited. Following a serious incident the trust had taken a decision for wards to risk assess the provision of alcohol gel at patients' bedsides; some wards had made the decision following the risk assessment to provide personal issue alcohol gel to staff. Soap dispensers we reviewed were in good working order.
- All patients were provided with hand hygiene wipes to clean their hands prior to meal service.
- During the inspection, we observed good compliance with IPC policies; for example, rooms were available for the isolation of patients, and patients requiring isolation were isolated.
- As the hospital was mainly for emergency surgery, staff did not carry out surgical site infection surveillance. This was completed for knee replacement and cardiac surgery on the Castle Hill Hospital site.

- Environmental cleaning schedules were available and displayed in public areas. We reviewed patient led assessment of the care environment (PLACE) results for the trust and noted they were 96%, which was slightly below the 98% England average for 2015.
- We reviewed five pieces of clinical equipment and noted these to be clean and labelled.
- The infection prevention and control (IPC) team delivered training both face to face and via e learning. IPC training compliance rates for the Surgery Health Group were 75.7% below the trust target of 85%.
- The trust had completed a review of clinical areas undertaking operating procedures and classified them as ward, operating or clean room standards.

Environment and equipment

- In 2015, the trust was asked to take action to address concerns identified regarding the flooring and walls within theatres. The trust was also asked to review access and waiting areas for theatres and recovery area. During this inspection, we noted major improvements in the theatre environment. Work was still to be completed; however, the work carried out to date provided an improved environment for patients, staff and improved compliance with infection prevention and control standards.
- In 2015, the trust was also asked to review access and security arrangements for theatres and recovery area. This work was yet still to be completed so remained a risk.
- Equipment we reviewed had been electrically safety tested.
- In the majority of occasions, for the resuscitation equipment we checked staff had recorded that checks were completed. However, on ward 10, the trolley was unlocked and the drawers were found to be cluttered and untidy.
- Wards had individual resuscitation checklists to complete on a daily basis, these were stored in a file on wards we visited, to be compliant with the audit wards had to have completed the checks daily and have no more than two checks missing in the month. Scores for the Health Group had improved in the previous months.
- In the Day Surgery Unit, a potential issue with monitoring carbon dioxide levels in stage one recovery was identified. We discussed this concern at inspection and were reassured, by the operating department recovery staff, that there were procedures in place to make sure patients were safe. Following the inspection we also received written confirmation that the issue was resolved and the monitoring equipment was in place.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation.
- Within the Day Surgery Unit, stock was stored on the floor within theatre corridors, a fire escape within this area was cluttered with rubbish and trollies, we reported this at the time of the inspection and staff took immediate action and removed the items.
- The environment within the day surgical unit did not allow a clean to a dirty flow. During the inspection, we witnessed dirty waste leaving theatre through the anaesthetic room corridor passing patients lying on trollies. The theatre suite only had one door entry and exit for patients, we saw post-operative patients pass waiting pre-operative patients.
- We reviewed the trolley used for difficult airway access within the Day Surgery Unit and noted that it was not easy from visual observation to identify what equipment was single use or how it was decontaminated. This did not reflect recent improvements suggested by the Difficult Airway Society. It was recommended by the difficult airway society to have clearly and concisely labelled drawers; they suggest downloading images to label difficult airway trolley drawers, to enable easy access to equipment in emergencies.

Medicines

- On surgical wards we visited medicines were appropriately stored, with access restricted to authorised staff. On the majority of occasions, staff prescribed and administered medicines appropriately.
- Controlled drugs were appropriately stored; administration records were maintained; however, on most areas visited daily balance checks were not performed in line with the trust policy. On ward four, daily balance checks had been missed on seven occasions in the month of April 2016.
- From prescription charts we reviewed, medical staff did not always follow the trust procedure and safe practice when cancelling a prescribed medicine. Pharmacists had checked the majority of charts we reviewed; checks included ensuring patients were prescribed the same medications they had been taking at home, unless this was no longer appropriate.

- Emergency medicines were readily available and they were found to be securely stored and in date.
- The majority of medicines fridges were secure, however a fridge on Ward 40, was not locked during the inspection. Temperature records were monitored and maintained in most areas.
- Within the day surgical unit, we found medication for the current patient in theatre left on the worktop whilst a different patient was in the anaesthetic room; this practice had the potential for mistakes to be made when administering medication.

Records

- Paper records were available for each patient that attended the wards or department; the trust used a computerised patient administration system, however most records and patient assessments were still paper based.
- Electronic boards were available on all wards visited, which provided easy access for staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans.
- We reviewed 30 sets of medical and nursing care records whilst on site and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of the review or administration of medication as per compliance with trust policy and professional standards.
- Patient records were stored in notes trollies that could be locked, or were stored in secure areas.
- The wards and departments used risk assessment records. Those we reviewed showed that documentation for falls and completion of dementia and delirium pathways were not always completed accurately, especially on Wards 12 and 120. We reviewed twelve sets of notes and found that two had been completed correctly; staff were able to explain the process of falls assessments. On the majority of occasions, staff completed pressure care assessments and intentional rounding documentation accurately.
- Completion of venous thromboembolism (VTE) assessment was 77.9% for March 2016 lower than the trust compliance rate of 100%.
- Individualised patient care plans we reviewed on Wards 12 and 120 were not always completed accurately.
- Ward quality assurance audits were carried out on a monthly basis; five sets of notes were audited each week and areas audited included tissue viability, IPC and patient experience. Staff on Ward 60 had started to involve junior members of staff in the audits; staff we spoke with said that documentation had improved because of the auditing.

Safeguarding

- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff we spoke with were able to describe their roles in relation to the need to report and take action as required when safeguarding issues were identified.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by refresher training. We reviewed safeguarding training compliance rates for July 2015 to April 2016 and they showed 84.6% compliance with a trust target of 85%.
- Examples of safeguarding referrals made within the Surgical Health Group included patient neglect identified on admission and patient disclosure of female genital mutilation.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e-learning programme.
- The trust target for mandatory training completion was 85% compliance; training data we reviewed showed an overall training compliance rate for the Surgery Health Group of 85.1%. On ward 12 over 90% compliance was recorded for all elements of training.
- Individual levels of compliance for training ranged from 82.5% to 92.1%.
- The Surgery Health Group human resources team provided a rag rated spreadsheet to ward managers on a quarterly basis showing levels of compliance. On ward 60 fire training was rated red with 74% compliance, mental health training was 71% and resuscitation training was77%. All other aspects of training were rated green.
- New staff received a corporate and a Surgery Health Group induction, which included some aspects of their mandatory training.
- New or junior medical staff received a corporate induction and departmental induction-training programme.

Assessing and responding to patient risk

Surgery

- In 2015, the trust was asked to take action to ensure use of the best practice guidance, such as the safer steps to surgery checklist.
- The hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. The hospital reviewed compliance with the safety checklist via audit, with five sets of notes checked every month, for every theatre. Results we reviewed showed 100% compliance, however an internal audit report provided to us by the trust reported 54% compliance in the reporting period November 2015 to January 2016. The report was completed for 50 patients in most specialities, a recommendation from this report (published in March 2016) was to re-audit one month later and set up a working group to review the form. Post the inspection, the trust confirmed that a working group had not been developed and no further audit had been completed. A new theatre assurance tool had been developed since the internal audit results and the results from June 2016, showed 100% compliance for the WHO audit compliance.
- During the inspection, we reviewed 16 sets of surgical notes containing WHO checklists and we observed 15 occasions when WHO checklists were completed. On the majority of occasions the checklist were completed; however from our observations it was apparent the completion was undertaken without effective involvement of the whole clinical team, for example sign in and final briefing had no input/involvement from the operating surgeon. No verbal communication was apparent for sign in and final brief on two occasions and on another occasion a band two member of staff had signed for the instrument count. It was unclear whether a registered member of staff oversaw this. We also noted that on five occasions no verbal communication occurred on the appropriate use of antibiotic prophylaxis, pre-operative warming, blood glucose control or VTE risk assessment, this should occur in the time out step.
- We had concerns over 15 incident reports we reviewed May 2015 to March 2016 where missing needles and sutures were reported post operatively and incorrect swab counts. We highlighted our concerns at the time of the inspection and the senior management team spoke with us about a new theatre assurance tool. Results from June 2016 showed 100% compliance for the WHO audit compliance.
- The trust used the national early warning score (NEWS) tool; surgical areas used a paper based version to record the early warning score. Nursing staff identified deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with were able to articulate the clinical condition of a deteriorating patient, however did not appear to have consistent knowledge of the actions required to escalate a deteriorating patient for medical staff review. The clinical trigger response action flowchart outlined in the deteriorating patient policy required staff to escalate to foundation level two medical staff when the patients score triggered five or six. Within surgery, at this hospital, foundation, level two staff were not available and staff were escalating to foundation level 1 staff. The trust carried out internal audits of the NEWS and we noted on average a 96.8% compliance that appropriate action was taken for NEWS of seven or above in the reporting period January 2015 to February 2016. Audit data from April 2016 to June 2016 showed 100% compliance for most areas. Within the Health Group strategy, it had been recognised that the development and delivery of improved identification and management of deteriorating patients was required.
- From 23 sets of notes we reviewed we did not see effective escalation of all deteriorating patients. For patients that had deteriorating early warning scores, documentation of escalation and review was available for nine patients, in six patients action was documented as being taken, however this action did not always reflect action identified in the related clinical policy. In six patients that had deteriorated action or escalation was not apparent from the notes. The implementation of the early warning scoring system did not support the process for early recognition and early intervention of patients who were becoming unwell.
- We reported our concerns about the escalation of deteriorating patients to the senior management team at the time of the inspection. In the period between the announced and unannounced inspection the trust said they had completed case note reviews on two patients and planned to improve education on the area concerned and planned to implement an e-observations package in this area. During the unannounced part of our inspection, we attended the same ward again, Ward 12, and noted that NEWS charts were not completed accurately on two out of three sets of records reviewed.

- We had concerns over consultant review of elective orthopaedic patients during June 2016. Evidence we saw showed that ward rounds had only occurred on six occasions. We discussed this with the senior management team who informed us that consultant job planning reviews had been undertaken and that improvements would be made post September 2016, No formal protocols were in place to allow nursing staff to discharge patients without medical staff review.
- Staff were aware of escalation procedures for issues of concerns on their wards or departments.

Nursing staffing

- In 2015, we gave the trust a requirement notice to take action to ensure that there were at all times sufficient numbers of suitably skilled and experienced staff.
- At this inspection, across the surgical wards and departments there were 814.6 Whole time equivalent (WTE) registered nursing posts and 752 WTE unqualified nursing posts. We reviewed vacancy rates and this showed a 7.6% vacancy rate. All surgical wards we visited had some vacancies.
- The trust's planned nurse to patient ratios for ward areas was 1:8 day shift, and 1:10 night shift for all surgical wards. The surgical wards displayed for public view the planned and actual nurse staffing levels for each shift.
- The trust used the safer nursing care tool to assess nursing staff requirements per ward and department, per shift. We reviewed the safer staffing report dated May 2016 for surgical wards, and on average, there was a 78% fill rate for registered nursing (RN) staff per day shift and 85% fill rate for night shift. For care staff the average fill rates were 100% for a day shift and 133% for night duty. Data we reviewed ranged between 95% to 66% average fill rate for registered nurse RN day shifts and 92% to 77% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 252 registered nurse shifts reviewed, we saw that 97 shifts were staffed at below the established levels for day and night shifts. Staffing levels we reviewed on Wards 6, 7, 40 and 120 all showed periods of staffing levels below the establishment.
- The Surgery Health Group used bank and agency staff to improve staffing levels; we reviewed use of bank and agency staff and noted 1.3% agency usage.
- We had concerns about the staffs' understanding of the levels of acuity of patients nursed within the high observation bay (HOB) and the related staffing levels. Staff we spoke with said the patients were classified as level two critical care patients. National guidance recommends that level two patients have one registered nurse to two patients. However, within the HOB unit, we saw one registered nurse to four patients. The trust's protocol for admission to this area classified the patients as level one and stated a 1:4 staffing level was acceptable. The patients we saw at inspection were all level one.
- The Surgery Health Group was actively recruiting to vacant posts, both local and international recruitment events had been undertaken, an intake of new staff from the local university were due to commence employment in September 2016.
- Twice daily safety brief reviews took place each day across the hospital, the purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Ward co-ordinators attended safety briefings. Prior to making decisions discussions were held around the skill mix, harm rates of pressure sores, falls and infection status, availability of other staff. Staff were often moved from their substantive area because of these discussions.
- The trust had recently developed new roles to support the nursing ward teams. These included ward personal administrators to help ward sisters with ward administration duties, discharge facilitators and ward hygienists. All surgical wards had access to these members of staff. Staff we spoke explained the difference these roles had made, especially discharge facilitators and ward administrators.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that patients' clinical conditions were discussed and levels of support or risks were identified.
- We reviewed planned vs actual hours for allied health professionals within the Health Group: these were similar for qualified and unqualified staff.
- Within theatres at this hospital, 16 WTE operating department practitioner posts were vacant. They also had six; senior nurse and five junior staff nurse vacancies and two health care assistant vacancies.

Surgical staffing

- For all surgical specialities a consultant was present on site 8am until 6pm Monday to Friday. Acute general

surgery had consultant presence 8am until 1pm weekends and bank holidays and trauma had consultant presence 8am until 6pm weekends and bank holidays.

- On-call cover was provided 24-hours a day by junior doctors; two registrars were present onsite 8am until 8pm and one present 8pm until 8am seven days a week covering general surgery. Trauma had resident registrars and on call registrars available. All other specialities have on-call registrars available. Core trainee and foundation level doctors were available 24 hours a day, seven days a week. Neurosurgical registrars were on site until 10pm; however, staff we spoke with said that they generally stayed onsite overnight due to new admissions and deteriorating patients. Overnight one junior doctor covered multiple areas without support from foundation level two doctors. Staff we spoke with said that they would contact the registrar if they were concerned.
- An on-call rota for the major trauma team had been agreed; however this had not been implemented at the time of the inspection.
- Trauma meetings were held every morning, to discuss all admissions who had been admitted overnight and any deteriorating trauma patients, prioritisation was then given to patients who were the most unwell and they were reviewed first.
- We found that the medical skill mix was similar to the England average for consultants at 43% (England average 41%), registrar group 37% (England average 37%), and junior doctor level 14% (England average 12%). Middle career level was lower than the England average at 6% (England average 11%).
- At the time of the inspection, surgical wards and departments had in their establishment budget monies for 372 WTE surgical medical staff. In post there was 342.7WTE including 152.5 WTE consultants and 190.1 WTE junior doctor and middle grade posts. We reviewed vacancy rates and this showed vacancies of 12 WTE surgical consultants (7.3%), 14.7 WTE junior doctor vacancies (approximately 7%), and three WTE middle grade posts. The senior management team spoke to us about the gaps in the junior doctor's rota, especially overnight; this was also highlighted on the risk register. During and post the inspection the trust confirmed that 89% of all junior doctor posts had been filled for the new August intake.
- Junior doctors we spoke with said that within vascular surgery significant gaps were apparent in the rota, especially from 5pm until 10pm. Whilst on the vascular ward we were told there was a gap of one week in every five for the 5-10pm timeslot when a junior doctor from other areas covered vascular surgery. Where possible these shifts were made available to locum booking, however not every shift was filled. General surgery registrars covered vascular surgery overnight (including some vascular registrars), with support from on call vascular consultants; the senior management team were aware of the issue.
- All junior doctors we spoke with said that consultants were accessible on an on-call basis; however, they felt there was a gap in experience especially for new juniors in post. They provided examples of the impact of this gap being patients not been clerked and assessed in a timely manner. Some junior doctors we spoke with said about a lack of timely senior review of patients of concern. The senior management team had highlighted on the risk register their concerns over patients not receiving a timely review due to insufficient junior doctor cover, they highlighted to us that all posts were filled for the new doctor intake in August 2016.
- To help address the gaps in the junior doctor rota, nurse practitioner roles had been developed to undertake some of the roles junior doctors undertake; these staff were available within neurosurgery.
- The senior management team where aware of junior medical staff concerns throughout surgery and had undertaken rota reviews to improve the workload and support within general surgery; however, they spoke with us that this review had led to a decreased level of support within vascular and neurosurgery.
- The Surgery Health Group used locum staff to improve staffing levels; we reviewed use of locum staff during the reporting period of April 2015 to March 2016 and noted 7.8% agency usage.
- Formal medical handovers took place twice a day with informal handovers occurring during the shift when staff changed, we did not observe these during the inspection.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff. We saw that only six consultant orthopaedic ward rounds had taken place in the month of June 2016.

Surgery

Major incident awareness and training

- The trust had a major incident and business continuity plan. This was available to staff on the trust intranet.
- Staff we spoke to had an awareness and understanding of their roles in major incidents.

Are surgery services effective?

Requires improvement

In 2014, we rated surgical services at HRI as 'Good' for effectiveness; this was not inspected during the 2015 inspection. Following the 2016 inspection, we rated surgical services at Hull Royal Infirmary as 'Requires improvement' for effectiveness because:

- National audit performance was variable; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 showed that the trust score was worse than the national average for six out of the 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- The trust was a mortality outlier for the reduction of fracture of bone (upper and lower limb).
- When audit results identified areas for improvement, actions plans were not always available or did not include further actions required to meet the recommendations of the report.
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.

However,

- Patients' treatment was based on national guidance. Compliance against this guidance was monitored by the trust.
- Policies for the Health Group we reviewed were up to date
- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- Patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Patients were consented for surgery in line with trust policy and department of health guidance.

Evidence-based care and treatment

- We saw patients' treatment was based on national guidance, such as the National Institute for health and Care Excellence (NICE), the Association of Anaesthetics, and from the Royal College of Surgeons.
- The services measured compliance with national guidelines. Data we reviewed from March 2016 showed that one clinical policy and one clinical guideline were overdue for review, and all procedure documents were compliant.
- We saw evidence of discussions in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines.
- Policies were stored on the trust intranet and staff we spoke with said they were able to access them.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery, examples of these included hip fracture and neurosurgery pathways. Physiotherapy led pathways were available for spinal surgery. The Health Group recognised that referral criteria within some pathways required standardising, and they were planning to address this in the coming months.
- The Health Group had a local audit programme and these were discussed during audit sessions for the Group.
- Wards and departments we visited took part in the audits of infection prevention and control practices, medication and documentation these audits, known as 3G audits, during 2015/2016. The outcome was that the surgical wards had been rated as outstanding (none), good (four), requires improvement (12) and inadequate (one).
- Some staff we spoke with were not knowledgeable about sepsis pathways and application of the protocol, one patient's notes we reviewed on Ward 60 had not been screened for sepsis despite them deteriorating and meeting the screening criteria.

Pain relief

- We saw that patients were offered pain relief.
- Patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Staff used a pain-scoring tool to assess patients' pain levels; staff recorded the assessment on paper records.
- Some surgical patients received intravenous patient controlled pain relief trust post-operatively.

Surgery

Nutrition and hydration

- We saw patients were offered drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes by using a validated Nutrition Screening Tool - nutritional risk assessment documentation. Documentation we reviewed showed good levels of completion.
- Staff we spoke with provided examples of arranging cooked meals for patients for breakfast. However, the trust did not provide access to suitable and nutritious hot food, out of hours, when a patient had been to theatre or was not able to go to theatre. Staff and patients we spoke with said the provision of hot meals was limited, with only snack and cold foods being available after 6pm.
- We observed two meal services on Ward 12 and noted that three out of five patients requiring support with eating did not receive this within five minutes of being provided with warm food. However, on Ward 120 support required with eating was provided in a timely way.
- Patients had access to fresh water where appropriate and the majority of fluid balance charts we reviewed were accurately completed.
- The trust staggered theatre fasting times, however, because of list overruns some patients we spoke with did fast for longer times than planned. The trust did not undertake internal fasting audits.
- A snack menu was available on all surgical wards. This provided patients with additional food between meals such as cakes, yogurts and ice creams.

Patient outcomes

- At the time of the inspection, the trust was classified as a mortality outlier with the Care Quality Commission for reduction of fracture of bone (upper and lower limb) patients and for cardiac artery bypass graft. This meant that deaths within these two areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable and what lessons could be learnt. The trust had identified actions required to improve outcomes for patients with a reduction of fracture of bone (upper and lower limb), this was followed up by the national mortality team.
- At Hull Royal Infirmary, compared to the England average the risk of readmission following elective surgery was worse in vascular surgery, about the same in ophthalmology, and better for neuro-surgery. Non-elective surgery readmission rates were worse/ higher than the England average in plastic surgery and about the same in trauma and orthopaedics.
- The national bowel cancer audit (2015) showed worse than England average performance for the three indicators, including data completeness and review by a clinical nurse specialist.
- Laparoscopic surgery rates showed that this was only attempted on 24% of occasions, which was worse than the England average of 57%. No action plan was available to detailing improvements required.
- We found that the emergency laparotomy organisational audit 2015 showed that the trust scored was worse than the national average (0-49%) for six out of the 11 outcome measures including consultant surgeon review within 12 hours of emergency admission 39% (national average 47%), preoperative review by consultant surgeon and anaesthetist 38% (national average 58%) and a consultant anaesthetist presence in theatre 37% (national average 65%). The trust was only rated green (70-100%) in one outcome measure and that was for direct postoperative admission to critical care. The remaining four outcome measures were all rated as amber (50-79%). We reviewed the trust action plan for the audit and noted actions for further implementation of the laparotomy pathway and a resources review. It did not include any actions to improve patient access to consultants.
- The lung cancer audit (2015) showed better performance than the England average results for both discussion at a multidisciplinary team meeting (97% for the trust compared with 93.6% England average) and the percentage of patients seen by a clinical nurse specialist which was 83.9% compared with 78% England average. However, the percentage of patients receiving surgery was lower at 13.5% than the England average 15.4 %. We requested to review the trust action plan for the audit, an action plan was available; this only detailed two actions including a further audit not the actions required in the recommendations of the report.
- The trust participated in the national hip fracture audit. Findings from the 2015 report showed that the trust performed worse than the England average for five out of the eight indicators. Performance was better than the England average for four indicators. Best practice guidance recommends than surgery is carried out on

patients with a reduction of fracture of bone (upper and lower limb) within 48 hours following attendance, the hospital performance was worse than the England average with only 49.6% of patients having surgery on the day or the day after admission (England average 72.1%). Data we received from the trust showed a marked improvement in the number of patients having surgery within 36 hours from 32.7% in quarter one 2015 to 69.4% in the quarter ending March 2016. The trust had recruited a trauma co-ordinator who now reviewed patients' access onto the trauma list. We reviewed the trust action plan for the audit and noted that the trust completed RCAs for any cases not operated on in 36 hours; however, due to the information shared within the investigation reports, we were unable to identify how learning from these incidents was being achieved.

- Patient reported outcome measures (PROMs) showed that the trust performed better than to the England average for both groin hernia indicators, three varicose vein indicators and one hip replacement indicator. It performed worse than the England average for two of the three knee replacement indicators.
- The Surgery Health Group monitored performance against a range of clinical indicators via a performance dashboard. This data included compliance with NICE guidance and national audits.
- We reviewed the trust's trauma unit peer review report 2014/2015. This highlighted a number of areas of concern including the lack of provision of dedicated trauma consultant, dedicated trauma ward and collection of data. Since the peer review, the trust had identified a ward for major trauma patients, and improved education and data collection within the Health Group. An action plan was available and on review showed that and a business case for a major trauma consultant rota had been agreed, but was yet to be implemented.

Competent staff

- The Health Group had an internal appraisal target to achieve 85%. Appraisal records we reviewed showed that within the Health Group in May 2016, 87.7% of staff had an up to date appraisal. Data for medical staff appraisals was not available. All staff we spoke with said they had received an appraisal in the last year and thought these had been beneficial.
- Specific ward based induction was undertake on the orthopaedic wards this involved training on traction, mobility and physiotherapy needs.
- On Ward 40, we saw evidence of speciality based training being undertaken with sessions planned for sepsis, chest drains and orthopaedic trauma.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.
- A teacher practioner was available covering Wards 4, 40 and 70. They had developed induction booklets and training packages and assessments of competency.
- Staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.

Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed. Whilst on the wards we saw staff working with the tissue viability team and the diabetes specialist team.
- Referrals were sent to the dieticians from the Surgical Health Group, however due to vacancies within the team referrals received were being prioritised for clinical need some patients that required seeing a dietician prior to discharge did not always manage to be seen, however a letter was sent to the GP explaining this.
- Occupational therapist and physiotherapists held daily meetings on the orthopaedic wards. They also attended ward rounds to review progress or discharge arrangements for the patients. The physiotherapy team also attended neurosurgical pre-assessment meetings to assess a patient prior to admission.
- Physiotherapy staff were integrated into the neurosurgical team and had physio-specific pathways.
- Staff within the Surgery Health Group said that they had positive working relationships within the multidisciplinary team. Physiotherapy staff said that they felt part of the ward team.

Seven-day services

- On-site junior medical cover was available seven days a week; consultants supported the on-site medical staff out of hours and were available on an on-call basis.

- Registrars or foundation level one junior doctors reviewed patients on admission.
- Surgical wards and departments had access to diagnostic and radiology services 24 hours, seven days a week to support clinical decision making.
- Access to occupational therapy was available Monday to Friday and physiotherapy services were available six days a week, with emergency cover on a Sunday.
- Occupational and physiotherapy services were available seven days a week for neurosurgery patients.
- Pharmacy staff were available six days a week and an on-call service was available out of hours.

Access to information

- Staff recorded information about patients in paper format and on a computer based patient administration system.
- Handover reports were electronic and contained relevant information.
- Discharge summaries were prepared for the GP, records we reviewed showed these contained relevant information.
- The neurosurgical department has an electronic referrals system for the medical registrars. Staff working in this area said that this system has improved communication and reduced errors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed clinical records and observed that patients consented to surgery in line with trust policy and department of health guidance.
- Nursing and medical staff obtained consent via both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining consent before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff said us they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff said that where this was not possible and due to the nature of the surgery, staff had to make best interest decisions to enable lifesaving treatment to proceed. Staff said that these decisions were documented within care records.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the Surgery Health Group showed 86.6% of staff had undertaken mental capacity training against a trust target of 85%. Deprivation of liberty safeguards training was completed by 84.6% of staff.
- Consent audits were carried out, results were disseminated, and recommendations with deadlines were made.
- On the neurosurgical unit, individualised care plans were used for the restraint of patients, these included a flowchart to aid decisions when the use of mittens for patients with delirium was being considered.
- The trust held all paperwork relating to MCA on the intranet, staff we spoke with were aware of how to locate assessment information and record best interest decisions.

Are surgery services caring?

Good

In 2014, we rated surgical services at HRI as 'Good' for caring; this was not inspected in the 2015 inspection. In 2016 we rated surgical services at Hull Royal Infirmary as 'Good' for caring because:

- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- We saw positive interaction between patients and staff. The short observational framework for inspection (SOFI) we carried out showed that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The NHS Friends and Family test (FFT) response rate was 33% similar to the England average of 31%. There were a high proportion of patients who would recommend the services.

Compassionate care

- We spoke with 28 patients and three relatives during the inspection. We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.

- Patient-led assessments of the care environment (PLACE) for the trust showed privacy, dignity, and well-being scored 81%, which was below the 86% England average level.
- The NHS Friends and Family test (FFT) is a national survey that measures satisfaction with the healthcare the patient has received. The response rate was 33% similar to the England average of 31%. There were a high proportion of patients who would recommend the services data ranged from 88% to 100% in the reporting period March 2015 to February 2016.
- Wards and departments we visited displayed their friends and family results. We saw 96.6% of patients would recommend ward 12 in May 2016, and 85% for Ward 120.
- During the unannounced inspection, we carried out on four wards a short observational framework for inspection (SOFI). Through our observations, we saw that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The majority of patients we spoke with were happy with the standard of care they received, all had drinks and call buzzers located within easy reach. Patients we spoke with said that staff did not take long to answer call bells; during the inspection we did not hear any call bells ringing for long periods. On Ward 12 we observed five calls bells all going off at the same time, four of these were answered within two minutes.
- We observed staff closing curtains/doors whilst delivering personal care. It was difficult to maintain confidentiality in the day surgical unit as the screening and admissions area did not have a door.
- We observed a therapy assessment session and this was delivered in a patient centred way, with language and tone of voice adjusted for the patient, so they could understand the instructions.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they knew who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients we spoke with were all aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.
- During the inspection, we observed a ward round on Ward 12 and witnessed good patient engagement and patient involvement in decision-making. Adequate time was taken to explain the plan to patients.

Emotional support

- A multi-faith chaplaincy service was available for patients.
- Clinical nurse specialists were available within surgery and attended the wards to provide support and advice to patients and staff
- A psychiatry liaison team from the local mental health trust worked with the hospital and offered support to patients with physical and mental health problems.

Are surgery services responsive?

Requires improvement

In 2014, we rated surgery services at HRI as 'Good' for responsiveness; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgery services at Hull Royal Infirmary as 'Requires improvement' for responsiveness because:

- Patients were not always able to access services for treatment in a timely of effective manner. The trust did not meet national performance indicators for treatment and cancer indicators. A local trajectory for the trust to achieve 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted referral to treatment time RTT data and cancer standards was above the agreed local trajectory for both April and May 2016.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter two, 2015.The trust cancelled 177 patients' operations from March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.
- We saw mixed sex accommodation provided on the high observation area on Ward 40; this area admitted both female and male patients, patients in these areas were classified as level one dependency patients. National

guidance indicates that it is acceptable to have level two patients in mixed sex accommodation; however patients who were categorised as level one must not be mixed. The trust's policy stated that level one HOB patients would be mixed sex but every effort would be made to ensure privacy and dignity was maintained in accordance with guidance. The trust said that this was in agreement with the local commissioners.
- The environment in the day surgical unit made it difficult to maintain privacy and dignity; the patient areas were separated by curtains which meant any procedures required or the gaining of consent prior to surgery could be heard by other patients and staff.

However,

- There was evidence of good practice in order to meet the individual needs of patients.
- The trust's policy was to close all complaints within 40 days; each Health Group had a target of 95% to achieve this. Within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data, which was 30% closure.

Service planning and delivery to meet the needs of local people

- The Surgery Health Group provided non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, neurosurgery. It also provided elective vascular and neurosurgery.
- The Health Group had taken into account of local transformation plans and commissioning decisions when creating their strategy.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients, incomplete pathways were set at 92%.
- The trust performance of meeting referral to treatment targets (RTT) for patients admitted for treatment within 18 weeks of referral was below the national standard of 92%. Trust data from April 2016 showed that 86% of patients were being admitted within the 18 weeks from referral. Speciality specific data showed that no surgical specialities were meeting the incomplete standard; data we reviewed ranged between 53.3% to 90.1% performance to March 2016.
- A local trajectory for the trust to achieve 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted RTT data was above the agreed local trajectory for both April and May 2016.
- We reviewed performance against the cancer indicators and noted that three cancer indicators were not achieved by the trust in February 2016; these were the 31 day drug indicators, the 62 day standard and the 62 day screening indicator.
- A local trajectory for the trust to achieve cancer standards had been agreed with commissioners and NHS improvement and recent data supplied by the trust showed that performance was above the agreed local trajectory for both April and May 2016.
- The trust reported to us the data management issues since the implementation of the new patient administration system from June 2015 had affected data collection. The trust was carrying out internal verification of patients on the list and clinical reviews of waiting patients to ensure patients did not come to harm during the waiting list process.
- Theatre usage was 71% for day surgery and 83.6% for main theatres for December 2015 to February 2016. The data ranged from 64.6% to 99.5% usage in the same period.
- Elective theatre lists were available six days a week and emergency theatre lists were available seven days a week. Services shared access to theatres for emergencies overnight and at weekends.
- The percentage of patients whose operations were cancelled and who were not treated within 28 days was consistently better than the England average from April 2013 to December 2015.
- However, the percentage of patients whose operations were cancelled and who were not treated within 28 days between March 2015 and December 2015 was higher at 3.8% than the equivalent period a year early which was 2.4%.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter two, 2015.The trust cancelled 177 patients' operations from March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.
- No surgical patients waited over 52 weeks for treatment in March 2016.

- The average length of stay data was similar (3.4 days) to the England average (3.3 days) for all types of elective admissions. If patients were stable and required longer admission, they were transferred to the Castle Hill Hospital site for further treatment and rehabilitation.
- Non-elective average length of stay performance was about the same, 5.1 days, as the England average. However, per speciality data showed a lower than the England average length of stay for plastic surgery and upper gastrointestinal surgery and a longer length of stay for trauma and orthopaedics.
- During the inspection, no wards had medical patients located on them (medical outliers).
- Staff provided telephone access to patients for advice and guidance post discharge following surgery.

Meeting people's individual needs

- We observed mixed sex accommodation whilst on inspection in the high observation bay on Ward 40 which admitted both female and male patients. Staff we spoke with said that this was acceptable because the patients were classified as level two critical care patients. However, the trust's protocol for admission into this area indicated that patients were level one-dependency patients as per the critical guidance. This national guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however patients categorised as level one must not be mixed. The patients we observed were all level one. The trust's policy stated that level one HOB patients would be mixed sex but every effort would be made to ensure privacy and dignity was maintained in accordance with guidance. The trust said that this was in agreement with the local commissioners.
- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available; however, on one area (Ward 40) there were no disabled toilets available in the male side of the ward, disabled toilets were only available within the female section of toilets.
- The pre-assessment team or the admitting ward reviewed patient's needs on admission, in regards to hearing difficulties.
- Translation services were available for people whose first language was not English. Staff we spoke with said that this service was very responsive and if consent was being gained, there was access to staff who would visit the hospital and interpret face-to face.
- Patients with particular needs were identified to staff at the ward safety briefings, for example, learning disabilities, mental health and dementia.
- A lead nurse for learning disabilities was available in the trust, staff working within the wards were aware of how to contact the lead nurse. Families of patients with learning disabilities were supported to stay with patients. Staff working within the Surgical Health Group provided examples of when they had used learning disability passports, supporting patients with a learning disability through the admission, by referral to learning disability specialist nurse and by accommodating relatives to stay with patients.
- Healthcare assistants on the majority of occasions provided one to one observation and support of vulnerable patients.
- A vulnerable adult link nurse was available within theatre recovery, carers and parents were allowed into the recovery area.
- The department used a butterfly symbol to support people living with dementia, we saw some areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms. However, no specific areas were identified on the wards to be dementia friendly. Staff we spoke with on Ward 12 were knowledgeable about the needs of patients living with dementia.
- Basic information for staff about patients was identified on boards behind the beds, for example the butterfly symbol and acronyms for mobility and dietary requirements and support.
- There were links between specialist nurses and ward staff to ensure continuity of care and support for patients.
- Specialised equipment required for bariatric patients was available. Commodes, chairs, and other equipment was stored on the Castle Hill site as this was the site for planned bariatric surgery. If required on the Hull Royal site, staff were aware of how to arrange transport.
- Discharged patients were given the ward telephone number following discharge to contact staff if they have any concerns post-operatively.

- Staff working in neurosurgery had identified that patients' who were post discharge with neck fractures had additional needs, such as waiting in outpatients departments for long periods was not in the best interests of these patients. Nurse practitioner staff had developed an aftercare programme for 12 weeks to support the patients with visits to a ward for their follow up clinic appointments.
- Adults and children were not separated to receive care in the recovery area of main theatres or within both areas of the day surgical unit. The senior management team was aware of this issue, however due to the provision of specialised ventilation within women's and children's theatres, staff were unable to prevent this occurring.
- Relevant information to patients was displayed on the walls of corridors of wards we visited, such as discharge information, learning disability and butterfly dementia scheme.
- A range of leaflets were available for patients within surgical wards and departments e.g. prevention of pressure ulcers, venous thromboembolism prevention and information for a patient's discharge.
- Two patients out of six spoken with on Ward 120 complained to us about the noise level of the nursing staff on the ward, especially overnight. During the inspection we did hear a high level of noise coming from the nursing office, this could be heard in the patient bays.

Learning from complaints and concerns

- The trust had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS).
- There were 217 complaints received within the Health Group from April 2015 to February 2016. The top three complaint themes were associated with treatment received (145), delays, waiting times and cancellations (27) and attitude of staff (19).
- The trust's policy was to close all complaints within 40 days; each Health Group had a target of 95% to achieve this. Within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data, which was 30% closure.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.
- Staff talked to us about changes in practice that had occurred post a complaint, for example improved patient information leaflets.
- Complaints were shared with staff via team meetings and individual conversations.

Are surgery services well-led?

Requires improvement

In 2015 we rated surgery services at HRI as 'Requires improvement'. At the 2016 inspection, we saw there had been some improvements however, the rating for well-led at Hull Royal Infirmary remained as 'Requires improvement' because:

- Whilst the Health Group held governance meetings there was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed.
- Although the senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.
- Most of the nursing staff we spoke with expressed concern about the response from some of the senior nursing staff working in the site co-ordination team to addressing staff shortages in the Health Group.
- We were unable to identify effective documentation of discussions around gaining assurance and removing risks from the register.
- The majority of audits for NEWS and WHO checklists, recorded 100%, however during the inspection we did not see evidence that the clinical practice required to produce 100% audit scores was embedded.

However,

- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust values and strategy.
- We found an improved staff culture within the hospital, staff we spoke with said this had improvement.

- There was a risk register in place. Risks for the Surgical Health Group were discussed at the integrated governance meeting and items requiring escalation to the Operational Quality Committee were clearly identified.

Vision and strategy for this service

- In 2015, the trust was asked to take action to ensure there was the development of a long-term clinical strategy for the Surgery Health Group. Since the last inspection, the Health Group had developed a five-year strategy 2016- 2021. The strategy referenced national reports and recommendations and was aligned to the trust values and strategy. Aims within the strategy included the provision of safe and effective care, delivering key standards and improved productivity and efficiency.
- Staff we spoke with working in the clinical areas were not aware of the directorate vision and strategy; however this document was a recent development, they were aware of the elective/ emergency split between sites and they could articulate the values of the trust.
- We reviewed the surgery operational plan, which identified vision and goals. These included the separating of elective and non-elective activities, ensuring that patients were treated" in the right place, at the right time, by the right people, first time and within budget".

Governance, risk management and quality measurement

- The Surgery Health Group had a clear management structure; a new operations manager had commenced employment in the days prior to the inspection. All management posts were now filled with substantive staff. This new structure required further time to be established and embedded.
- The Health Group held governance meetings; we reviewed four sets of Health Group governance meeting minutes and noted discussion of risks and incidents. There was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed.
- There was a risk register in place. Risks for the Surgery Health Group were discussed at the integrated governance meeting; medical and nursing staff attendance at these meetings was good. Items requiring escalation to the Operational Quality Committee were clearly identified. The risk register reflected current risks relevant to the operational effectiveness of the Health Group. Data we reviewed from February 2016 showed four high risks, 39 medium risks and 21 low risks identified.
- However, we were unable to identify effective documentation of discussions around gaining assurance and removing risks from the register. Five risks had recently been identified by the Health Group to be removed from the register following a meeting. From written communications from the clinical teams, it was apparent that assurance was not available for four of these risks and discussions were ongoing between clinical teams and management.
- Audits had been completed within the Health Group to provide assurance on key performance measures e.g. the WHO checklist, NEWS completion, infection prevention and control, medicines management, documentation and theatre productivity issues. We saw that on the majority of occasions for NEWS and WHO checklists, 100% scores for the audits had been recorded, however during the inspection we did not see evidence that the clinical practice required to produce 100% audit scores was embedded. Within theatres a new theatre quality assurance audit tool had been developed; this audit had only just commenced and required a further period to assess the impact of the audit results on compliance.
- The senior management team said the main risks for the Health Group were staffing, junior doctor cover overnight, RTT and cancer standards performance. These were all issues identified on the current risk register controls measures had been identified.

Leadership of service

- The Surgery Health Group had a new senior management structure. Staff commented that they were pleased that there was now a stable, permanent workforce after having interim roles for some months. The senior management team recognised that they needed more time to develop and become fully effective in their roles.
- From our discussions with staff, the majority of nursing staff said that senior leadership was good and staff felt listened too.
- Most of the nursing staff we spoke with expressed concern about the response from some of the senior nursing staff working in the site co-ordination team.

They provided examples of staff being moved from their substantive ward areas to ease periods of understaffing in other areas. Staff we spoke with said that when they expressed concern about leaving the substantive area with low staffing levels and they did not always feel supported and listened too.

- The trust had commissioned a review of the trust's spinal surgery service, following a number of near misses and never events. This review was carried out by the Royal College of Surgeons in June 2015. The review highlighted various recommendations which the trust were addressing.
- Most of the wards we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies. On Ward 60 we reviewed the notes of these meetings and found that relevant topics had been discussed for example; nutrition, revalidation of nurses and discharge planning.
- The majority of staff we spoke with said that the executive team were visible on the wards and departments.
- Staff sickness in the Health Group was 3.3% in May 2015, which was better than the target of 3.9%.

Culture within the service

- At ward level, staff we spoke with described the culture as improving, they highlighted the past issues with regards to bullying; however said that things had improved since the new executive team had been in post.
- One member of senior nursing staff provided an example of where they had been concerned about issue-affecting patients and had highlighted this directly to the Chief Executive and swift action to rectify the issue had been taken.
- Staff spoke about their colleagues in a positive manner.
- Staff spoke with us about feeling able to raise concerns and feeling listened to by their immediate senior team.
- In the previous year the trust had recent a Yorkshire and Humber trainee survey 2015 this report highlighting concerns of doctors in training, these concerns included low morale, bullying and a lack of support to trainees. The senior management team had responded to this report by reviewing the rota of on-call foundation level staff and improving support mechanisms.

Public engagement

- The NHS Friends and family test (FFT) had a response rate at ward level of 33%, which was better than the England average of 31%.
- An ex-patient of the neurosurgical unit attended the unit every Friday to talk to patients and families and provided support to people with a brain injury through his charity; this charity had also raised funds for additional equipment for the ward.
- Wards we visited had “You said, we did boards” which highlighted actions taken because of patient feedback, for example, a patient had said they were disturbed at night, the ward had launched a reduced noise at night campaign.

Staff engagement

- Department managers spoke with us about an “open door policy” for staff to discuss issues with them.
- The Surgery Health Group had scored the second highest score for staff engagement on the 2015 staff survey.
- The trust held a yearly ‘Golden Hearts’ award ceremony to recognise great work from staff. Staff working within the Health Group had recently been awarded the Golden heart. The trust had a staff award system in place called golden hearts. A neurosurgery consultant won the outstanding clinician award, and a member of the Health Group human resources team won the outstanding individual. The theatre department team leader had recently been awarded the good leader golden hearts award and the surgical service had been awarded the service improvement award.
- Staff had been involved in choosing the new values for the organisation of care, honestly and accountability.

Innovation, improvement and sustainability

- Staff we spoke with were proud of the modernisation of the workforce in relation to the new ward support roles developed over the last year.
- An international award had recently been awarded to the ophthalmic unit: the ophthalmic unit of the year award 2015/2016. This was awarded for the ophthalmic unit most appreciated by its patients for quality of service.
- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.

Surgery

- The Gastroenterology department received a national award for introducing a service to support liver research in the community.
- The colorectal team had introduced a nurse led two-week wait clinic to increase available capacity.

Critical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull and East Yorkshire Hospitals NHS Trust provides critical care services at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). The Surgery Health Group managed the service.

There are two intensive care units (ICU) at HRI. ICU1 had 10 beds and ICU2 had 14 beds. The units are both general/ neurosciences units and are adjacent to each other on the same floor. The units are staffed to care for 12 level three patients (who require advanced respiratory support or a minimum of two organ support) and 10 level two patients (who require pre-operative optimisation, extended post-operative care or single organ support) across the floor.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2015 and 31 December 2015 there were 1213 admissions with an average age of 59 years. Fifty six percent of patients were non-surgical, 16% planned surgical and 28% emergency or unplanned surgical. The average length of stay on ICU was three days.

A critical care outreach team provided a supportive role to medical and nursing staff on the wards when they were caring for deteriorating patients or supporting patients discharged from critical care. The team was available 24 hours a day, seven days a week.

The critical care service is part of the North Yorkshire and Humberside Critical Care Network.

A comprehensive inspection was undertaken in February 2014. We rated safe, effective, caring, responsive and well led as good. The service was rated as good overall.

During this inspection we visited both units and tracked patients from ICU to the ward. We spoke with five patients, three relatives and 24 members of staff. We observed staff delivering care, looked at 17 patient records and nine medication charts. We observed a nursing handover. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

We rated critical care as 'Good' overall in 2014 and as 'Requires improvement' overall in 2016 because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% national standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified that controls for some of the risks on the risk register were limited and unsustainable. There was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action of some of the risks on the risk register.
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.
- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts. There was no documented evidence that some patients were seen by a consultant within 12 hours of admission, twice daily ward rounds did not take place. Medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015).
- Planned nurse staffing levels were not consistently achieved and this impacted on the capacity of the critical care units.
- Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- We saw evidence during our inspection of patients who were referred to critical care requiring level three care that had not been escalated in line with trust policy.
- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015). Patients did not have access to formal psychology input following critical care.
- The service had limited mechanisms of collecting patient or relative feedback.

However, we also found:

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence-based guidance, standards, best practice and legislation.
- There was clear nursing and medical leadership on the units and in the critical care outreach team and staff had confidence in the units' leadership.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- We observed patient centred multidisciplinary team working.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

Critical care

Are critical care services safe?

Requires improvement

We rated safe as 'Good' in 2014 and in 2016 it was rated 'Requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, the frequency of the consultant on call rota and staffing in the critical care outreach team.
- Medical staffing was not in line with guidelines for the provision of intensive care services (2015) as some patients were not seen by a consultant within 12 hours of admission, twice daily ward rounds did not take place and the out of hours medical staff to patient ratio was higher than recommended.
- The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 86-97% in the day and 80-92% at night which included the use of bank and agency staff due to high levels of vacancies. This meant that planned staffing levels were not consistently achieved. Nursing documentation included quality and safety checklists, we found numerous occasions where these checklists had not been completed at night.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. Staff worked within the challenge of the environment but space and storage was clearly an issue.

However,

- There had been no never events, or serious incidents. Staff understood their responsibilities to raise concerns and report incidents.
- The number of staff in the service that had completed mandatory training was above the trust's target.

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between May 2015 and April 2016.
- There service reported no serious incidents between May 2015 and April 2016.
- The units reported 113 incidents between 1 January and 31 March 2016; 77% of these were graded as no harm, 19% as minor harm and 4% as moderate harm. The moderate harm incidents related to unavoidable deep tissue pressure damage. Themes of the minor and no harm incidents were low staffing levels, restraint of patients, for example, using mittens for patients' own safety and medication administration.
- Staff reported incidents using an electronic system. They were aware of what to report as an incident and how to report it.
- Staff could identify on the form when an incident involved a patient that had been referred to the critical care outreach team so a copy was sent to the critical care outreach lead.
- Senior staff had completed training to investigate incidents and shared information from incidents by email and at team meetings.
- Junior medical staff told us they received useful feedback after reporting an incident.
- A safety briefing formed part of the nursing handover; we observed one during our inspection and issues that were discussed included learning from incidents, safeguarding, treatment limits and patients with confusion or delirium.
- Cross-site critical care mortality and morbidity meetings were held monthly. The trust provided an example of the record from the meeting. Minutes included any clinical action needed and lessons learnt from the review by the responsible staff member. Junior medical staff were encouraged to attend these meetings.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust included the process for duty of candour in the 'Being Open when Patients are Harmed' policy.
- Senior staff gave us an example of when they had applied the duty of candour following an incident of moderate harm.

- The trust had a duty of candour intranet site to provide information for staff.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter and, blood clots or venous thromboembolism.
- The unit displayed safety thermometer information visible to staff and visitors.
- Data for the units from July 2015 to May 2016 showed between 83% to 100% harm free care on the day the data was recorded.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to visitors prior to entering the unit.
- All areas on the unit were clean and tidy.
- Equipment was visibly clean and was labelled with the date it had been cleaned.
- ICNARC data showed ICU2 had 5.1 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was significantly higher than similar units; we discussed this with medical staff who explained this figure included patients who had an invasive line and may have been cared for on a ward prior to admission to critical care.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- There was evidence in the record that ten out of 13 patients we reviewed had been screened for MRSA in line with trust policy.
- Infection control training information provided by the trust was not site specific. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 86.8% of registered nurses, 83.3% of estates and ancillary staff, 81.3% of additional clinical services staff and 54.6% of administrative and estate staff had completed infection control training.
- Staff completed infection prevention and control audits. Information provided by the trust for November 2015 showed 86% compliance in ICU1 and 89% compliance in ICU2. The results showed concerns about commodes, dust, storage of equipment and the catheter algorithm, however, no comparative results or action plan were provided.
- Records for flushing taps to prevent Legionella were not available to view on ICU2; the records on ICU1 had not been completed since 7 June 2016.
- The units had facilities for respiratory isolation.

Environment and equipment

- The unit was secure; access was by an intercom.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- The environment did not comply with national building standards (HBN04-02 guidance on designing critical care units, including bed space requirements and the location of a unit in a hospital), however, this was noted on the risk register in line with guidelines for the provision of intensive care services (2015) and due to be reviewed the month following our inspection.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.
- Staff checked the defibrillator and other emergency equipment daily. Records for this showed three gaps in the four weeks prior to our inspection.
- Disposable items of equipment were stored appropriately. We found more than 10 pieces of out of date plastic disposable equipment; these were dialysis and cannula accessories and adaptors. The nurse in charge addressed this immediately and removed the items.
- The service kept up to date environment and equipment maintenance records.
- We checked over 40 pieces of electrical equipment; all of them had up to date safety test stickers on.
- Staff told us they did not experience delays in obtaining equipment or with equipment maintenance.
- Staff received training on the use of equipment and gave an example of a new piece of equipment being brought onto the unit and the manufacturers providing training on its use. We saw evidence of equipment training in team meeting files.

- There was a lack of storage space on both units. At the time of our inspection one of the bed spaces on ICU2 was being used as a storage area and the linen cupboards were used to store items other than linen, for example communication boards.
- During our inspection we observed that one of the fire exits was partially blocked with chairs. Senior staff told us some staff had recently completed simulation training that involved fire evacuation and the training had been put into practice during a recent evacuation due to a fire on the floor below.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Emergency medications were stored in a sealed container in the drug fridge.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- We reviewed nine medication records. Eight had been completed in line with national and trust guidance; on one record the doctor's instructions whether to continue with a medicine was unclear.
- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely and all components of the record were in one place.
- Medical staff completed a daily critical care assessment form that met the National Institute for Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals). However, the document did not have a date, version or review date on.
- Nursing documentation included care bundles and quality and safety checklists. Staff explained how these were used, however, we found numerous occasions where the quality and safety checklists were not completed at night time. We raised concerns about this with senior staff during our inspection.
- Medical documentation did not record that care was delivered in line with guidelines for the provision of intensive care services (2015). For example, records showed evidence of a consultant ward round once a day rather than the recommended twice a day and there was not always a record of a consultant review within 12 hours of admission to critical care.
- Information governance training information provided by the trust was not site specific. The trust target was 85%. Within the service, 100% of scientific, therapeutic and technical staff, 81.8% of registered nurses, 90.9% of support staff and 70% of administrative and estate staff had completed information governance training.

Safeguarding

- Staff were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Safeguarding training information provided by the trust was not site specific and did not provide detail on the level of safeguarding training. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 89.2% of registered nurses, 81.8% of support staff and 80% of administrative and estate staff had completed vulnerable adults training.
- In the service 0% of scientific, therapeutic and technical staff, 87% of registered nurses, 90.9% of support staff and 80% of administrative and estate staff had completed safeguarding children training. The trust target was 85%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and fire training. Annual updates of mandatory training topics were planned into team meetings.
- Mandatory training information provided by the trust was not site specific. Overall compliance with mandatory training in the service was 86.8%. This was better than the trust target of 85%.
- Resuscitation training information provided by the trust was not site specific. The trust target was 85%. However, in the service 71.3% of registered nurses and 50% of support staff had completed resuscitation training.

Assessing and responding to patient risk

Critical care

- The critical care outreach team was available 24 hours a day, seven days a week. The team consisted of senior nurses who were supported by a consultant intensivist for one session a week. They supported patients stepped down from critical care and reviewed patients alerted to them through the NEWS referral system. The team also supported patients nursed on wards with tracheostomies, delivered non-invasive ventilation outside of critical care units and were a member of the cardiac arrest and trauma team.
- Staff on the wards told us they had a high regard for the service provided by the critical care outreach team.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team responded to 4,671 referrals across both HRI and CHH. That was on average 13 referrals a day.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team followed up 1,368 patients from both units. That was on average four patients a day.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- We had concerns that the escalation of NEWS on some wards was not in line with trust policy and there was a lack of treatment escalation plans completed by ward staff. We saw two patients during our inspection that were referred to critical care requiring level three care that had not been escalated in line with trust policy. When critical care staff reviewed these patients their assessment found them to be inappropriate for admission to critical care. The critical care outreach team had been involved in work to address this with the resuscitation and deteriorating patient committees and a trial of electronic observations had taken place on some wards.
- Patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.
- At the beginning of their shift, we observed staff completing bedside safety checks.
- We observed a support worker immediately seek advice from a member of the senior team when a patient's ventilator alarm sounded.
- The units accepted paediatric admissions while waiting for the dedicated intensive care transport service for children. This was approximately 30 admissions a year. One intensivist was a paediatric anaesthetist and there was a paediatric link nurse. The unit had appropriate, in date paediatric equipment and a resource file.
- During our inspection, we followed the transfer of a patient with a new tracheostomy from critical care to a ward. We found the tracheostomy care bundle had not been completed by the agency nurse or the co-ordinator on discharge from critical care. This was a risk to patient safety as the date of the tracheostomy and the size of the tracheostomy tube was not documented. The nurse on the ward had received training to care for patients with a tracheostomy and had set up the appropriate safety equipment.

Nursing staffing

- Nurse staffing met the guidelines for the provision of intensive care services (2015) minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients' ratio for level two patients.
- The units displayed the planned staffing figures; however, the actual staffing figures were not on display.
- The planned staffing figures included two supernumerary clinical co-ordinators, one based on each unit. This was in line with the guidelines for the provision of intensive care services (2015).
- The service had 50 whole time equivalent (WTE) registered nurse vacancies across the trust in April 2016. This was recorded on the risk register, recruitment was underway and the divisional nurse manager was undertaking a workforce review.
- The trust provided information on staffing levels for the six weeks prior to our inspection. The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 86-97% in the day and 80-92% at night. This meant that planned staffing levels were not consistently achieved. Senior staff and the coordinator planned staffing across both sites according to each units capacity.
- The trust used an agency that supplied staff that were trained in critical care. The units made block bookings of regular staff to work on the unit. Senior staff told us agency staff received an induction to the unit; however, there was no record to show an induction had taken place. Agency staff worked in a bed space adjacent to trust staff for support.

- The units employed trust bank staff who had previously worked on the units. The use of bank and agency staff was not greater than recommendations in the guidelines for the provision of intensive care services (2015).
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. The critical care outreach lead had written a standard operating procedure for the suspension of the critical care outreach service; this had not been ratified at the time of our inspection. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- The critical care outreach team generated an electronic handover document.
- We observed a unit handover where clear patient information was provided. The nurse coordinator allocated nurses to patients and considered continuity of care and the experience and skill mix of the staff.

Medical staffing

- Critical care had a designated clinical lead consultant.
- The consultant establishment in critical care was 16 WTE. At the time of our inspection the service had four vacancies and one consultant on maternity leave. The 11 consultants in post covered the rota which resulted in a more than one in six on call frequency.
- The units met the requirements of the guidelines for the provision of intensive care services (2015) for medical staffing between Monday and Friday 8am to 6pm. Care was led by a consultant in intensive care medicine and the work pattern delivered continuity of care. The consultant to patient ratio did not exceed the recommended 1:8 to 1:15.
- Overnight and at the weekend the consultant to patient ratio exceeded the recommended 1:8 to 1:15 as one consultant covered both units.
- There was no evidence that consultants completed twice daily ward rounds which was not in line with the guidelines for the provision of intensive care services.
- Two anaesthetic trainee doctors were on site overnight; one was based on the unit and was supported by the on-call consultant intensivist.
- The service employed trainee Advanced Critical Care Practitioners (ACCP's). Three were due to qualify three months after our inspection; an additional two trainees were due to qualify in 2017. Three more trainees and one qualified ACCP were due to start in the service three months after our inspection. The ACCP's were not part of the junior doctor rota. The aim was for one ACCP to be based on the units on every shift.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans and completed regular table top exercises.
- Senior staff described the process to manage peaks in demand. This included a clear risk assessment with decisions made by senior staff in conjunction with bedside staff.
- Staff knew how to access the major incident and continuity plans on the intranet.

Are critical care services effective?

Good

In 2014 we rated critical care services as 'Good' for effective. In 2016 we rated effective as 'Good' because:

- Care and treatment was planned and delivered in line with current evidence based guidance.
- Most patient outcomes were in line with similar units.
- We observed patient centred multidisciplinary team working.
- The units had a teacher trainer in post and staff were supported to maintain and develop their professional skills.

However,

- Only twenty five percent of nurses had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%.

Evidence-based care and treatment

- The units' policies, protocols and care bundles were based on guidance from NICE, the intensive care society and the faculty of intensive care medicine. Staff demonstrated awareness of the policies and knew where to access them.
- The units had an up to date delirium policy.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.

- The trust's tracheostomy care bundle and resources were in line with National Tracheostomy Safety Project guidance.
- The units were participating in the provision of psychological support to people in intensive care (POPPI) research project. This was a national randomised controlled trial to find out if psychological training for nurses improved patients' well-being after a stay in the intensive care unit.
- The physiotherapy team completed a national rehabilitation outcome measure 'Chelsea Critical Care Physical Assessment Tool' a scoring system to measure physical morbidity in critical care patients.
- A physiotherapy lecturer practitioner planned to undertake a study to understand the physical problems patients suffered on the ward following a stay in critical care.
- The critical care outreach team worked with staff on the units to complete an unplanned admission to critical care audit and a readmission within 48 hours of discharge audit.

Pain relief

- A pain management specialist nurse visited the unit and reviewed patients who were receiving pain relief infusions. Staff referred other patients that would benefit from review.
- The service had a pain link nurse who attended relevant meetings and training.
- We observed staff assessing pain using the trust scoring system and giving support to patients who required pain relief.
- Two patients told us their pain was well controlled, that staff regularly checked their levels of pain and that they did not have to wait for additional medications if they needed them.

Nutrition and hydration

- Staff assessed patients' nutritional and hydration needs daily and acted upon the findings.
- We observed a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.
- A dietitian visited the unit daily. We were informed a speech and language therapist attended the unit when staff referred patients.
- During our inspection we observed water was available and within reach for patients who were able to drink.
- A white board in the patient kitchen showed details of specific patients' dietary requirements. High protein and high calorie snacks were available for patients.

Patient outcomes

- We reviewed the intensive care national audit and research centre (ICNARC) data from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 1.02. This was in line with similar units.
- The units had a 1.8% unplanned readmission in 48 hours rate. This was higher than the 1.3% rate of similar units.
- The ICNARC data coordinators worked with clinical staff to collect additional information the service used for research and audit.
- The critical care outreach team collected patient outcomes in an electronic database.
- The trust provided a list of titles of projects on the units audit program. Topics included ICU delirium, six hour sepsis care bundle, inadvertent hypothermia in intensive care patients and record keeping.
- Senior nurses completed the trust's nursing quality metrics.

Competent staff

- Senior nursing staff had been allocated responsibilities; these included completing appraisals, managing sickness and clinical expert roles. Nursing staff had link nurse roles, for example, infection prevention and control, pain, pressure care and nutrition.
- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. However, information provided by the trust showed that at May 2016 76.9% of nurses and 62.5% of additional clinical services staff on the units had received an appraisal. This was worse than the trust target of 85%.
- The unit had a teacher trainer who was responsible for coordinating the education and training for staff. This met the recommendations of the Guidelines for the Provision of Intensive Care Services (2015).
- Twenty five percent of nurses in the service had completed a post registration critical care qualification. This was lower than the minimum recommendation of

50%. All staff completed the national competency framework for adult critical care nurses as the first step towards meeting the post registration in critical care qualification recommendation.
- Staff within the critical care outreach team were working towards the national outreach competencies. Two staff in the team were completing an MSc and all staff had completed in-house advanced clinical skills.
- New members of nursing staff received an induction onto the unit, were allocated two mentors and had a supernumerary period.
- Simulation courses were available to staff; recent courses had been held on paediatric critical care and evacuation.
- The trust supported trainee ACCPs to complete an advanced practice module at a local university, advanced life support, faculty of intensive care medicine and non-medical prescribers training.
- Nursing staff told us they had been supported to attend training courses on respiratory care, renal care and completing a root cause analysis.
- Some support staff had been trained to set up ventilators ready for patient use and take patient observations with supervision.
- Teacher trainers, critical care outreach and physiotherapists delivered the Hull interdisciplinary tracheostomy course. The course was due to be advertised externally at the time of our inspection.
- Senior staff had completed a debriefing course to support staff following traumatic events.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from occupational health and human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection.
- Two physiotherapy teams worked on the units; one for neurosurgical patients and one for general critical care patients. Nurses told us they had access to occupational therapy and speech and language therapists when required. A dietitian and pharmacist visited the unit daily.
- We saw in records that when staff made referrals to the multidisciplinary team they responded promptly within 24 hours.
- There was no microbiology ward round due to lack of resource; however, staff could access microbiology advice when required.
- A ward clerk worked two hours on each unit Monday to Friday. At the time of our inspection there was no cover for sickness or weekends, however, recruitment for additional ward clerk support was underway.
- Each unit had a full time ICNARC data entry coordinator.
- Senior staff were supported by a secretary who completed administration work for the unit, follow up clinic and the patient support group.
- Both physiotherapy teams had introduced weekly rehabilitation ward rounds with consultants and goals were documented in the patient record. One of the five records for patients who had been on the units for more than 10 days we reviewed had an up to date rehabilitation goal documented. This suggested the practice had not yet been embedded.
- Staff referred patients to the trust's rehabilitation consultant for review when a need was identified.

Seven-day services

- A consultant intensivist was available and completed a ward round seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A specialist critical care pharmacist visited the units Monday to Friday to check prescriptions and reconcile patients' medicines. The pharmacy was open seven days a week with a 24 hour on call service.

Access to information

- The ward clerk admitted and discharged patients on the trust's electronic patient management system. If a patient was to self-discharge they would send an electronic discharge summary to the patient's GP.
- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital. A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Critical care

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- Staff we spoke with demonstrated some understanding of consent, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- Junior medical staff reported mental capacity was assessed as part of the daily review. This section of the patient record had not been completed on 19 out of 20 days in one of the records we reviewed.
- MCA training information provided by the trust was not site specific. The trust target was 85%. Across the service 100% of scientific, therapeutic and technical staff, 91.3% of registered nurses and 50% of support staff had completed MCA training.
- DoLS training information provided by the trust was not site specific. The trust target was 85%. Across the service 100% of scientific, therapeutic and technical staff, 88.3% of registered nurses and 25% of support staff had completed DoLS training.
- Senior staff had written an appendix to the trust restraint policy to make it was applicable for critical care. Staff were aware of the restraint policy and could explain the process they would follow if mittens were needed to be used for patient safety.
- During our inspection one patient was wearing mittens. Staff had completed a delirium assessment on the patient. The guideline for the use of hand mittens in neurosurgical patients in the patient's record was out of date (due to be reviewed in 2005). The record also contained an up to date individual risk assessment and observation chart, however, these had not been fully completed. We observed staff had removed the mittens the following day as the patient was more settled.
- A member of security staff was undertaking patient watch duty with one patient on the unit. They told us they had received a full day of training for this role.

Are critical care services caring?

Good

In 2014 we rated caring as 'Good' and this rating was maintained at the 2016 inspection because:

- Patients were supported, treated with dignity and respect, and were involved in their care.
- Feedback from most patients was positive about the way staff cared for them.
- We observed all staff responded to patients' requests in a timely and respectful manner.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.
- Staff showed a good understanding of end of life care. Patients, relatives and received support from chaplaincy staff.
- Staff had been nominated for trust awards in recognition of the care they provided.

However,

- There was no regular psychological support available to patients following critical care.

Compassionate care

- The unit did not carry out patient surveys. Thank you cards from patients and relatives were on display.
- We observed curtains being drawn around patients' beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- All staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- Most patients we spoke to were very happy with the care they had received. They described the staff as kind, caring and helpful. They felt safe and able to ask for anything they may have needed.
- Staff had been nominated for trust awards for examples of care such as arranging a wedding on one of the units in an hour and a half and arranging an end of life patient's transfer home so they were able to pass away in their own environment.

Understanding and involvement of patients and those close to them

- All the patients and relatives we spoke with told us they had been kept informed of the treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.

Critical care

- We observed staff explaining to patients and visitors what was happening during care delivery.
- One patient with a tracheostomy who was unable to communicate verbally informed us they felt communication from staff on the unit was good.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff told us they received a good level of support from the specialist nurse for organ donation. We observed staff contacting the specialist nurse for advice.
- During our inspection we observed staff fully involving relatives in decisions about changes to treatment plans.

Emotional support

- Staff provided the opportunity for a patient diary to be kept. Patients and relatives were invited back to a clinic to collect and review the diary with staff and visit the unit if they wished.
- During our inspection we observed a chaplain visit the unit. Staff welcomed them and they visited a patient and their relatives.
- We observed staff respond appropriately to the emotional needs of relatives.
- Staff showed a good understanding of end of life care. We observed a patient being moved from the main ward area to an individual cubicle to maintain dignity at the end of life. The patient was transferred by experienced members of the nursing team.
- A former patient's spouse had set up a critical care patient support group that met regularly and offered telephone support to patients or relatives when they needed it.
- There was no regular psychological support available to patients following critical care. We found evidence that patients may benefit from psychological support as they suffered from intrusive and distressing thoughts and dreams. We informed senior staff about this at the time of our inspection.

Are critical care services responsive?

Good

In 2014 we rated responsive as 'Good'. At the 2016 inspection the rating was 'Good' because:

- Access to care was managed to take account of peoples' need. The delayed discharge and out of hours discharge rates were better than similar units.
- There had been no patients ventilated outside of critical care in the last 12 months.
- There had been no mixed sex accommodation breaches in the last 12 months.
- The facilities and premises were appropriate for the services being delivered.
- Staff took account of and were able to meet people's individual needs.

However,

- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015).
- There had been 42 cancelled elective operations across both sites due to a lack of critical care capacity.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision could be flexed to meet the differing needs of level 2 and 3 patients; however, at the time of our inspection the provision was limited by nurse staffing.
- The service had produced a patient and relative support information leaflet. This included advice about financial support, social care and support including mental health services and carers support. There was also information about the critical care support group.
- The rehabilitation after critical illness service was limited. Critical care outreach staff reviewed all patients who had been ventilated or in critical care for two or more days following discharge, however, the frequency of the visit depended upon the team's capacity. There was no medical or multidisciplinary input to the follow up clinic.
- A visitors' waiting room was available outside the unit. Staff could meet visitors in private by using the separate quiet room; this had just been decorated at the time of our inspection. Overnight accommodation for relatives was available.

Meeting people's individual needs

- Translation services were available to patients whose first language was not English. Staff knew how to access

the service. We saw evidence in a patient's record that an interpreter had been present when the consultant had discussed resuscitation with a family of a patient who lacked capacity.
- Staff could access leaflets in different languages if required.
- Staff told us they felt able to support patients with dementia and learning disabilities and would seek support from the nurse in charge on the unit if they needed it.
- The chaplaincy team visited the unit regularly and staff told us they were able to meet patients' multi faith needs.

Access and flow

- The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient.
- Records for two patients showed staff recorded the time of the decision to admit the patient to critical care; both patients arrived in critical care within four hours. This was in line with guidelines for the provision of intensive care services (2015).
- Information provided by the trust showed that between March and May 2016 the average bed occupancy for ICU1 was 78% and 71.5% for ICU2. This was lower than the England average. However, senior staff told us the bed occupancy data was based on a number of level 3 beds that they were unable to staff and was not an accurate reflection of the units activity.
- Data provided by the trust showed in the last 12 months:
  - there had been 42 cancelled elective operations across both sites due to a lack of critical care capacity;
  - there had been no adult patients ventilated outside of critical care;
  - there had been no mixed sex accommodation breaches;
  - The ICNARC data from 1 April to 31 December 2015 showed the unit had transferred 0.6% patients due to non-clinical reasons. This was not in line with guidelines for the provision of intensive care services (2015); however, this was in line with similar units and the network average.
- The ICNARC data from 1 April to 31 December 2015 showed the delayed discharge rate was 2.4%. This was lower than similar units' rate of 4.6%.
- The ICNARC data from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 1.8%. This was lower than similar units' rate of 2.6%.

Learning from complaints and concerns

- Staff were aware of the process for managing concerns and complaints and how to access it.
- The unit displayed information and leaflets on how to make a complaint.
- The trust provided a copy of a complaint received in March 2016. The response included an apology and an investigation into the concerns raised in the complaint.
- The matron visited some patients on the ward following discharge from critical care. One patient raised concerns about the way some members of staff delivered care. The matron shared this feedback with staff who were able to make changes to their practice.

Are critical care services well-led?

Requires improvement

At the 2014 inspection we rated well led as 'Good'. In 2016 we rated well led as 'Requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014. We also found new issues around the identification, management and escalation of risks in the service.
- Staff gave us examples of a lack of action of some of the risks on the risk register. Controls for some of the risks were limited and unsustainable and there was not clear evidence or assurance of escalation of the risks beyond the Health Group.
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.
- The service had limited mechanisms of collecting patient or relative feedback.

However,

- There was clear nursing and medical leadership on the units and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the units' leadership.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- Staff were happy in their work and felt that the culture on the units was open and honest.

Vision and strategy for this service

- The Surgery Health Group strategy 2016 – 2021 was in draft at the time of our inspection. It set out objectives that were in line with the trust's vision, values and goals.
- The key priorities for critical care in the strategy were operational and focussed on nurse and medical staffing, the development of new advanced practitioner roles, reduction of cancelled operations and the completion of a demand and capacity analysis to highlight capacity constraints to the trust and the critical care network.
- The management team were proud that the units had maintained good outcomes in the ICNARC data despite the challenges they faced with staffing and the environment.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

- The service held monthly business team meetings that included multidisciplinary attendance. We reviewed minutes from these meetings; governance, ICNARC data, equipment and the risk register were some of the agenda items discussed. Following each meeting an action log was completed with timescales.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. The unit's risk register identified the following key risks: consultant vacancies, delayed discharges, cancellation of elective surgery due to nurse vacancies, risk to services and patient safety due to nurse vacancies and non-compliance with building guidance. The risk register showed that limited controls were in place to mitigate these risks.
- Staff gave us examples of a lack of action of some of the risks on the risk register. Recruitment of consultants had not been actioned promptly, incorrect vacancies had been advertised and a block had been placed on locum consultant appointments. Due to the limited and unsustainable controls in place for some of the risks, for example, consultant staffing, we requested evidence from the management team of escalation of these risks to the executive team. The team provided copies of the Executive Management Committee risk register report and the Surgery Health Group report to the Operational Quality Committee and Health Group Board; however, these did not give clear evidence or assurance of escalation of the risks.
- During our inspection we identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.

Leadership of service

- Senior staff were visible and approachable. There was clear nursing and medical leadership on the unit and in the critical care outreach team.
- It was clear from our conversations, observations and data we reviewed that staff had confidence in the unit's leadership. Most staff reported feeling supported by their teams and managers.
- A small number of staff raised concerns about the lack of support that was offered by some senior staff members during times of pressure. However, during our inspection we observed senior staff offering support to staff at a busy and stressful time on one of the units.
- During our inspection, we saw examples of strong leadership at unit level; however, staff told us that senior managers from the executive team lacked understanding of the demand on the units and the capacity of critical care. Staff gave us examples of senior managers in the trust assisting in patient transfers from other areas of the hospital to critical care when they had been made aware there was no capacity in critical care.

- Senior staff had completed the internal and external leadership training and received dedicated management time.
- The management team was very proud of all the staff and the patient care they provided.
- Senior staff attended regular cross site meetings as well as site specific meetings and the trust senior nurse forum.
- Junior medical staff told us they felt supported by consultants at all times.

Culture within the service

- Staff we spoke with told us they were happy in their work, felt supported, able to raise concerns and that the culture on the units was open and honest.
- Staff were proud to be able to give holistic care to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- Senior staff had worked to reduce sickness in the service, information provided by the trust showed registered nurses sickness was 4% and other staff 2.6%.
- Staff had access to a counselling service in the trust.
- Staff had completed professional and cultural transformation training and all staff who had worked in the trust for a long period told us the culture had improved and they were optimistic about the future.

Public engagement

- The units displayed thank you cards from patient and relatives.
- A patient and spouse had set up a patient support group; the spouse had attended staff meetings to feedback their experiences, examples of changes introduced from this was for staff to let the patient know if they were leaving the room and changes to some staff's routines on a night shift.
- Staff had nominated the patient support group for a trust award.

Staff engagement

- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions. The consultants were involved in and actively instigated this process.
- Regular staff meetings were held. We saw evidence in the minutes that incidents, training, clinical supervision and equipment were some of the topics discussed.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- The critical care outreach team was part of a critical care outreach regional network forum to benchmark services and share best practice.
- The service had successfully recruited and retained Advanced Critical Care Practitioners (ACCPs). Feedback from the ACCPs on their role and training was very positive.
- The service had submitted a successful business case to use a new electronic clinical management system to collect ICNARC data and critical care outreach data to provide more real time data to understand activity.
- The teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal for their training courses.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull and East Yorkshire Hospitals NHS Trust offered a range of maternity services for women and families within the hospital and community setting across Hull and East Yorkshire. Services ranged from specialist care for women with increased risks to a home-birth service and midwifery led care for low risk pregnancies.

The labour ward had 15 delivery rooms and a four bedded recovery area for women following an elective caesarean section. The delivery rooms were used for low risk midwife-led deliveries and higher risk consultant-led deliveries. One of the delivery rooms had a birthing pool. There was direct access to two obstetric theatres from the labour ward.

There were 16 teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics, general practitioner (GP) practices and children's centres.

Antenatal care was provided on ward 33 (Maple ward) which had 25 beds. Postnatal care was provided on ward 31 (Rowan ward) which had 32 beds and provided transitional care. A midwifery-led antenatal day unit (ADU) provided care for women from week 16 of pregnancy

Gynaecology inpatient services were provided on ward 30 (cedar ward) which had nine inpatient beds and a 10-bedded day unit for day case procedures. A nurse-led emergency gynaecology unit was available to women with acute gynaecology problems. A nurse-led early pregnancy unit (EPAU) was available for women up to week 16 of pregnancy.

The maternity service at Hull and East Yorkshire Hospital NHS Trust delivered 5,221 babies between January 2015 and December 2015.

The service offered medical and surgical termination of pregnancies (TOP). Between April 2014 and March 2015 the service carried out 507 medical TOP and 625 surgical TOP.

During our inspection we visited the labour ward, maple ward, rowan ward, the antenatal day unit, cedar ward, the early pregnancy unit, antenatal clinics and obstetric theatres. We spoke with 12 women, and 42 staff including senior managers and service leads, ward managers, midwives, community midwives, consultants, doctors, nurses, anaesthetists, midwifery support workers, administrators and domestics. We reviewed 14 sets of maternity records and a further 10 sets on our unannounced visit.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was good. However, the safe domain was rated as required improvement because the availability of consultants on the labour ward was below the national recommendations. In May 2015, CQC carried out an announced focused inspection to review medical and midwifery staffing and safeguarding training. The service was rated as good.

Maternity and gynaecology

Summary of findings

At the comprehensive inspection in 2014 we rated the service overall as 'Good'. At the 2016 inspection this changed and overall we rated maternity and gynaecology services as 'Requires improvement'.

- We found process for recognising deteriorating patients were not always reliable. It was not clear from observation charts how frequently observations should be repeated if a patient was unwell.
- The service did not meet the national benchmarking for midwifery staffing. Data was not collected on the number of women who received 1:1 care in labour to provide assurance about midwifery staffing levels.
- We found that some governance arrangements did not always allow for identification of risk.
- Lessons learnt following a recent never event were not embedded.
- We found that in some areas the approach to service delivery was reactive especially in relation to how the service had implemented the Growth Assessment Protocol (GAP).

However:

- Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
- Patient outcomes were in line with national averages when compared to similar services.
- Women spoke positively about their experience and said they felt well supported and cared for.
- The trust had engaged with the public and sought their views over the development of the midwifery lead birthing unit.
- We saw strong leadership at a local level. Staff felt supported and felt that their concerns would be listened to.

Are maternity and gynaecology services safe?

Requires improvement

At the previous CQC inspection we rated safe as 'Good'. At the 2016 inspection this rating had changed to 'Requires improvement' because:

- The service had not provided assurance that lessons had been embedded following a recent never event.
- We had concerns that the system in place for recognising deteriorating patients was not robust. It was unclear from observation charts how frequently observations should be repeated leading to staff using their clinical judgement.
- The service did not meet the national benchmarking for midwifery staffing. The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ratio of 1:28. Between January 2016 and March 2016 the ratio of midwives to births was 1:32. The service did not collect data on 1:1 care in labour and therefore did not have assurance about midwifery staffing levels.
- Actual staffing levels on Rowan, Maple and Cedar ward were below planned staffing level.
- We found guidelines for safeguarding children were out of date.
- Records and confidential patient information was not also stored securely.

However:

- Clinical areas were clean and tidy and we observed good practice in relation to infection prevention. The service scored well on cleanliness audits.
- Medications were stored securely in appropriately locked rooms and fridges. Fridge temperatures were checked and recorded daily.

Incidents

- The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trusts

electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.

- Between May 2015 and April 2016 there were 991 incidents reported within maternity and gynaecology services to the National Reporting and Learning System (NRLS). 890 (89.8%) resulted in no harm, 59 (6%) resulted in low harm, 38 (3.8%) resulted in moderate harm, 3 (0.3%) resulted in severe harm and 1 (0.1%) resulted in death. Themes of incidents reported included: staffing resources, shoulder dystocia, 3rd/4th degree perineal tears and post-partum haemorrhages (PPH).
- There were 14 serious incidents reported to the NHS strategic executive information system (STEIS) between May 2015 and April 2016. There was no apparent theme to the incidents. Examples of incidents reported included unplanned maternal admission to intensive care unit. For each serious incident the service completed a root cause analysis (RCA). A root cause analysis is a structured method used to analysis serious incidents.
- We reviewed three RCA and found actions plans and lessons learnt were identified in line with the serious incident framework guidelines 2015. For example, ensuring accurate completion of fluid balance charts and correct recording of observations on MEOWS charts. Actions included providing feedback to staff.
- Never Events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- In maternity and gynaecology services, between May 2015 and April 2016 there had been one never event reported.
- The never event related to a retained foreign object post procedure in October 2015. We reviewed the RCA and subsequent recommendations, which included supervisory investigation of the staff involved, feedback on lessons learnt, assessing the feasibility of introducing plastic bags used in theatre to count swabs and embedding the culture surrounding swab counting.
- As an immediate response the service introduced a sticker to record pre and post swab counts and wrote to all midwifery and medical staff to ensure they followed the correct procedure. The service introduced new perinatal records which included a section for recording pre and post procedure swab counts. We reviewed 15 sets of records where women underwent a perineal repair and found that pre and post swab counts were not completed in nine sets.
- The service produced a video following the never event that was used as part of a training package to support lessons learnt from never events within the organisation. 11 midwives, five midwifery assistants and two student midwives had completed the training. We asked staff about lessons learnt from incidents, only one midwife referred to the never event. We were not assured that learning from the never event had been embedded.
- Senior midwives and medical staff held weekly maternity case review meetings to discuss individual cases and identify lessons learnt. Examples of incidents discussed in February 2016 included, post-partum haemorrhages (PPH) over 1.5 litres, admissions to intensive care unit (ICU) or high dependency unit (HDU), shoulder dystocia, still births, and unexpected transfer to neonatal intensive care unit. A written summary of the meeting was placed on HEY247 (intranet) so all staff could review any learning points.
- Staff were able to give examples of lessons learnt from incidents. For example, one observation chart was now used for women attending antenatal clinic rather than using a separate observation chart for each attendance. This enabled staff to monitor any changes or trends in a woman's blood pressure.
- Staff said feedback from incidents was shared in a number of ways including; ward meetings, HEY247 and face to face feedback. Staff said labour ward discussed 'topic of the week' at handover to share any lessons learnt. We observed a handover on labour ward and the 'topic of the week' was not shared.
- Maple and Rowan ward had a monthly newsletter that was emailed to all staff and included lessons learnt from incidents and complaints. We saw examples of the ward offering an education session to midwives to update staff on the situation, background, assessment, recommendation (SBAR) handover tool. This was in response to three separate incidents reported because the SBAR tool was not fully completed when women were discharged to the community midwifery team.

- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). We reviewed the minutes from these meetings and found outcomes from serious case reviews were discussed and recommendations were made to improve care and treatment.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff spoke about duty of candour and understood the importance of being open and honest with patients. Staff were able to give examples of when the duty of candour had been applied for example following a medication error. It was also evident in the serious incident investigations we reviewed that the duty of candour had been applied.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The full safety thermometer was not displayed on the wards we visited. Wards only displayed information on the number of falls and pressure ulcers. At the time of our inspection, no falls or pressure ulcers were reported on any of the wards we visited.
- We reviewed safety thermometer data for ward 30 and found the percentage of harm free care reported in April and May 2016 was 100%. In June 2016 the percentage of harm free care fell to 89%.
- The maternity safety thermometer allowed maternity services to monitor and record the proportion of mothers who have experienced harm free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a check used by midwives and doctors to assess the health of a new-born) of less than seven at five minutes and those who are admitted to a neonatal unit.
- The labour ward did not submit or display the maternity safety thermometer, however, we did see information displayed about key performance indicators including; the number of post-partum haemorrhages, the methods of delivery and the number of episiotomies.
- Between January 2016 and March 2016 the service used the maternity safety thermometer to survey 116 women. The report showed that on average 70% of women experienced harm free care and 76% of women perceived feeling safe. When compared to data collected between May 2015 and July 2015 the percentage of harm free care and perceived feeling of safe had deteriorated. For example between May 2015 and July 2015, 79% of women experienced harm free care and 88% of women perceived feeling safe.

Cleanliness, infection control and hygiene

- From June 2015 to June 2016 there were no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA), two cases of Clostridium Difficile (C. difficile) and one case of Methicillin Sensitive Staphylococcus Aureus (MSSA) within maternity and gynaecology.
- The service completed a RCA for each case of C. difficile to identify any lessons learnt. Examples of lessons learnt included educating all doctors within obstetrics and gynaecology on the importance of contacting microbiology before prescribing certain antibiotics and ensuring women were promptly isolated.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of the ward and there was clear signage encouraging visitors and staff to wash their hands. We observed staff encouraging visitors to use hand gel when they entered clinical areas.
- In April 2016 the infection, prevention and control team carried out an audit of the labour and delivery ward. The audit compared current practices against 40 infection control standards. The ward was not compliant with 13 standards. Areas identified as not compliant included, the storage of equipment and supplies, the management of sharps, clean equipment been appropriately labelled and the management of clinical waste. The audit did not include an action plan or any recommendations. The labour ward since employed ward hygienists who were responsible for the cleanliness of the ward and kept cleaning rotas up to date.

- Weekly cleanliness reports were submitted for all clinical areas. In March 2015, the labour ward achieved 99.5% compliance, gynaecology theatres were 99.1% compliant and Rowan Ward was 99.2% compliant.
- We observed staff using personal protective equipment when required, and they adhered to 'bare below the elbow' guidance. Women we spoke to said they had observed all disciplines of staff washing their hands and using hand gel.
- Single rooms were available in all areas if a patient needed to be isolated.
- All areas we visited appeared visibly clean, staff cleaned equipment after use and used green cleaning assurance stickers to indicate it was clean and ready for use.
- Cleaning rotas were displayed in all delivery rooms on the labour ward. We looked in four delivery rooms including the birthing pool and saw the cleaning rota was up to date.
- All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% in June 2016.
- Treatment rooms in the antenatal day unit had cleaning checklists that were completed and up to date.
- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- Women were screened for MRSA before undergoing elective caesarean sections as part of the pre-operative assessment.
- We saw evidence in records of women been offered the seasonal flu vaccination at antenatal appointments.
- In the 2015 CQC Maternity Survey, the service scored 9.2 out of 10 for the cleanliness of rooms and wards and 8.7 out of 10 for the cleanliness of toilets and bathroom facilities. Both results were similar scores to the England average.
- All staff groups were above the trusts target of 85% for infection, prevention and control training with the exception of medical staff who were 83.3% complaint.

Environment and equipment

- All entrances to the labour ward, Rowan ward and Maple ward were locked and admission was only possible via a telecom system. Staff and visitors gained entry and could only exit via a swipe card system. Closed-circuit television (CCTV) cameras were installed at the entrances to the labour ward, Rowan ward and Maple ward. This complied with Health Building Note 09-02 – Maternity care facilities (2013).
- There was adequate equipment on the wards to ensure safe care; staff confirmed they had sufficient equipment to meet patients' needs. Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour.
- Specialist equipment for women with a high body mass index (BMI) was available when required
- There were two dedicated obstetric theatres located just off the labour suite, this enabled easy access.
- We checked 12 pieces of equipment including; blood pressure machines, infusions pumps, cardiac monitors and suction machines. All equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing.
- Each directorate had a planned preventative maintenance programme which identified the frequency of equipment testing.
- The labour ward was situated on the second floor and could be accessed via a lift or stairs. Midwives had a priority key for lift access that could be used in an emergency so women could quickly access the ward. Staff said this was tested on a regular basis.
- The labour ward had 15 delivery rooms and a four bedded recovery bay for women who had undergone an elective caesarean section and fitted the criteria for enhanced recovery. All the delivery rooms had en-suite facilities and a wet room. Delivery rooms 1 to 5 were used for women with higher risk scores as they were closer to the nurse's station. Rooms 10, 11 and 12 were used for women at lower risk.
- A birthing pool was available on the labour ward; safety nets were stored in the room. Staff ran yearly emergency pool evacuation simulation as part of their mandatory training.
- The labour ward had a separate room for bereavement and for women and their family, who were experiencing the loss of an infant.
- Resuscitation trolleys were easily located on the main corridors in each of the areas we visited. We checked the adult resuscitation trolleys in all the clinical areas and found daily checks had been completed in line with best practice in all clinical areas with the exception of Beech ward. We found three days in June and two days in April when staff had not completed daily checks.

- The labour ward had emergency neonatal trolleys and obstetric trolleys outside of delivery rooms for women who were in labour. This ensured any emergency equipment was accessible.
- Daily checks for neonatal resuscitaires on labour ward were completed. However, we found one neonatal resuscitaire on rowan ward that had two days in June where daily checks had not been completed.
- The neonatal unit was situated in close proximity to the labour ward. Staff we spoke with informed us that paediatric staff could attend emergencies quickly.
- Cedar ward had nine inpatient gynaecology beds and a 10-bedded day unit for day case procedures.
- Patient led assessments of the care environment (PLACE) assessed how the environment supported patients' privacy and dignity, food, cleanliness and general building maintenance. The service completed PLACE audits on cedar, rowan and maple ward in June 2016. The audit results were positive and found that the environment on the wards supported good care. A PLACE audit was not undertaken on the labour ward.
- The labour ward did not have a formal handover room. Staff used an empty delivery room leading to staff having to stand.

Medicines

- Maternity and gynaecology services did not report any serious incidents relating to medication errors that resulted in serious harm.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- We checked the storage and administration of controlled drugs in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded.
- Intravenous fluids were securely stored in all the clinical areas we visited.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge temperatures were checked and recorded daily. There were no gaps in recording.
- Staff understood their responsibilities for raising concerns if the fridge temperature went out of range and said they would contact pharmacy.
- We checked 16 prescription charts and found these had been fully completed, patients were getting their medication promptly and any allergies were clearly recorded. We found one chart where a dose was omitted and it was not documented why this was not administered.

Records

- Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GP's. Results from antenatal tests were documented in these records.
- The service used paper records and had recently introduced new documentation from the perinatal institute.
- Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.
- Each month a supervisor of midwives (SOM) undertook a spot check record audit of five sets of records. The results were reported at the monthly SOM meetings and any trends or good practice were disseminated to clinical areas. The records were randomly selected from the maternity case review meetings and audited against 20 specific aspects of antenatal, intrapartum and postnatal care.
- Medical records on the labour ward and maple and rowan ward were stored securely in line with the trusts data protection policy.
- The 'fresh eyes' approach was used to review CTG's and we saw evidence of this in patient records.
- We reviewed 14 sets of records and found each woman had a named midwife responsible for their care, individualised care plans for pregnancy and labour were documented and VTE risk assessments were completed.
- On rowan ward we found a folder stored behind the nurses station that contained confidential information relating to the perinatal mental health liaison team. The folder contained 11 letters for 11 different women. There was a risk that this confidential sensitive information could be accessed. We informed the ward manager who moved the folder and assured us it would be stored securely.

- Records were not securely stored on the day unit on cedar ward. Records were kept in a trolley behind the nurse's station, this was often unattended. We also found unattended medical records left out on the nurse's station. There was a risk that people could easily access confidential patient information.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding women and children and worked alongside staff to ensure that systems and processes were in place.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- All midwives could make safeguarding referrals via an electronic referral system. Staff were able to give us examples of safeguarding referrals made including domestic abuse and female genital mutilation (FGM). Purple forms were placed in women's records to highlight any safeguarding referrals; we saw evidence of these forms in patient records.
- Training records showed 88.6% of nursing and midwifery staff and 84.6% of medical staff in the Family and Women's Health Group had completed safeguarding children level 2 training.
- Additional information provided by the trust showed 100% of nursing staff in gynaecology had completed safeguarding children level 3 training; however 0% of medical staff had completed the training. In obstetrics, 73.6% of midwifery staff had completed safeguarding level 3 training, no information was provided for medical staff in obstetrics.
- The trust had a policy in place for the management of women with female genital mutilation (FGM) and their new-born infant. The trust reported each case to the Family and Women's Health Group Board via the Divisional Monthly Report and submitted data on the number of cases of FGM to the Department of Health. From January 2016 to the time of our inspection, 13 cases of FGM were reported.
- The labour ward displayed a poster with information about FGM and highlighted the mandatory reporting duty and what staff needed to know.
- FGM training was included in the caring for vulnerable women study day. In total 194 midwives out of 218 midwives had attended the training. This equated to 90%.
- Caring for vulnerable women study days had introduced the topic of Child sexual exploitation (CSE) in June 2016, this included trafficking and modern day slavery. To date, 12.7% of midwives had completed the training. The remaining midwives were allocated to training dates later in the year. The service was due to commence CSE briefing sessions in October 2016.
- The service did not have any routine questioning or formal risk assessment for patients where CSE was suspected. Staff said they would be able to identify the signs of CSE. There was no written information available on CSE; staff said they would print information from the internet.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situation where abuse or neglect of children is suspected'. However, four specific guidelines we reviewed on the trust's intranet were out of date including:

- 'Safeguarding children: children and domestic violence' expired in September 2015.
- 'Safeguarding children in whom illness is fabricated or induced' expired in June 2015.
- Safeguarding children: managing allegations or concerns against staff' expired in June 2014.
- 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.

- We observed handover on the Rowan and Maple ward and observed staff raising safeguarding concerns and discussions regarding referrals to the safeguarding team.
- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. However, Rowan ward did not run any live drills of the abduction policy.
- The service used pressure relieving mattresses that alarmed when babies were moved from their cots. It was noted on the risk register that the current

mattresses were no longer been replaced or repaired if broken. The service was looking at introducing security tagging and had visited other trusts to look at how this could be implemented.
- Girls under 13 years of age who presented to the pregnancy advisory unit were automatically referred to the safeguarding team.
- We saw safeguarding information leaflets displayed on the Cedar ward and the labour ward.
- Midwives routinely asked about domestic violence at booking and at subsequent appointments. The antenatal day unit had placed a poster about domestic violence in the female toilet. Women used the toilet to give urine samples, and the poster asked women to place a black dot at the bottom of the specimen bottle if they had concerns about domestic violence. The midwives would recognise this and take the women into a private room to discuss further.

Mandatory training

- The trusts mandatory training programme included fire safety, information governance, infection control, conflict resolution, resuscitation, moving and handling training, major incident training, safeguarding children, vulnerable adults and safety training. The trust target for mandatory training was above 85%. Compliance with mandatory training was reported in the monthly Family & Women's Health Group, women's services divisional report. In April 2016, overall compliance was above 85% for all clinical areas with the exception of gynaecology nurse specialists (71.43%), obstetrics/gynaecology medical staff (82.31%) and midwifery education staff (44.9%).
- Staff told us they could access trust mandatory training either via an electronic learning system or could attend face to face training.
- All staff could access there mandatory training record via HEY247. Staff received alerts to indicate when training was due. Ward managers were able to monitor mandatory training compliance and there was an escalation process in place for staff that were not compliant with mandatory training.
- Midwives attended an annual mandatory day two training programme. Training included CTG interpretation, safeguarding, supervision, contraception, neonatal resuscitation, venous thromboembolism (VTE), sepsis, antenatal screening, mental health and safe sleeping (introduced in 2016). Training records from 1 January 2016 to the 30 June 2016 showed 81 out of 214 midwives had attended the training. The remaining midwives were allocated to training dates later in the year.
- The labour ward held monthly training with the anaesthetic staff and ran emergency drills of clinical scenarios for example, the management of a deteriorating patient or a massive obstetric haemorrhage. The service used a simulation doll to simulate clinical scenarios.

Assessing and responding to patient risk

- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing.
- Patients on the Cedar ward were assessed using the NEWS score. We reviewed four sets observation charts and found that observations were recorded and scores calculated correctly.
- Patients on the labour ward, Rowan and Maple ward were assessed using the MEOWS score. We reviewed MEOWS charts and found it was unclear from the observation charts when a patient should be escalated and how frequently their observations should be repeated. The observation charts advised staff to "contact a doctor for early intervention if the woman triggers one red or two yellow scores at any one time". However, there was no further guidance on how frequently observations should be repeated.
- We spoke with five midwives and they all said they would use their clinical judgement to determine how frequently patients' observations should be repeated, they were not aware of any guidance.
- The escalation policy in the trusts guidance on maternity early recognition of severe illness and referral to high dependency care in pregnancy/postnatal period was not clear. The guidance stated that if one yellow score was identified this should instigate more frequent observations, and if a red score was triggered women should be referred to medical staff.
- We discussed this with senior staff and as an immediate action they were going to display an escalation ladder in clinical areas. On our unannounced visit we only saw this displayed on rowan ward.

- The service had not audited MEOWS charts in the last six months. The service audit plan for 2016/17 included 'audit of early recognition of severe illness in pregnancy and postnatal period guideline'.
- Staff could describe the process for escalating concerns if a patient was deteriorating, staff told us they would contact on call registrar or consultant and they could also contact the critical outreach team. Paediatricians were available if staff had concerns about a baby.
- The trust used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. The trust had a modified maternity WHO checklist. We found inconsistencies in the completion of the WHO checklist. We reviewed the records 14 women, eight of which had been to theatre. The WHO checklist was incomplete in five sets of records. On our unannounced visit we reviewed a further 10 sets of records, four women had been to theatre and in two sets of records the WHO checklist was incomplete
- The trust audited compliance with the WHO checklist. Between January 2016 and March 2016 the audit found 100% compliance with the WHO checklist
- We observed two surgical procedures and found during the first procedure arrangements were in place to ensure checks were made prior to, during and after in accordance with best practice principles. However, on the second procedure the obstetrician did not ensure checks were made after the procedure.
- The trust had a policy for the emergency transfer from homebirth to hospital and postnatally to another unit.
- We saw evidence the unit used the 'fresh eyes approach' a system that required two members of staff to review foetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation.
- Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors, this determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics.
- Consultant obstetricians were available out of hours for emergency caesarean section and if a patient's condition gave rise for concern.
- Un-booked women who presented labouring were delivered as per the trusts protocol and referred to the safeguarding midwife.
- The antenatal day unit had introduced a red, amber and green (RAG) system to prioritise women. Any women who presented with reduced fetal movements, epigastric pain, severe headache, nauseas and vomiting or hyperemesis management were categorised as red and were seen within 15 minutes. Women who required presentation scans, blood pressure checks, CTG's or had been referred from antenatal clinic were categorised as amber and were seen within an hour. Women who needed a post 42 week fetal well-being check after declining induction or had a possible urinary tract infection were rated as green and were seen within two hours. Women who presented with antepartum haemorrhage, meconium stained liquor or any labouring women were escalated to the labour ward.
- Medical cover on the antenatal day unit was available from doctors who worked on the labour ward. Staff reported that medical reviews of women were often delayed due to the unavailability of doctors. We reviewed incident data and found 14 incidents related to delays in medical reviews. No patient harm was reported as a result of these incidents.
- The service had an agreement in place with the local ambulance service to attend babies born before arrival at home.
- The wards used a green symbol outside of a patient's room to indicate any patients who were at risk, for example patients with mental health problems.

Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). The service did not meet the national benchmark for midwifery staffing. Between January 2016 and March 2016 the ratio of midwives to births was 1:32. This was also above the trust target of 1:30.
- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations outlined in the National Institute for Health and Care Excellence (NICE) safe staffing guidelines. The staffing establishment was last reviewed in 2015.
- The service had completed a business case to review the midwifery establishment and work towards the recommended ratio of 1:28.

Maternity and gynaecology

- The service did not collect data on the number of women who received one to one care in labour. There was no audit process in place to ensure the provision of one to one care.
- Senior staff said that despite the midwife to birth ratio been higher than the national recommendations, they were assured women received one to one care through the friend and family survey results and the CQC maternity report.
- We spoke with four women and they all said they had received one to one care in labour.
- Between April 2015 and March 2016, 95 incidents reported were related to staffing resources, inappropriate staffing levels and lack of suitably trained/ skilled staff.
- Cedar ward had 2.45 whole time equivalent (WTE) nurse staffing vacancies and Rowan and Maple ward had 2.19 WTE midwifery staffing vacancies. The service was actively recruiting to the vacancies. Staff felt the "remarkable people, extraordinary place" recruitment strategy had been effective and the service retained student midwives.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing levels.
- Staffing levels were reviewed twice daily via an online trust safety brief and reported monthly via the maternity dashboard to the Health Group board and chief nurse. Staff were aware of escalation protocol should staffing levels fall below the agreed levels. The service offered staff overtime or would move staff from other areas for example, community midwifery.
- From May 2015 to May 2016 the average sickness rate for midwifery staff was 5.9%. A review of individual wards showed that the labour and delivery ward had the highest levels of staff sickness (8.9%).
- Locum usage was the highest amongst community midwifery. In January 2016, the percentage of locum staff was 1.9%, in February 2016 it was 1.8% and in March 2016 the percentage rose to 4%.
- Staffing fill rates were reported in the trust's monthly safe staffing reports. In April 2016 on Cedar ward registered nurse fill rates were 66% for day shifts. The fill rates for healthcare assistants were 109% for day shifts. The service had attempted to fill some of the registered nursing shifts with healthcare assistances to mitigate any risk to patients. On Maple ward the fill rates for midwives were 78% for night shifts. On labour ward the fill rates for midwifery assistants on a day shift were 68%. The fill rates for midwives on a day shift were 118%. We reviewed the safe staffing report for May 2016 and June 2016 and found that the fill rates were the same.
- We reviewed planned and actual staffing levels between 25 January 2016 and the 18 April 2016. On the labour ward, actual un-qualified staffing hours were below the planned hours. However, we saw actual qualified staffing hours were above the planned staffing hours to mitigate for the reduction in un-qualified staff. For example, between the 22 February 2016 and 21 March 2016 non-qualified planned staffing hours were 1215.5 and the actual non-qualified staffing hours were 719.5. However, the planned qualified staffing hours were 2932 and the actual staffing hours were 3210.75.
- On Rowan ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 1976.4 and the actual qualified staffing hours were 1650.1. Non-qualified planned staffing hours were 783 and the actual non-qualified staffing hours were 654.5.
- On Maple ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 1874.3 and the actual qualified staffing hours were 1712.5. Non-qualified planned staffing hours were 977.8 and the actual non-qualified staffing hours were 795.8.
- On Cedar ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 979.5 and the actual qualified staffing hours were 597.8. Non-qualified planned staffing hours were 674.6 and the actual non-qualified staffing hours were 451.8.
- The service had two obstetric theatres and a dedicated theatre team for all elective caesarean sections. If a second team were needed for an emergency caesarean section, a midwife would go into theatre to scrub. RCOG standards for The Safer Childbirth: Minimum Standards

for the Organisation and Delivery of Care in Labour (2007) state midwives should not be undertaking the 'scrub' role and recommended that there is a dedicated theatre team.
- We observed a morning handover on the labour ward and on the antenatal/postnatal ward. The handover was detailed and concise. Staffing and patient allocation was discussed however; the handover did not include the 'topic of the week' which we were told was used to communicate wider issues which needed dissemination, for example, learning from incidents.

Medical staffing

- Between January 2014 and June 2015 there were, on average, 102 hours of consultant cover per week on the labour ward. Between December 2015 and March 2016 there was an improved level of cover to 109 hours per week. This was above the trust target of 98 hours per week.
- The medical staffing skill mix was similar to the England average. At the trust, consultants made up 36% of the medical staffing compared to the England average of 35%. Middle grade doctors (with at least 3 years' experience) made up 6% of the medical staffing compared to the England average of 8%. Registrars made up 52% of medical staffing compared to the England average of 50% and junior doctors made up 6% of medical staffing compared to the England average of 7%.
- Trust information stated there was designated consultant presence on labour ward Monday to Friday, 8:00am to 19:00pm. Resident on call cover was available from 20:30pm to 8:30am. The same level of cover was provided for gynaecology patients.
- Staff reported the consultant obstetricians were available when needed and patients said they received consultant and medical care which met their needs.
- A consultant anaesthetist was allocated to the labour ward and was available 24 hours a day, seven days a week.
- At weekends and on bank holidays the on-call consultant carried out twice daily ward rounds. Out of hours, the on-call consultant was required to attend within 30 minutes when needed.
- Daily antenatal and postnatal ward rounds took place daily in line with current guidance and staff reported consultants were contactable when required.
- There was no designated medical cover for the antenatal day unit. When a doctor was required staff would contact the registrar for obstetrics or gynaecology. Staff said there could be delays in medical staff attending if the situation was not urgent.
- Within obstetrics and gynaecology medical staff, the vacancy rates were 2.2%.
- From January 2016 to March 2016 the locum usage within obstetrics and gynaecology staff ranged from 10% in January 2016 to 9.9% in February 2016 to 10% in March 2016.
- At times of increased capacity within the trust, medical outliers were cared for on the cedar ward. Staff said patients were reviewed daily by the medical team and they were able to obtain medical assistance to the ward if they were concerned about a patient's clinical condition.
- We observed a medical handover on the labour ward. The handover was comprehensive and advised on prioritisation of work. It involved the multidisciplinary team.

Major incident awareness and training

- Escalation policies for maternity services were in place and there was a clear process to implement plans during times of shortfalls in staffing levels.
- Maternity services had not been suspended at the trust, however staff were able to describe the arrangements and there was a robust escalation policy in place.
- The trust had a major incident policy that identified the roles and responsibilities of staff in different clinical areas. Not all staff were clear of their role in such events.
- The labour ward had carried out major incident training and had simulated a fire on the ward.
- The multidisciplinary team including medical staff, midwives, midwifery assistants and operating department practitioners attended yearly Yorkshire Emergency Training (YMET). This enabled staff to maintain skills in a range of emergency situations, for example shoulder dystocia, cord prolapse, breech delivery, PPH, eclampsia and adult resuscitation.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good

At the 2014 we rated effective as 'Good' and this was maintained at the 2016 because:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Information about patients' care and treatment was routinely monitored and collected via the maternity dashboard. Outcomes for patients that used the service were in line with national averages when compared to similar services.
- Women were well supported and had been educated about feeding. The service had achieved the United Nations Children's Fund (UNICEF) baby friendly initiative level three accreditation.
- The implementation of the saving baby's lives in Northern England (SABINE) care bundle had reduced the number of stillbirths.

However:

- Some clinical guidelines had expired.
- Not all staff involved in the care of children and young people could explain Gillick competence and Gillick competence was not considered in the trust's guidance on supporting pregnant women with complex social factors.

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. All Staff could access guidelines, policies and procedures on the trusts intranet website.
- In March 2016 the service completed an audit of massive obstetric haemorrhages; to ensure compliance with trust guidelines and RCOG guidelines. The audit reviewed 16 case notes of women who experienced blood loss of more than 1500mls. The audit found that in 100% of cases consultants were present when needed, there was clear communication amongst the relevant members of staff, the placenta was checked and documentation was clear. Fluid balance charts were initiated in all cases but 25% were found to be incomplete and in some cases there was a delay in commencing the massive obstetric haemorrhage protocol. The audit recommended further training for staff on the estimation of blood loss.
- The service completed an audit in March 2016 to ensure the management of multiple pregnancies were in accordance with trust guidelines. The audit found that the trust was above 80% complaint with the guidelines. Recommendations included improving documentation on uptake of first trimester screening and to consider introducing a care check list into patients' records to improve documentation. Timed actions from the audit were due for completion in September 2016.
- We reviewed 50 policies, guidelines and pathways on the trust intranet. They all had a version number and a review date. Eleven were out of date. For example, management of obstetric haemorrhage had a review date of November 2015 and maternity early recognition of severe illness and referral to high dependency care in pregnancy/post-natal period had a review date of November 2015.
- The trust had implemented changes to practice following the saving babies lives in Northern England (SABINE) study. The midwifery teams were using growth assessment protocol (GAP) which was based on standardised fundal height measurements and plotting on a customised growth chart.
- The care of women undergoing a caesarean section was seen to be managed in line with NICE Clinical Guideline 132. The service used stickers in women's records to record the category and timing of caesarean sections. In March 2015 the service audit practice against local and national guidelines. The audit reviewed 82 sections that were classified as a category one. A category one caesarean section should occur within 30 minutes as it is a situation where an immediate life threat to a woman or baby has been identified. The audit found 14 cases were delayed and performed over the 30 minute guidance time. Reasons for delays included, awaiting the on call consultant to arrive (1), women initially declining caesarean section (1), medical staff busy (1), graded incorrectly (1), and no reason documented in 8 cases. Actions from the audit included disseminating the results to staff, and to repeat the audit in 2016/2017. No other actions were included with the audit.

- The service had introduced a carbon monoxide (CO) monitoring clinic in line with NICE PH26, smoking: stopping in pregnancy.
- We found staff adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary consent forms (HSA1 and HSA4).

Pain relief

- Women received information of the pain relief options available to them, this included, nitrous oxide and oxygen (Entonox®) piped directly into all delivery rooms, access to a birthing pool and epidurals.
- In January 2015 the service completed an audit of pain relief and satisfaction in patients following caesarean section. The audit review practice against NICE guidelines and local policies. The audit surveyed 50 women and reviewed the drug and anaesthetic charts of 50 women. The audit found 90% of women were satisfied with analgesia on day one post caesarean section, 78% of patients had opioids prescribed as needed (PRN), 100% had regular paracetamol and non-steroidal anti-inflammatory drugs prescribed and 94% had antiemetic's prescribed. Recommendations from the audit included changing local guidance on regular opioid prescription which was due for review in May 2015.
- Women said staff gave them the opportunity to discuss different options of pain relief when completing their birthing plans.
- Six women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed. One woman said she did not receive adequate pain relief during induction of labour.
- Women who had undergone gynaecological procedures said they received sufficient pain relief and nursing staff responded to requests for pain relief promptly.
- The service provided a 24-hour anaesthetic and epidural service. Two of the women we spoke with had received an epidural and said they received them in a timely manner.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital between April 2014 and March 2015 ranged from 65.4% and 67.8%. This was below the England average of 76%. The percentage of women breast feeding on discharge from the hospital during the same period ranged from 51.6% to 68.2%.
- The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service achieved level three accreditation following reassessment in May 2016. The report recognised the significant improvements the trust had made and found 83% of women said staff had offered to show them how to hand express, 92% of women understood baby led feeding and how to recognise feeding cues and 80% of women confirmed they were aware of how to recognise effective feeding.
- The service had an infant feeding coordinator who was responsible for the coordination of quality infant feeding practices in accordance with the UNICEF UK baby friendly initiative (BFI).
- Seven women said they felt well supported and educated with feeding. Women had been shown how to make up formulas and were supported with breastfeeding.
- Rowan ward had a milk kitchen to allow new mums to bring formulas onto the ward and be educated on the correct way to make up feeds.
- All midwives and midwifery assistants had completed baby friendly initiative (BFI) training.
- Rowan ward had a DVD for women to help educate and support them with feeding.
- Women had no concerns about the food and told us that different dietary and religious requirements were catered for.

Patient outcomes

- The trust monitored and recorded patient outcomes on a monthly performance dashboard. The trust had started to participate in a Yorkshire and Humber regional maternity dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues. This was in accordance with recommendations of the Royal College of Obstetricians and Gynaecology 2008.
- The trust did not have any active maternity outlier alerts, 'outlier alerts' are a description used to describe when a service lies outside the expected range of performance.

Maternity and gynaecology

- Between January 2015 and December 2015, HRI delivered 5221 babies. Of the 5221 deliveries, 98.7% of these were single deliveries and 1.3% were multiple births. This was comparable to the England average.
- Between January 2015 and December 2015, 63.7% of births were normal vaginal deliveries. This was above the England average of 60%. Data that the trust submitted the monthly maternity dashboard showed that between January 2016 and March 2016 the percentage of normal deliveries remained above the England average.
- The number of elective caesarean deliveries between January 2015 and December 2015 was 11.7%. This was similar to the England average of 11.3%. Data from the trust maternity dashboard showed the percentage of elective caesarean deliveries had increased to 12.9% in January 2016, 12% in February 2016 and 14.1% in March 2016. This was in line with the trust target of 13.9% but above the England average of 11.3%.
- The number of emergency caesarean deliveries between January 2015 and December 2015 was 13.8%; this was lower than the England average of 15.3%. Data from the trust maternity dashboard showed the percentage of emergency caesarean sections had increased above the national average of 12.1% in January 2016 to 16.2%. The percentage reduced to 10.9% in February 2016 and increased again in March 2016 to 13.6%.
- The increased number of emergency and elective caesarean sections had increased the average caesarean section rate to 27.3% between December 2015 and March 2016. This was above the trust target of less than 26.2%
- Staff were aware that the number of caesarean section deliveries was above the England average. As a response to this the service were working towards offering a midwifery led vaginal birth after caesarean section (VBAC) clinic and medical staff reviewed cases to look at the decision making process in relation to emergency caesarean section.
- The percentage of instrumental deliveries (forceps and ventouse) at the trust between January 2015 and December 2015 was 10.2%. This was lower than the England average of 12.8%.
- Between December 2015 and March 2016, 44 deliveries resulted in 3rd or 4th degree perineal tears. This was in line with the trust target of less than 20 deliveries a month.
- Between December 2015 and March 2016, 23 women suffered a postpartum haemorrhage (PPH) (a blood loss following delivery of over 1500mls). This was in line with the trust target of less than 10 deliveries a month.
- There were four unplanned maternal admissions to the intensive care unit between December 2015 and March 2016. The unit reported one maternal death. As a response to this the trust completed a root cause analysis. Contributing factors that were disseminated for learning included ensuring VTE risk assessments were correctly assessed and scored.
- Shoulder dystocia occurs when a baby's shoulder becomes stuck behind the mother's pelvic bone. The number of shoulder dystocia increased for two consecutive months in December 2015 and February 2016 to seven and six respectively. This was above the trust target of less than six a month. All the cases were discussed at the weekly maternity care review and staff said there was no obvious reason for the increase.
- Between April 2014 and March 2015 the trust report 27 stillbirths, this was a reduction from 32 stillbirths in the previous year**.** This improvement in the rates of stillbirth was attributed to the implementation of SaBiNE care bundle (focusing on reducing the number of stillbirths) and introducing customised growth charts to monitor babies' growth during pregnancy.
- The percentage of births to mothers aged 20-34 between January 2015 and December 2015 was higher than the England average and accounted for 81.4% of deliveries, in comparison to the England average of 75.6%. During the same period, the percentage of births to mothers aged 20 and under at HRI was 4.8%. This was higher than the England average of 3.5%.
- Between April 2014 and March 2015 the service carried out 507 medical terminations of pregnancies (TOP) and 625 surgical TOP.
- We reviewed the trust performance data for antenatal and new-born screening 2015/2016. The service was above target for all antenatal and new-born screening targets with the exception of antenatal sickle cell and thalassaemia screening – timeliness of test and new-born blood spot screening avoidable repeat tests.
- The trust was aware of the significant drop in compliance with antenatal sickle cell and thalassaemia screening. The trust was a national outlier. Actions taken by the trust included running extra clinics on a weekend and making changes to the referral system so that women were appointed by gestational age. To reduce

the rate of new-born blood spot screening avoidable repeat tests the service had worked with the neonatal team and delivered training on blood spot screening to staff.

Competent staff

- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. The national recommendation is for a ratio of SOMs to midwives of 1:15. Between January 2016 and March 2016 the ratio of supervisors to midwives was above the recommended local supervising authority (LSA) ratio of 1:15. In January 2016 the ratio was 1:16 and in February and March 2016 the ratio was 1:18. To address this, the service had supported midwives to complete the preparation of supervisor of midwives course. Three midwives completed the course in May 2016.
- All midwives said they had a designated SOM. Staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- Appraisal rates were reported in the services monthly divisional report. In May 2016, 85% or more staff had completed an appraisal in most clinical areas with the exception of labour ward (81%), antenatal clinic/ antenatal day unit (79.3%) and specialist midwives (66.7%).
- The majority of staff we spoke with said they had completed an appraisal or were expecting one in the future. Staff said the appraisal process was valuable and allowed them to discuss their development and learning needs.
- Senior staff told us core midwifery staff worked in each area, whilst other staff rotated between departments and this included the community midwives. This meant staff had the knowledge and skills to be able to work in different areas and flexibly meet the needs of the service.
- Newly qualified midwifery staff had a period of 'preceptorship', where they received additional support and went through a competency programme. The programme was a well-structured development package that ensured midwives developed their competencies. It included training in suturing, epidural top management, cannulation and scrubbing for theatre.
- We spoke with midwives who were working through their preceptorship programme and they felt supported; they also told us they had been supernumerary for two weeks and were allocated a 'buddy'.
- Medical staff, midwives, midwifery assistants and operating department practitioners attended yearly Yorkshire Emergency Training (YMET). This enabled staff to maintain skills in a range of emergency situations, for example shoulder dystocia, post-partum haemorrhages, cord prolapse and management of the deteriorating patient. From 1 January 2016 to the 30 June 2016, 142 staff had completed the training including 103 midwives. The remaining staff were allocated training dates later in the year.
- Midwifery assistants completed annual observation training to develop skills in identifying the signs of pre-eclampsia, taking manual blood pressures, documentation and escalation.
- Midwives on Rowan ward were allocated shifts on the special care baby unit to develop competencies in administrating intravenous antibiotics to babies.
- Community midwives held yearly skills and drills training and covered topics specific to the community setting for example, resuscitation at home and suturing.
- The trust had a comprehensive theatre training package for midwives. It provided theoretical and practical knowledge required for midwives to extend their scope of practice in obstetric theatre. All 43 core labour ward midwives had completed the training, and 25 out of 54 rotational midwives had completed the package. The remaining midwives were allocated onto future training dates.
- Midwives working on the antenatal day unit had completed scanning training delivered by a consultant in fetal medicine. Competencies were reviewed annually.
- Midwifery and medical staff completed CTG training as part of the mandatory day two training package. There was an interactive computer based training system that covered CTG interpretation and fetal monitoring. It was used alongside CTG training.
- The consultant obstetricians provided support and mentorship for junior doctors. Junior doctors told us they had the opportunity to attend training sessions and participate in s. They felt well supported by the ward team and could approach senior colleagues for advice if needed.

- On a weekend women who required inpatient gynaecology treatment were cared for on ward 35. Staff had completed a training programme covering, guidelines of care for major gynaecology surgery and gynaecology emergencies, documentation, equipment required for gynaecology procedures and specialist medication. The trust did not provide data on the number of staff who had completed the training. The gynaecology triage nurse was available to support staff if required.
- The early pregnancy assessment unit was nurse-led. Staff said they felt well supported in their role and had completed a comprehensive competency package. We reviewed the competency package and saw evidence of a comprehensive framework. Staff had to gather a portfolio of evidence before been deemed competent to work independently.
- Staff said they felt encouraged to gain professional competencies and attend courses. We heard examples of staff attending a two day conference on early pregnancy.
- Staff on the early pregnancy assessment unit had weekly clinical supervision sessions with the consultant where complex cases were discussed and any updates to practice were shared.
- Nursing staff and midwives said they felt supported in the revalidation process.
- There were midwives with special interest. These included safeguarding, antenatal and new born screening, practice development, infant feeding coordinator and a healthy lifestyle midwife. The service also had a vulnerabilities midwife who saw women with substance misuse, mental health problems, alcohol abuse, learning difficulties and teenage pregnancies.

Multidisciplinary working

- We saw evidence of multidisciplinary working within clinical areas. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.
- On discharge from the unit discharge letters were sent onto GP's, community midwives and health visitors detailing summaries of antenatal, intrapartum and postnatal care. An electronic discharge summary was also completed on an electronic patient record system.
- Staff said they could access support and advice from specialist nurses/midwives and confirmed there were systems in place to request support from other specialities such as pharmacy, the acute care team and physicians.
- Staff described accessing the critical care outreach team if they were concerned that a patient was deteriorating.
- The vulnerabilities midwife worked closely with community midwives, and there was a process in place for women who did not attend antenatal appointments.
- We saw effective use of the SBAR handover tool when women were transferred between the labour ward and Rowan ward.
- Midwives on labour ward and Rowan wad worked collaboratively to deliver care to patients on the enhanced recovery pathway.
- Anaesthetists attended the multidisciplinary team handover on labour ward and were made aware of any high risk women.
- Women who suffered from symphysis pubis dysfunction (SPD) were referred to a dedicated obstetric physiotherapist. A red pillow system had been introduced onto the wards to identify women who suffered from SPD.
- Staff said they had good support from the neonatal unit, and midwives had spent time on the unit to develop competencies in administering intravenous antibiotics.
- Women with a suspected mental health illness were referred to the perinatal mental health team for further assessment and treatment.

Seven-day services

- Access to a dedicated obstetric theatre team was available at all times, seven days a week. A consultant anaesthetic was allocated to the labour ward Monday to Friday. Out of hours an anaesthetist was available 24 hours a day, seven days a week.
- Consultants carried out ward rounds twice a day, seven days a week. Out of hours, the on-call consultant was required to attend within 30 minutes when needed as per the trust policy. Staff reported consultants were contactable when required and this included out of hours and weekends.
- There was an on-call rota of SOM. They were available 24 hours a day, seven days a week and provided midwives with support.
- The antenatal day unit was open from 8:30am to 8pm Monday to Friday and from 8:30am to 5pm Saturday and

Sunday. The unit saw women from 16 weeks pregnant. Scans were available each day as the staff were qualified to scan women. Out of hours, any phone calls were transferred to the maple ward.

- The early pregnancy unit was open seven days a week, 7:45am to 5:45pm Monday to Friday and 7:30am to 3pm Saturday and Sunday. This meant women who may experience the early signs of pregnancy loss could be seen in a timely manner. Out of hours any phone calls would be transferred to the cedar ward or to the gynaecology triage nurse.
- Cedar ward had nine inpatient beds and a 10-bedded day-case unit. The ward open from Monday to Friday and was closed on a weekend. If patients needed inpatient care over the weekend, women were transferred to ward 35. A specialist gynaecology triage nurse was available 24 hours a day on a Saturday and Sunday to offer support to ward 35 and triage any emergency gynaecology patients.
- Women undergoing a medical termination of pregnancy (TOP) attended cedar ward on a Saturday. This offered the women more privacy and dignity.

Access to information

- Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent electronically to patients GP's, health visitors and community midwives. Staff said they also faxed copies. Staff said if a woman had complex needs they would contact the relevant professional and give a verbal handover in addition.
- All staff could access test results using an electronic system.
- Patients who used the services had access to informative literature. At booking all women received a pack that contained information about health lifestyles, fetal movements and VTE.
- Information leaflets were available in ward areas on a variety of subjects such as contraception, induction of labour, going home with pre labour rupture of membranes at term, breech deliveries and your baby's movement in pregnancy.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the site and find information on antenatal and new born screening, healthy lifestyles and infant feeding. The website also had a list of other useful websites that women and families could access.
- Women undergoing a surgical TOP received a discharge letter summarising the procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLs) was part of mandatory training for staff. Training data provided by the trust showed 71.4% of nursing, midwifery and health visiting staff had complete depravation of liberty (DOLS) training. This was below the trust target of 98%. All staff groups were over 85% compliant with mental capacity act (MCA) training with the exception of medical staff in gynaecology where 82.9% of staff had completed the training.
- In August 2015 the service undertook a patient information and consent audit. A sample of 10 patients records were identified from the obstetric department and were audited against the trusts patient information and consent to examination and treatment policy. The service was 100% with 22 of the 30 standards. In 40% of records there was no record of the discussion held with patients and in 20% of records the patients name was not printed. The audit had an associated action plan. .
- Women told us they were given sufficient information to enable them to make an informed choice about the delivery of their baby.
- Staff we spoke with were able to explain the process of ensuring patient consent was gained and demonstrated an understanding of the MCA. At the time of our inspection there were no patients subject to a Deprivation of Liberty application.
- We saw evidence in patients records of consent forms been completed for women undergoing caesarean sections and instrumental deliveries. Consent forms detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for termination of pregnancy (TOP) was carried out within the legal requirements of the Abortion Act 1967. We reviewed three sets of records and found women were correctly consented for the procedure and forms were signed by two doctors.

- Staff could not articulate what was meant by Gillick competence and were unable to provide evidence of how they would ensure a patient had the maturity to make a decision about their care and treatment. The one exception was staff in the pregnancy advisory service that used Gillick competencies as part of their pathway to assess if a patient could make decisions about their treatment.
- The trust had guidance on supporting pregnant women with complex social factors, this included women under the age of 16. Initial guidance published in March 2016 did not refer to Gillick competency. The trust provided an updated version of the guidelines (July 2016) that included guidance on Gillick competency.

Are maternity and gynaecology services caring?

Good

At the 2014 inspection we rated caring as 'Good' and this remained as 'Good' at the 2016 inspection because:

- Women spoke positively about the care and treatment they had received. Feedback from women was consistently positive and women said they felt well supported and cared for. The service scored about the same as other trusts in the CQC survey of women's experiences of maternity services.
- People felt involved in their care and were supported in making decisions.
- Staff provided emotional support and responded compassionately. Family's emotional needs were valued by staff.

Compassionate care

- The trust received 175 responses to the CQC survey of women's experiences of maternity services 2015. The trust scored about the same as other trusts for care received during labour and birth, staff during labour and birth and care in hospital after birth.
- Data from the NHS Maternity Friends and Family Test showed that between January 2016 and March 2016 on average 95% of women would recommend antenatal care at the trust. This was slightly below the England average of 96%. 100% of women would recommend their birth experience this was above the England average of 97%. On average 96% of women would recommend the postnatal ward. This was above than the England average of 94%. On average 94.5% of women would recommend postnatal community care.
- We saw letters and cards of appreciation and positive comments about people's experience displayed on the labour ward.
- We spoke with 12 women, all of whom spoke positively about their experience. Women told us they felt well cared for and that the midwives made them feel safe. Women told us staff were always available if they needed them, staff introduced themselves and promptly responded to buzzer including during the night.
- Women who were over 16 weeks pregnant could contact the antenatal day unit if they had any concerns. We observed good interaction between midwives in the antenatal day unit and women who were ringing for advice. We heard staff providing encouragement and reassurance to women who were anxious and worried.
- Gynaecology services included an early pregnancy assessment unit for women who were under 16 weeks pregnant. The unit had a private room that could be used for sensitive meetings for women who had experienced a miscarriage.

Understanding and involvement of patients and those close to them

- Women said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.
- From patient records we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.
- Results from the CQC survey of women's experiences of maternity services 2015 showed that the service scored 8.3/10 for being involved in decisions about their care during labour and birth and scored 9.5/10 for the partner being involved as much as they wanted. These results were similar to other trusts.
- Rowan ward allowed partners to stay to provide support in certain circumstances and only if the woman was in a side room. Partners could visit Rowan ward from 9am to 9pm.
- The local supervising authority (LSA) report 2015 found the service met the standard for care planning and

supporting women's choices including place of birth. The service provided evidence of birth plans that SOM's had completed to support women with complex and difficult birth choices.

Emotional support

- Families' emotional needs were valued by staff. The labour ward had a separate bereavement room away from the main delivery suite, so women and their families experiencing pregnancy loss had privacy. Staff said families could use the room for as long as they needed. The chaplaincy service could also provide support if requested.
- The service did not have a specialist midwife with a specialist interest in bereavement. However, staff had received bereavement training and support from the Stillbirth and Neonatal Death Society (SANDS), a charity that provides support for bereaved parents and their families. The service was in the process of recruiting a midwife with a specialist interest in bereavement.
- The labour ward offered bereavement photography as part of a memento package to families who had experienced a stillbirth or neonatal death. The free service was run by a group of volunteers who had experienced infant loss.
- The trust and Hull SANDS held a memorial service on a twice yearly basis for families who have experienced the loss of a baby or child.
- Women who attended the pregnancy advisory service were supported in making an informed choice about their TOP options. Women were offered the opportunity to be referred to a counsellor, ensuring the emotional needs of women were met.
- Support was given to families for the sensitive disposal of fetal/placental tissue. Staff supported families and enabled them to make an informed choice with burial and funeral arrangements. Written information leaflets were also given to women.
- Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
- Women with a suspected mental health illness were referred to the perinatal mental health team for further assessment and treatment.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.

Are maternity and gynaecology services responsive?

Good

At the 2014 inspection we rated responsive as 'Good' and this rating was maintained at the 2016 inspection because:

- The needs and feedback from people were taken into account to plan and deliver services to ensure they meet the needs of the local population. Service users were involved in planning the service.
- The enhanced recovery pathway for women undergoing elective caesarean section enabled women to be discharged home the next day.
- Women using the service felt they could raise concerns and complaints and they would be listened to. Complaints and concerns were taken seriously by the service and were acted on in a timely manner.

However:

- Medical outliers on the gynaecology ward were having an impact on elective procedures.
- A lack of capacity in consultant antenatal clinics had resulted in an increased demand on the antenatal day unit.
- There was a lack of capacity within the scanning department following the implementation of growth assessment protocol (GAP).

Service planning and delivery to meet the needs of local people

- Community midwives carried out routine antenatal care. Clinics were based in GP surgeries or children's centres to bring care closer to home. Consultant antenatal clinics ran from Monday to Friday for higher risk women.
- Women had the option to either deliver at home or on the labour ward, the service had recognised the limited

choice available to women following the closure of the separate birthing unit on another site in 2012. The service was planning on developing a midwifery lead unit on the labour ward.
- The enhanced recovery pathway for women following an elective caesarean section enabled them to be discharged home the next day.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the information on healthy lifestyles.
- The service was developing its transitional care beds on the Rowan ward. Transitional care was an area where babies who needed a little more support could stay with their mum rather than go to the Special Care Baby Unit. This meant mum and baby did not have to be separated.
- The labour ward had a dedicated bereavement room.
- Partners could visit the postnatal ward from 9am to 9:00pm. Partners could only stay overnight in certain circumstances and if the women was in a side room.

Access and flow

- Between October 2014 and December 2015 the bed occupancy was below the England average.
- Between May 2015 and April 2016 there were no maternity unit closures.
- The antenatal day unit was open from 8:30am to 20:00pm Monday to Friday and from 8:30am to 17:00pm Saturday and Sunday. Women from 16 weeks pregnant could self-refer or be referred by their midwife or GP for a range of problems such as reduced fetal movement. Scans were available each day as the midwives were qualified to scan women. Out of hours, any phone calls were transferred to the antenatal ward.
- The antenatal day unit had introduced a red, amber and green (RAG) system in a response to the increased activity on the unit. The system enabled midwives to prioritise women. It was introduced in February 2016 to improve patient flow through the unit. The impact on waiting times had not been audited but staff felt the system was more effective.
- Staff raised concerns about the lack of capacity in consultant antenatal clinics. We reviewed clinic rotas from the week commencing the 11 July 2016 to the week commencing 30 May 2016 and saw the weekly number of available consultant clinics ranged from seven to 15. Staff said this impacted on patients because women would see different consultants leading to a lack of consistency and changes to birthing plans.
- We spoke to four women, and they all said they had seen different consultants throughout their pregnancy.
- Staff said the lack on consultant antenatal clinics had increased the demand on the antenatal day unit. We reviewed information on the number of women seen in the antenatal day unit and found that from 2014 to 2015 the number of women seen in the year had increased from 12,866 to 13,887.
- At the time of the inspection senior staff said the next available clinic appointment was in the third week in July. If a woman required an emergency appointment they would overbook the clinic or refer women to the antenatal day unit. The service had not completed an audit to assess if the number of clinic slots met the service needs.
- The service was below its target for booking appointments before 12 completed weeks' gestation. The trust target was over 93.2%. In December 2015 the service achieved 88%, in January 2016 the service achieved 79%, in February 2016 the service achieved 77% and in March 2016 the service achieved 88%. The trust said that the implementation of a new IT system had resulted in women not receiving appointments in a timely manner. The trust had introduced a direct access clerk that booked women within an hour for their booking appointment.
- The trust had implemented the growth assessment protocol (GAP) in October 2015 to improve patient safety in maternity and reduce the rates of stillbirths. Staff raised concerns that there was not enough capacity to offer women the required number of scans. Staff said women who required seven to 10 scans were only having three. We spoke to the senior leadership team who said this was identified on the service risk register and the number of scanning slots had been underestimated. They had submitted a second business case and were hoping to increase the capacity in September 2016 following the recruitment of sonographers.
- The service had introduced enhanced recovery for elective caesarean patients who met the criteria. Women stayed on the labour ward for 30 minutes post procedure and were then transferred to Rowan ward.

Staff had not yet audited the pathway but estimated it had saved approximately 60 bed days a year. Women were been discharged home the next day in comparison to staying two days.

- Induction of labour took place on the antenatal ward. We reviewed incident data and saw between April 2015 and March 2016, three women had their inductions delayed. Women could attend as an outpatient for induction of labour with a balloon catheter (a mechanical process used to dilate the cervix and promote the onset of labour). This gave women more flexibility.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the labour ward by a midwife. Consultants reviewed patients in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- The early pregnancy unit provided care for women under 16 weeks pregnant and was open seven days a week, 7:45am to 17:45pm Monday to Friday and 7:30am to 15:00pm Saturday and Sunday. Midwives or GP could refer women or, women could self-refer if they had a history of three or more miscarriages or a previous ectopic pregnancy. Out of hours any phone calls would be transferred to the cedar ward or to the gynaecology triage nurse.
- From the trust divisional monthly report we saw the percentage of TOP carried out within two working weeks of initial assessment in October 2015 was 97.6%, in November 2015 was 98.3% and in December 2015 was 96.7%. This was highlighted as green on the trust dashboard, indicating it was in line with the trust target.
- Cedar ward was open Monday to Friday. On a weekend any remaining inpatients were transferred to ward 35. The service reduced the number of transfers by having an elective day case list on a Friday. The ward opened on a Saturday to provided care and treatment to patients undergoing a medical TOP.
- On a weekend a gynaecology triage nurse was available 24 hours a day.
- Staff said on a Saturday night and Sunday the trust opened Cedar ward and medical outliers were moved onto the ward. Staff said they would complete an incident form when this happened. We reviewed incident data and found between April 2015 and March 2016 there were nine incidents relating to the ward remaining open on a weekend. We spoke to staff who said this was challenging. For example, on a Monday the ward had a list of elective patients and no available bed at the start of the shift. Staff said they did usually manage to accommodate all the planned admissions however; this was impacting on the service.
- It was identified in the services divisional report that pressures on the gynaecology ward from outlying medical patients was having an impact on the elective gynaecology procedures. Between January 2016 and March 2016, 12 patients had their elective gynaecology procedures cancelled because a bed was not available on cedar ward due to medical outliers.
- The trust had criteria for medical patients outlying on the gynaecology ward. The criteria stated patients have an agreed discharge plan of 24 to 48 hours. On our unannounced visit the ward had eight medical outliers. Four elective gynaecology patients had their procedures cancelled. Staff said the medical outliers on the ward were not in line with the criteria. For example, one patient was waiting for a MRI and did not have an agreed discharge plan. There was a doctor on the ward reviewing the patients and staff said it had been escalated to bed managers.

Meeting people's individual needs

- Women told us they felt their individual needs were met and they felt listened to and able to participate in decisions about their care.
- The service had a vulnerable women midwife who was responsible for women who misused substances, had mental health problems, women with complex social needs, refugees, teenage mums and women with learning disabilities. The vulnerabilities midwife visited clinical areas daily to offer advice and support to staff.
- A vulnerability tool kit was in place for all staff. It outlined what staff could do to address the needs and improve pregnancy outcomes for women with different vulnerabilities included, drug/alcohol misuse, mental health issues, learning difficulties, domestic abuse and women under the age of 16.
- The service had a healthy lifestyle midwife who was responsible for supporting women throughout pregnancy and postnatally to achieve a healthy lifestyle.
- In all areas we visited midwives described how to access interpretation services through either booking a

planned appointment or using a telephone system called 'language line'. Community midwives and staff on rowan and maple ward had access to an I-pad which had a translation app.
- On the wards we visited we did not see any written information in different languages. Staff said they did not have access to any written material in different languages but they had access to an internet based tool for translation purposes.
- Midwives told us that bariatric equipment was available for women and was easily accessible.
- The rooms on the delivery suite were large and all had en-suite facilities which allowed wheelchair access.
- Rowan ward allowed partners to stay to provide support in certain circumstances and only if the woman was in a side room. Partners could visit Rowan ward from 9am to 9pm.
- Following pregnancy loss or TOP women were offered a choice in the disposal of the pregnancy remains. They were also offered support with funeral arrangements.
- Cedar ward opened on a Saturday for women undergoing medical TOP, this allowed all women to have a side room and offered them more privacy and dignity.
- The service worked closely with the Doula project. The project trained volunteers to offer support to vulnerable women.
- Families who experienced pregnancy loss were offered a post mortem.
- Midwives completed mental health risk assessments at booking and throughout women's antenatal and postnatal care. Women were asked if they had a history of mental health problems and the 'Whooley' questions. The questions are used as a screening tool to identify potential depression. A positive response triggered a referral to the appropriate agency for example, general practitioner, health visitors and the perinatal mental health team.

Learning from complaints and concerns

- The service reported formal complaints on the monthly performance dashboard. Minutes from monthly clinical governance meetings demonstrated that complaints were discussed.
- The service had a system in place for handling complaints and concerns. Staff said they would try and resolve complaints at a local level and were aware of the procedure to follow.
- Between February 2016 and April 2016 the service received 20 complaints and 43 PALS concerns were raised. 16 of the complaints related to care and treatment, two complaints related to care and comfort including privacy and dignity, one related to communication/record keeping and one related to a safeguarding after a patient developed a pressure sore.
- The SOM team produced an attitudes and behaviour training DVD for staff in response to feedback from women via complaints.
- We reviewed three responses to complaints. On two of the occasions the trust met with the families and included a copy of a being open report which summarised the discussion. The response to complaints included actions to be taken for example, ensuring all midwives gave sufficient information to women on discharge regarding any possible complications.
- Sharing of lessons learnt from complaints was done during handover on the labour ward. Maple and rowan ward produced a monthly newsletter where lessons learnt from complaints were disseminated.
- Cedar ward had leaflets about the patient advice and liaison service to inform patients about how to raise concerns or make a complaint. Not all women we spoke to knew how to make a complaint but said they would raise any concerns with the staff.

Are maternity and gynaecology services well-led?

Requires improvement

At the previous CQC inspection in 2014 well led was rated as 'Good'. We identified some concerns at the 2016 inspection that meant well-led was rated 'Requires improvement' because:

- Some of the governance arrangements did not enable the effective identification of risk and we found some risks were not clearly identified by the senior management team.
- Lessons learnt from the never event were not fully embedded with all staff. We saw evidence of pre and post swab counts not consistently been recorded in patient records. The services audit process was not robust enough to give assurance that lessons had been learnt.

- The system's in place for recognising deteriorating patients were not robust. Within obstetrics, the observation charts lacked a clear escalation procedure. The service had not completed an audit of patients modified early obstetric warning scores (MEOWS).We found in some areas the approach to service delivery was reactive in relation to the implementation of growth assessment protocol (GAP). Senior staff said the number of scanning slots had initially been underestimated.

However:

- Staff felt engaged and listened to and spoke passionately about driving service improvement.
- We saw strong leadership at a local level and staff spoke positively about being able to raise concerns.

Vision and strategy for this service

- The trust vision of 'great staff, great care, great future' was embedded in the service and staff were able to articulate what 'great staff, great care, great future' meant to them.
- The women's service division had an operational plan for 2016 to 2018. The strategic vision and goals was to provide safe, high quality care to patients.
- The service had key priorities for each Health Group. The priorities were timed and assessed against measureable outcomes. Senior staff were able to articulate these prioritise for obstetrics the priorities including reviewing obstetric scanning capacity and the development of the Midwifery Led Unit on the labour ward. Key priorities for gynaecology services included the development of outpatient procedures and the development of a procedural suite.

Governance, risk management and quality measurement

- The trust had a clinical governance midwife who was responsible for facilitating governance and risk management and ensured policies and guidelines were up to date. The clinical governance midwife reviewed all incidents.
- The service had monthly clinical governance meetings. We reviewed the minutes of the meetings and saw that they were well attended. Issues discussed included feedback from incidents and serious incident action plans, complaints, patient safety alerts and the risk register was discussed and updated. Previous actions were reviewed and monitored.
- Local risk registers assisted the women's service division in identifying and understanding the risks. Risk registers were reviewed on a monthly basis and any concerns were escalated through the Health Group governance meetings. We reviewed the local risk register. There were 11 risks, all had risk scores attached to them, review dates and existing controls to mitigate the risks. Examples of risks identified by the service included, security tagging for babies. This was given a risk score of eight. Controls put in place included the use of pressure sensitive mattresses. The trust had visited other units to review tagging systems and was in the process of introducing a tagging system.
- There was some alignment between what staff had on their 'worry list' with what was on the risk register. For example, obstetric ultrasound scanning capacity.
- The service did not meet the national recommended midwifery staffing ratio of 1:28. As the service did not collect data on the number of women receiving one to one care in labour we asked how they assured themselves they had the correct staffing ratio. Senior staff said they used feedback from the CQC survey and feedback through friends and family surveys.
- We found that learning from the never event had not been fully embedded. We saw evidence of pre and post swab counts not consistently been recorded in patient records. The services audit process was not robust enough to give assurance that lessons had been learnt.
- During our inspection we raised concerns about the lack of a clear escalation procedure on the MEOWS charts and the lack of clarity relating to how frequently observation would be repeated. An audit of MEOWS had not been completed by the service. As an immediate action the trust advised they were to display the escalation ladder in clinical areas. On our unannounced inspection, we only saw this displayed on the Rowan ward.
- Following the implementation of GAP in October 2015 staff raised concerns that there was not enough capacity to offer women the required number of scans. Senior staff said the number of scanning slots had initially been underestimated and they had submitted a second business case to recruit further sonographers.
- Staff raised concerns about the lack of capacity in consultant antenatal clinics. We saw the number of weekly clinics ranged from seven to 15. The service had not completed an audit to assess if the number of clinic slots met the service needs.

- Performance and outcome data was monitored and reported through the Family & Women's Health Group monthly divisional report. All areas had targets and it was highlighted if figures were outside of acceptable limits.
- The trust had started to participate in a Yorkshire and Humber regional performance dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues.
- The service had completed a benchmarking exercise following the publication of the Kirkup report (2015). Following the review, evidence was provided to demonstrate how the service met the recommendations and areas where further action was required. There was no clear action plan for example, the service identified the need to improve the process of learning lessons from incidents and complaints, but there was no associated action plan to demonstrate how this was to be achieved and who was responsible.

Leadership of service

- Maternity and gynaecology services were part of the women's division which formed part of the Family and Women's Health Group. A Clinical Director, Divisional Nurse Manager, Head of Midwifery and Divisional General Manager led the service and reported to the Medical Director, Nurse Director and Operations Director who formed the Health Group triumvirate.
- Senior staff had access to the trust board and felt listened to.
- We saw strong leadership at a local level and ward mangers were aware of the challenges in delivering good quality care and identified strategies to address these. Staff spoke positively about the leadership at ward level and felt well supported and listened to. Staff said they felt confident to raise concerns and felt they would be listened to.
- Staff said they felt well supported by their line managers but the senior management, matrons and the head of midwifery were not always as visible in clinical areas.
- The labour ward had a rota of senior midwives who acted as shift coordinators and were supernumerary.
- Each midwife had a named SOM. The trust was not achieving the recommended ratio of 1:15 midwives to SOM. In January 2016 the ratio was 1:16 and in February and March 2016 the ratio increased to 1:18. The service was putting actions in place to address this through supporting midwives in completing the preparation of supervisor of midwives course.

Culture within the service

- Staff were encouraged to be open and honest. All staff were aware of the duty of candour and were able to give examples of when this had been implemented.
- The trust had introduced insight training which aimed to address bullying and improve the culture within the organisation. Staff said it helped them understand individual's behaviour and felt it had improve the culture, developed intrapersonal working relationships and improved group cohesion on the unit.
- The ward manager on Maple and Rowan wards sent thank you cards to staff to highlight good practice and give staff recognition for their hard work. Staff said this made them feel appreciated.
- Staff said that they enjoyed working at the trust and were proud of their department. The staff we spoke with said they felt supported and felt confident in raising concerns.
- Staff recognised that during times of heightened activity staff were under pressure but felt that everyone worked together as a team to make the workload more manageable. All staff said having more staff would improve this situation.
- Ward managers had an 'open door' policy to encourage staff to discuss any concerns.
- Student midwives spoke of a positive learning environment and said they had received good mentorship. They said they would work at the trust.

Public engagement

- Data from the NHS Maternity Friends and Family Test showed that between January 2016 and March 2016 on average 95% of women would recommend antenatal care at the trust. This was slightly below the England average of 96%. 100% of women would recommend their birth experience this was above the England average of 97%. On average 96% of women would recommend the postnatal ward. This was above than the England average of 94%. On average 94.5% of women would recommend postnatal community care
- Following the closure of the midwifery lead birthing centre in 2012, some women reported a lack of choice

about birthing locations. The service had responded positively to this and had engaged with members of the public in planning a new Midwifery Led Unit on the labour ward.
- Maple ward displayed 'you said, we did'. Examples displayed included women reporting not enough privacy in the four bedded rooms for private conversations, in response; the ward had allocated a room for private discussions.

Staff engagement

- Staff told us they felt engaged and involved in service development; they felt their ideas were listened to. Staff said they had been asked about their concerns and suggestions for service improvements.
- The service had involved midwives and medical staff in a safety summit to discuss antenatal consultant clinics and the antenatal day unit. From the summit four work streams were formed. Staff said work was still ongoing to address the issues.
- We saw evidence of staff been engaged in improving services. The footprint of the maple and rowan ward was been changed to develop an area for transitional care. We reviewed minutes from the team meeting to discuss the improvements and saw the meeting was well attended and staff feedback was taken into consideration.
- Staff were engaged in developing the midwifery led unit on the labour ward and had visited other trusts to look at different ways of working.
- The service was seeking feedback from staff on the new birthing notes from the perinatal institute.

Innovation, improvement and sustainability

- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.
- The outpatient induction of labour with balloon catheter service had been accepted for publication in the International Journal of Obstetrics and Gynaecology and was presented as an E-poster presentation at the Royal College of Obstetricians and Gynaecologists conference.
- The service had introduced an enhanced recovery pathway following caesarean section. This was implemented in May 2016 and was associated with early discharge home and promoted normality.
- Development of a midwifery led unit within the labour ward. Staff demonstrated an outward thinking approach through visiting other units to gather ideas.
- The service was developing a business case to implement the role of a bereavement midwife.
- Midwifery staff were undergoing competencies to undertake intravenous antibiotic treatments for neonates to reduce and prevent unnecessary separation of baby and mum.
- The service was chosen as a pilot site for the National Society for the Prevention of Cruelty to Children (NSPCC) film to help parents care for a crying baby and cope with the stresses of sleeplessness and crying.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Hull Royal Infirmary is part of the Hull and East Yorkshire Hospitals NHS Trust. The Family and Women's Health Group provides a range of children's and young people's services for the population of Hull and surrounding areas. These include medicine (a 20 bedded ward), surgery (a 22 bedded ward), a paediatric high dependency unit (PHDU - four beds), and a neonatal unit. The neonatal unit is a 26-cot regional tertiary unit serving Hull, East Yorkshire and the Yorkshire and Humber region.

The paediatric assessment (PAU) unit was open 24 hours a day and contained 10 beds. It was used to assess children to decide if they needed to be admitted. Children and young people aged 0-16 years attend the unit from either their GP or from Accident and Emergency.

Children's outpatients delivered general clinics for childhood illness and surgical conditions, as well as the specialist clinics for gastroenterology, respiratory, cardiology, neurology, neonatology, endocrinology, immunology and allergy, rheumatology, oncology, hepatology, and dietetics.

The trust had 7,522 episodes of care for children between January 2015 and December 2015.

In May 2015, CQC carried out a focussed inspection. We rated the caring domain as good and rated safe, effective, responsive and well led as requires improvement. Overall, the service was rated as requires improvement. This was because the staffing levels did not meet best practice and national guidance. Incidents investigation did not take place in a timely manner and lessons learnt relating to incidents were not effectively acted upon and audited. We also found that some facilities on the 13th floor were not effectively assessed to prevent harm for patients with mental health needs.

In June 2016, we inspected the paediatric outpatients, PAU, medical and surgical wards, day surgery unit, theatre recovery area, paediatric high dependency unit, and the neonatal unit.

We spoke with 11 parents, three children, and 58 staff. This included ward sisters, nurses, healthcare assistants, play staff, ward domestics, student nurses, doctors, operating department technicians, consultants and senior managers. We also held staff focus group meeting to hear their views of the service they provide. We observed care and treatment, inspected nine sets of care records and we reviewed the trust's audits and performance data.

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Services for children and young people

Summary of findings

At the 2015 inspection we rated children and young people services as 'Requires improvement' overall. In 2016 this rating had improved and was 'Good' overall because:

- Nurse staffing was appropriate and was planned using an acuity tool. Multidisciplinary working took place and staff worked well as a cohesive team. Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Requirements around the duty of candour were being met.
- The service performed positively in infection prevention and control audits.
- Policies were based on national and local guidelines. Consent to care and treatment was obtained in line with legislation and guidance.
- Staff treated children, young people and their relatives/carers with kindness, compassion, dignity and respect. Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- We saw children and young people being assessed and treated in a timely way. A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- Playrooms and a schoolroom were available to meet the learning needs of patients.
- Following our inspection, the trust informed us they had decided to commission an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's needs.
- Staff spoke positively about their managers and the culture of the trust and were able to articulate the trust's vision and values.

However,

- Not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patients and how those needs would be met.
- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.
- Records concerning the administration of medications were not appropriately completed.

Services for children and young people

Are services for children and young people safe?

Requires improvement

At the 2015 inspection we rated safe as 'Requires improvement'. The rating in 2016 was 'Requires improvement' because:

- We had concerns that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt
- Four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patient and how those needs would be met.
- Records concerning the administration of medications were not appropriately completed.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.

However:

- Requirements around the duty of candour were being met.
- Nurse staffing was appropriate and was planned using an acuity tool.
- The service performed positively in infection prevention and control audits.

Incidents

- We inspected the incident data provided by the trust. Between April 2015 and March 2016, there were 585 incidents reported by staff. Of these, 497 were not a risk, 83 were classified as a minor risk and four were a moderate risk and one major risk.
- Staff were encouraged to report incidents using the trust's electronic reporting system. The staff members we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.
- There were no never events in children's services reported. Never events are serious, preventable patient safety incidents that should not occur if the available preventive measures are in place.
- There were two serious incident reported to the NHS strategic executive information system (STEIS) between May 2015 and April 2016. Serious incidents (SI) are incidents that require further investigation and reporting. One SI from February 2016, related to the untoward outcome of a surgical procedure. A root cause analysis (RCA) had taken place, which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root cause of incident.
- The second SI was a closure of the Neonatal Intensive Care Unit (NICU) to external admissions, due to a suspected outbreak of Vancomycin Resistant Enterococci (VRE) infection in May 2015. The trust commissioned a peer review following the outbreak. The review was positive with a recommendation to continue with the reassessment of routine cleaning in high-risk environments.
- Between May 2015 and April 2016, five incidents were reported to the National Reporting and Learning System (NRLS). All of the incidents were either low or no harm. Due to low volumes of incidents reported, there was insufficient data to report on trends.
- We were concerned that not all incidents/near misses (including safeguarding incidents) had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt. For example, a young person had absconded from the hospital without the prior knowledge of their family or ward staff and due to their age and medical condition could have been at risk of harm. This had been graded as severity 'none' and as a consequence no investigation had taken place as to how this could have happened. We brought this information to the attention of the trust at the time of the inspection. Following the inspection, they informed us the incident had been retrospectively declared a serious incident investigation.
- At our previous inspection in May 2015, the trust required improvement in the timeliness of the incident investigation. We saw at this inspection how this had improved and the trust monitored the timeliness of the investigation approvals. The trust had a target rate for incident approval of 80% each month. On four occasions between April 2015 and February 2016 the rate was between 74 and 78%. This was identified at the divisional monthly meeting through the quality improvement overview plan and being monitored through the health governance group.

- As part of the trust's quality improvement plan, they were strengthening their audits of incidents. We saw the risk management policy and procedures stated the line manager/ investigation officer would accurately grade the actual severity of the incident. They would also decide whether further analysis/investigation was required and the member of staff who completed the incident form would be informed. This role was new and helped to make sure incidents were graded correctly. We were informed the incidents we reviewed, had not received the manager/ investigation officer review.
- We spoke with one of the line managers/investigation officers. They told us they had received training to carry out their role and were aware of their responsibilities. We understood the role of this officer commenced at the beginning of June 2016.
- Staff on the ward told us they were aware of their line manager's role and when they had reported an incident, they had received feedback.
- Safety briefings were taking place and a 'Lessons Learned' newsletter sent to all staff across the trust. The June 2016 edition, included lessons learned from an incident that occurred in an outpatient clinic.
- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). We reviewed the minutes of the January to March 2016 meetings. We saw outcomes from case reviews discussed and where appropriate, recommendations made to improve care and treatment. They assessed practice against guidelines and fed back from and to the Governance forum.
- The duty of candour is a regulatory duty that relates to openness and transparency. It 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.
- Staff spoke about duty of candour and understood the need to be open and honest with families when things went wrong.
- We saw eight examples of where the duty of candour had been applied. This showed the trust was open and transparent with families when things went wrong.

Cleanliness, infection control and hygiene

- In November 2015, the trust commissioned a peer review following a suspected outbreak of Vancomycin Resistant Enterococci (VRE) infection. The review commended the IPC team and staff on the unit for bringing the outbreak under control. Recommendations were made and included the continued reassessment of routine cleaning in high- risk environments.
- A National Specifications for Cleanliness Report audit took place weekly. A record from April 2015 to March 2016 showed the overall score (for the paediatric domestic, nursing and estates,) was between 95 and 100% compliance.
- The trust produced a weekly infection control monitoring report for the divisional nurse managers and infection control lead, to cascade to their teams. Additionally a 13-week summary report of the areas monitored was included in the Trust Board performance report.
- The service had an Infection Control/ Reduction Committee. We saw from the monthly paediatric governance meetings that the committee provided infection control feedback to the meetings.
- The areas we visited were visibly clean and equipment had dated stickers on them, which showed they were clean.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance to ward and patient areas. There was clear signage encouraging visitors and staff to wash their hands.
- Patient areas displayed 'How are we doing' boards. For example, on the paediatric assessment (PAU) we saw for the previous month (May 2016), the ward had scored 100% for ward cleaning and 92% in their handwashing audit.
- There had been no cases of MRSA and one case of Clostridium difficile infection in 2016/17. A Route Cause Analysis (RCA) took place to determine the cause. The investigation showed there had been no lapses in care identified.

Environment and resuscitation equipment

- Access to the children's wards was via an intercom system. There were surveillance cameras in place that enabled staff to monitor people visiting and leaving these areas and keep the children safe. We noted one of

the two intercoms was not working on the entrance to the paediatric wards. In the interim, the wards were sharing the intercom system and during the inspection, the faulty device was replaced.
- Each directorate had a planned preventative maintenance programme that identified the frequency of equipment testing.
- Safety testing of electrical equipment took place and had dated stickers on the equipment to show when it had been tested.
- Resuscitation and emergency equipment checks took place in each area we inspected. This meant the equipment would be available in an emergency.

Medicines

- In general, medicines and intravenous fluids were stored securely. We noted that there was a broken lock on a refrigerator used for the storage of chemotherapy drugs in the outpatient area. We were informed that the lock had been reported for repair.
- There were appropriate arrangements in place for storing, recording and managing controlled drugs.
- All medicines, including those for emergency use were checked at regular intervals and records showed they were 'in date.'
- Records showed that medicines requiring refrigeration were stored at the correct temperatures. However, on the paediatric medical ward 130, we found that the room in which the drugs refrigerator was kept was warm. The temperature of the room was not monitored. The temperature of the room should be below 25°C for the safe storage of medicines.
- We reviewed seven prescription charts and found on three occasions the administration record had not been signed. This meant there was no record to indicate the child had received the medication. We also saw the instructions for an antibiotic on one chart was unclear. When we asked the doctor if he had followed the trust's prescribing policy, they re-wrote the prescription.
- A paediatric pharmacist visited the wards daily Monday to Friday to clinically check prescriptions and reconcile patients' medicines. The pharmacist had checked all seven charts we reviewed.
- On the Neonatal Intensive Care Unit (NICU), staff were proactive in reducing the risk of harm from medicines. For example, a senior nurse analysed all incidents on the relating to medicines between January and May 2016. They then produced a monthly risk update bulletin for their ward colleagues. Another senior nurse responsible for medicines management attended the trust's medicine safety meetings. The nurse gave ward staff a written summary of issues raised at these meetings and learning was shared.
- The service used software that calculated the dose of emergency drugs for individual babies depending on their weight.

Records

- We inspected nine nursing and clinical records. General record keeping was of a good standard. We saw the respective paediatricians and surgeons had completed medical records.
- Staff told us that five sets of case notes were audited each week as part of their monitoring, and 'HEY Safer Care.' Ward clinical observations audits were carried out in April, May and June 2016 across all children and young people's service. The results showed clinical observations had been completed 100% of the time in all areas.
- Nursing documentation included a paper based booklet containing an ongoing nursing assessment, care and discharge plans. The records contained a list of staff names, signatures, initials and designation of who had entered information into the document. This meant there was also a record of who had provided care.
- The care plans were pre-printed and contained generic care needs that were adapted by adding further actions to provide individualised care. The information referred to assessments and tools staff should use when making decision about the care.
- Records reflected the action taken to meet a patient's individual physical needs and goals. This meant it was clear what treatment and care the patient required and received.
- In February 2016, a mental health risk assessment tool was used for children and young people who may pose a risk of harm to themselves or other. The risk assessment tool was introduced with a view to improve the quality of service for these patients and was to be re-audited in August 2016. Staff told us that they had not received training on the use of the tool.
- We inspected two sets of records that contained completed mental health risk assessment documentation. We saw an example plan of care and in one of the records a meal plan. However, we did not see

a mental health plan of care in either of the two records inspected. Therefore we could not be assured these patients were receiving care for their mental health conditions to meet their needs.
- The Children and young people's service was 85.5% compliance for staff having attended information governance training. The trust target for mandatory training was 85%.

Safeguarding

- The trust had a safeguarding adult and children's lead nurse with a named nurse and a designated consultant in the Family and Women's Health Group for safeguarding children. The Named Doctors for safeguarding children sat within the Family and Women's Health Group
- On the 1 June 2016, the safeguarding children's team had transferred to the management of the Assistant Chief Nurse to centralise the trust's safeguarding arrangements. We were told this would strengthen monitoring and governance of child safeguarding procedures.
- The trust used the national safeguarding training guidance that set out the training and competency of staff working with children and young people.
- In line with safeguarding guidance, staff within the Health Group had completed safeguarding level 1 & 2 training. One hundred and nineteen staff out of 130 (91.5%) had completed level 1 training and 570 staff out of 646 (88.2%) completed level 2.
- Information provided by the trust following the inspection, showed the children's service had achieved 71.3% level 3 safeguarding training. They also stated they were on track for delivery of their training target by the end of August 2016. The information had been included on the trust risk register for monitoring purposes.
- The process for recording completed training had been reviewed and staff non-compliant with their training had been given a timescale to attend.
- Staff confirmed they had received safeguarding training, demonstrated their knowledge and were aware of their obligations to report safeguarding cases. They also confirmed the training included learning about female genital mutilation and child sexual exploitation.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situations where abuse or neglect of children is suspected'. However, four other specific guidelines we reviewed on the trust's intranet were out of date including 'Safeguarding children: children and domestic violence' which expired in September 2015. 'Safeguarding children in whom illness is fabricated or induced', expired in June 2015 and 'Safeguarding children: managing allegations or concerns against staff', expired in June 2014 and 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.
- Staff we spoke with were aware of how to access to safeguarding documents.
- The computerised record system did not 'flag' where there may be potential safeguarding concerns from adults who may pose a risk to children. It did have the facility to show if there was a protection plan in place for the child or they had one previously.
- Following the inspection, the Chief Executive wrote to the CQC to provide assurance that since 4 July 2016, the safeguarding children practitioners performed a daily ward round (Monday to Friday,) in the paediatric inpatient areas. A review of all patients admitted and discharged over a weekend or bank holiday would take place the next working day. A document for capturing the ward rounds and reviews had been put in place.

Mandatory training

- Compliance with mandatory training was reported in the monthly Family & Women's Health Group, children's services divisional report. The training matrix provided by the trust showed overall compliance was between 82.5, and 94.3% in neonatal and paediatric clinical areas.
- The trust had a corporate and local induction programme. As part of their statutory and mandatory training, all new employees (including medical and nursing staff,) received training via e-learning prior to attending the Welcome Day.
- Staff told us the trust were very good at allowing staff to attend training and included both face to face and on line sessions.

Assessing and responding to patient risk

- Staff were trained in European Paediatric Advanced Life Support (EPALS) and confirmed scenario training took place on the ward and in the trust's clinical skills laboratory, two to three times a year.
- The children's service used a Paediatric Advanced Warning Score (PAWS) tool to assist nursing and medical staff identify deteriorating patients**.** The documentation contained the action to take in response to deteriorating scores and the records inspected had been completed appropriately. Staff confirmed they all completed annual training in the use of the tool and trust data showed 55 staff had received training.
- The unit worked with Embrace, a paediatric medical transport service to safely transfer children who needed specialised care. The Embrace service could locate a bed in a specialist paediatric service if necessary and transfer the patient. Staff were aware of the guidance to follow in accessing Embrace and the paediatric anaesthetist would remain on the ward until the team arrived.
- At our previous inspection in May 2015, we identified risk assessments were not in place with regard to the environment on ward 130. This included the absence of a safe room for children and young people with mental health needs and a ligature risk assessment.
- In September 2015, the trust wrote to CQC and confirmed that the trust complied with HBN 23: Hospital Accommodation for Children and Young People in relation to ligature risk. The trust explained that a Child and Adolescent Mental Health Service CAMHS practitioner had been involved in the assessment of the environment, which included ligature risks, and the appropriateness of not having a designated safe room. They had also been instrumental in the development of an individual daily, risk assessment tool, which included an assessment of their need for supervision. The tool was used for children and young people with mental health needs, who posed a risk to themselves or others. The tool which was introduced in February 2016 and recently amended was to be audited in early August 2016. Staff told us they were using the tool even though they had not received training.
- We saw the risk assessments in place and were informed that training for staff, identified as an action from the previous inspection had been booked with CAMHS for September 2016.
- Following our inspection, the trust informed us that it was to commission an out of area review by an independent mental health provider trust. This was to include a review of the risk assessments used, care planning and training needs to make sure the service is meeting people's needs.

Nursing staffing

- The children and young people services used an acuity tool to determine staffing levels. The tool was developed with reference to the Royal College of Nursing (RCN) document 'Defining staffing levels for children and young people's services.'
- The guidance identified the appropriate level of nursing staff required to care for patients in a variety of clinical settings. For example, on a general ward the staff to patient ratio was one registered nurse to five children. On the Paediatric High Dependency Unit PHDU, there was a recommended ratio of one registered nurse to two children.
- We were told that the emphasis was more on acuity of the illness/needs of the patient rather than by age banding.
- The guidance stated the ward sisters and lead children's nurse used a combination of known activity/acuity levels and their own experience. This was then discussed with the nurse director and head of finance before being finally approved
- The actual staffing levels we saw on the wards were generally a reflection of the acuity tool numbers. We also saw a patient receiving one to one care where identified, due to their risk assessment and level of dependency.
- Acorn ward staff told us that on occasions they had experienced a shortage of staff at the weekend; this occurred if someone unexpectedly needed to go to theatre. We were told in this instance the 'bleep holder' would be informed and asked for assistance to transport patients to ensure the ward maintained staffing levels.
- The band 6 and 7 roles (sisters) were flexible in order to provide appropriate clinical cover as required as part of the escalation policy.
- Seven days per week there was one or two play specialists on duty. In addition, Monday to Friday there was a housekeeper and ward clerk for each area.
- A senior paediatric nurse carried the unit bleep covering a 24-hour period. Part of their role was to ensure that contact was made with each ward /area at defined intervals during their shift to highlight bed capacity and any immediate or potential staffing issues. The senior

nurse was able to make decisions about re-deploying staff to ensure all areas were staffed safely in line with the acuity of the patients and the age ranges of these children.
- Staff told us that the use of bank staff and overtime hours was accessed when needed.
- Handovers occurred twice a day. The information included patients detail, reason for admission, current assessment, safety brief and ward updates including staffing levels.
- The Neonatal services used the 'Badger' system to record the acuity of the neonates and the required staffing levels. This was based on the British Association of Perinatal Medicines recommendations and the designation of cots
- Information provided by the trust following our inspection, showed the vacancy rate in June 2016 to be 9.34 whole time equivalent (WTE) nursing staff. The largest number of vacancies was in the Neonatal Intensive Care Unit (NICU) with 6.98 WTE vacancies. NICU had recruited to two vacancies, with the remainder being out to advert at the time of our inspection. The manager told us that staffing levels had generally been maintained in line with acuity in the interim. This had included the use of bank staff and overtime.

Medical staffing

- The proportion of consultants for the service was lower than the England average and the proportion of junior doctors was higher.
- There were 12.2 whole time equivalent (WTE) paediatricians, four paediatric surgeons and 5.35 WTE neonatologists, a total of 21.55 WTE (26%, compared to the England average of 35%)
- There was a consultant paediatrician in the hospital from 9am to 5pm Monday to Friday, covering the paediatric wards (PAU, PHDU, ward 130, medical patients on Acorn ward) and the emergency department.
- Additional support from a consultant paediatrician in the PHDU was available from 9am to 1pm Monday to Friday.
- Outside of these hours, there was the Paediatrics service on call cover, from 5pm until 8pm. They were then available on- call off-site, unless needed in the hospital,
- At weekends, a consultant paediatrician was present in the hospital from 9am to 12 mid-day. They would then be on call for the hospital. In total, 12.2WTE consultants contributed to the on call cover rota.
- There was a consultant neonatologist of the week present on site Monday to Friday, 9am to 5pm. They covered the neonatal service (NICU, labour ward and postnatal wards) with additional support from a second consultant for the special care baby unit and the postnatal ward. This role was a minimum of three days of the week.
- Out of these hours, a consultant neonatologist was available on call and would be present in the hospital a minimum of three hours a weekday evening and four hours Saturday and Sunday. At present 5.35 WTE consultant neonatologists, contributed to this cover.
- We were informed that there were two tiers of junior doctors providing continuous on site cover and that this was compliant with rotas in both general paediatrics and neonatology separately. This provided a minimum of two junior doctors cover in both areas 24 hours a day.
- However, some doctors told us there were gaps in the rota and shortfalls in junior doctor allocation. The risk register showed in March 2016 the allocation of junior doctors to the speciality had resulted in several unfilled posts. Plans had been put in place in an attempt to mitigate against this risk, these included: an attempt to recruit locum trust doctor posts and consultants to work twilight shifts on locum pay in order to support the service. The risk was to be reviewed in June 2016.
- We also reviewed two recorded incidents where there had been a delay in accessing the appropriately trained doctor for a Section 47, child protection medical. In one instance a police surgeon was used to mitigate the risk, the trust had liaised with the police.
- We saw on the incident report system in February 2016, two incidents had occurred because of unsafe levels of paediatric registrar staffing for the workload. Following lessons learned relating to the shortfalls within the junior doctor's allocation, the twilight registrar post initiated last winter was discontinued. This improved staff cover as it meant the paediatric registrar no longer had the extra duty of covering the twilight shift.

Major incident awareness and training

- Major incident and business continuity planning was in place as part of the wider trust continuity planning.

- Training records showed 100% of staff had received major incident training. Staff confirmed they had received training and were aware of their role in the event of a major incident.

Are services for children and young people effective?

Good

At the 2015 inspection we rated effective as 'Requires improvement'. In 2016 this rating had improved to 'Good' because:

- Policies were based on national and local guidelines.
- Consent to care and treatment was obtained in line with legislation and guidance.
- Multidisciplinary working took place and staff worked well as a cohesive team.

However:

- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.

Evidence-based care and treatment

·The trust monitored and identified whether they followed appropriate guidance relevant to the services they provided.

·We found that policies were based on national and local guidelines and accessible on the trust intranet site. All guidelines we inspected were in date and had been ratified at the Clinical Effectiveness, Policies and Practice Development meetings.

·We also saw the paediatric ward used appropriate guidelines in the management of patients under 18 years of age, with anorexia nervosa. The guidelines were jointly written by the Royal College of Psychiatrists and the Royal College of Physicians and used for patients with severe anorexia being admitted to general medical units.

Pain relief

- The service used the neonatal and paediatric pain guidelines.
- The trust's pain team contacted the paediatric surgery ward and the paediatric HDU each day. This was to review patients that were receiving analgesia with a nurse, document their assessment, and advice on their plan of treatment, whilst referencing the neonatal and paediatric pain guidelines.
- Discussion with staff and review of the records showed that pain management was considered by members of staff. The majority of staff was compliant with their training.
- At the time of our inspection, a pain link nurse-training day was being organised alongside the pain team. This was to address any future training requirements.
- The children's ward and units had access to play specialists and a range of distraction tools when required to provide an alternative means to lessen the impact of pain, discomfort or distress.

Nutrition and hydration

- Initiatives, such as the UNICEF Baby Friendly Initiative were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme developed by UNICEF and the World Health Organisation (WHO). It was designed to support breastfeeding and parent/ infant relationships, by working with public services to improve standards of care.
- Care plans we reviewed assessed the nutritional needs of patients. Records contained appropriately completed fluid balance charts.
- A dietitian visited the ward daily to provide advice on the diet and fluids patients should receive.
- Hot and cold beverages were available in each ward and unit and relative/visitors were encouraged to help themselves.

Patient outcomes

- From December 2014 until November 2015 the emergency readmission rate (within two days of discharge) for the under one year of age group was 3.6 patients. This was similar to the England average of 3.3.
- Multiple readmission rates for the one year age group in asthma, diabetes and epilepsy were lower and therefore better than the England average.
- The multiple readmission rates in the one to17 year old age group was higher than the England average for asthma (19.6% compared to 16.5%) , about the same as the England average for diabetes (13.6% compared to 13.2%) and lower than the England average for epilepsy (26.1% compared with 28.6%).

- There were emergency readmissions among patients in the 1-17 year old age group between November 2014 and October 2015. Two in paediatrics compared to the England average of 2.7; 1.6 in paediatric surgery compared to 2 readmissions, the England average and 4.6 in general medicine, compared to the England average of 2.2.
- The National Paediatric Diabetes Audit 2014/2015 identified there were 17.7% compared to the England average of 22.1% patients with controlled diabetes.
- The National Neonatal Audit Programme 2014 (published in November 2015) identified the percentage of babies less than 33 weeks gestation at birth receiving at least some of their own mother's milk at discharge home was 61%. This was similar to the England average of 60%.

Competent staff

- There were formal processes in place to ensure staff received training, supervision and an annual appraisal. All staff, including bank staff told us that they undertook mandatory training; training to ensure they had competencies to do their job and received an annual appraisal.
- Appraisal statistics included family and women's services. The internal appraisal target to achieve was 85%. In May 2016, the number of nursing and midwifery staff who had received an appraisal was 447 (85.6%). The number of medical staff who had received an appraisal was 70 (86.4%).
- Tailored reflection and support to medical and nursing staff involved in medication incidents was taking place. This was to ensure staff learnt lessons from incidents and were competent to do their job.
- To support lessons learnt from critical incidents, scenario training was taking place.
- We were concerned staff on the ward may not have the knowledge to care for children and young people with actual or suspected mental health needs. At the last inspection this was identified and the trust provided as action plan to deliver some bespoke training from the local CAMHS. The training had not taken place.
- Following this inspection, the trust wrote and provided assurance to CQC that a training needs analysis to review their competencies had taken place. A meeting had also been arranged with CAMHS services in July 2016 to review staff training needs and determine what other level of support and training can be offered to the staff. Training was identified for September 2016 and be delivered by CAMHS.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- Staff we spoke with gave positive examples of multidisciplinary working. We saw paediatricians and nursing teams, along with other allied healthcare professionals (dieticians, physiotherapists, pharmacists, play specialists) working together.
- The CAMHS team telephoned the ward each day to receive an update on their patients. They also visited twice a week if they had patients on the ward.
- MDT meetings took place and a brief account was included in the medical notes.

Seven-day services

- Consultants provided 24 hours on call service for seven days and staff reported they were available for ward rounds at the weekend and each day.
- There was Monday to Friday 24 hours support from pharmacy and outside of these hours, a pharmacist was available on-call.

Access to information

- Staff told us they had access to information for each patient, which included nursing records and results from any investigations.
- There were processes for informing GPs and health visitors of patient discharges.

Consent

- The trust had an up to date policy for consent and competency standards; this was accessible to staff through their intranet.
- Staff we spoke with understood the Gillick competency standard surrounding consent for children.
- They explained the consent process completed by surgeons and they encouraged the involvement of young people in decisions relating to their proposed treatment.

Services for children and young people

- Staff told us that consent was completed on the morning of the operation. Depending on the ability of the child to understand, the doctor would ask the child/ the parent to sign/countersign the consent form.
- We inspected two records where consent was obtained. The consent records were complete, dated and signed.
- Between February and March 2015, a paediatric surgical consent audit took place. Thirty records were audited; 75% relating to paediatric outpatients and 25% to inpatients. The outcome showed 100% of the time the documentation was legible and signatures obtained from parents and health care professionals. This was an improvement of 28% from the previous year's audit.

Are services for children and young people caring?

Good

In 2015 we rated caring as 'Good' and the 'Good' rating was maintained in 2016 because:

- Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Staff treated children, young people and their relatives/ carers with kindness, compassion, dignity and respect.
- Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- Good Friends and Family Test (FFT) results were achieved in 2015/16 for paediatric and the neonatal intensive care unit.

Compassionate care

- Throughout our inspection, we saw that patients and relatives/carers were treated with dignity, respect and compassion.
- All the staff we spoke with were passionate about their roles and were dedicated to making sure the children and young people had the best care possible.
- We observed staff providing care to children in a sensitive way; the nurses responded to crying babies where parents were absent, quickly comforting them.
- In the Friends and Family Test (FFT) from March 2015 to February 2016, the PAU, NICU and wards scored between 91.4 to 100% as a place people would recommend. In April 2016, PAU scored 94%. Whilst the NICU and the paediatric medical ward both scored 100% as a place people would recommend.

Understanding and involvement of patients and those close to them

- We observed staff explaining to families the care their child was receiving. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Families we spoke with felt involved and informed about the care of their child, and they had been involved in the decisions about care.

Emotional support

- Parents told us they were supported throughout their visits to the service.
- A chaplaincy service was available for children and families and a multi-faith prayer room was available on the ground floor at the trust.
- There were bereavement services available to support families.
- The trust and Hull Stillbirth and Neonatal Death Society (SANDS) held a memorial service twice a yearly for families who had experienced the bereavement of a baby or child.

Are services for children and young people responsive?

Good

In 2015 we rated responsive as 'Requires improvement'. In 2016 this rating had improved to 'Good' because:

- We saw children and young people being assessed and treated in a timely way.
- A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- The trust had a system for handling complaints and concerns, with learning from complaints and concerns disseminated to staff.
- Playrooms and a schoolroom were available to meet the learning needs of patients.

- The trust was commissioning an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's mental health needs.

However:

- There were limited facilities for the segregation of patients when needed, such as for infection control. We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow older children to be cared for by gender.
- There was also a lack of teenager environmental facilities.
- Parents told us they found the facilities to be poor.

Service planning and delivery to meet the needs of local people

- The trust was commissioned by the local Clinical Commissioning Groups to provide services for children and young people.
- The trust had plans for the development of the service and dedicated children and young people facilities. This had been identified at the last inspection. However, due to the financial constraints and other priorities the trust had not implemented these. The parents' sitting room facilities on the 13th floor had been improved following receipt of charitable funds.

Access and flow

- We saw children and young people being assessed and treated in a timely way.
- However, on the paediatric surgical ward staff told us that they were asked to take medical outliers (patients that should be on a medical ward). When this happened staff had experienced difficulty accessing the medical staff and this has meant a delay in the discharge of the patient.
- The PAU assessed children and young people between the ages of 0-16 years to decide if they needed to be admitted. They were referred to the unit either by their GP or from Accident and Emergency department. The service was available 24 hours a day.
- The average length of stay for non-elective care of children aged less than one year was zero days, and one day for the age group of one to 17 years of age. Both were in line with the England average.
- March 2015 to February 2016, the England average bed occupancy of neonatal critical care beds was between 70 – 75%. At the trust occupancy was at 100% in April, October 2015 and February 2016, 60% in June, August and December 2015 and between these variables the rest of the year.
- A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- A community team of specialist nurses provided continuing care on discharge from the neonatal unit.
- The children's service had commenced the training of three Advanced Nurse Practitioners (ACPs) to work in the paediatric assessment unit and support the emergency department. This was to assist the trust with its flow of patients through the emergency department as well as reduce the length of stay for children awaiting review.
- To help facilitate ease of access to the service for patients attending the outpatient department, extra clinics had been made available on a Saturday. In addition, we were told that staff sent a text to remind the patient or relative of their appointment.

Meeting people's individual needs

- The trust reported their transition to adult services was well established in some of the chronic illnesses such as cardiology, diabetes and neurology. However, they also reported that the service would further develop transitional arrangements in their 2016/17 Quality Improvement Programme and develop a trust wide transition steering group.
- The service did not have children's nurses who specialised in learning disabilities. Instead, the service accessed specialist support from adult services.
- Staff informed us within their safeguarding training, there was information relating to patients with a learning disability. Additionally, the staff had contact numbers and information leaflets to access specialist groups. For example, 'Downright Special …building a brighter future for children with Down Syndrome.'
- All children admitted to the general paediatric wards had an initial physical diagnosis. This included the patients who were admitted for a physical medical conditions associated with their mental health illness (for example, eating disorders below safe medical weight, and acute overdose requiring medical intervention).

Services for children and young people

- The number of children with a mental health condition admitted to a general paediatric ward over the previous 12 months was 87. This included, self-poisoning (68), anorexia, eating disorders (10), alcohol intoxication (five), and other mental health disorders (four).
- The service had a consultant paediatrician with a special interest in mental health and a hospital mental health liaison team. In addition, where children and young people admitted to the service had emotional, behavioural or mental health difficulties they were able to access specialist NHS CAMHS services provided by another NHS trust.
- Staff told us that they had access to interpreter services on the ward for children who may not speak English as a first language. The top three languages were Polish, Russian and Arabic. Interpreter services used by the trust included Language line, and British sign language.
- We observed a range of information leaflets to be available across the service. We saw information leaflets and contact details for support organisations in each patient area. For example, 'Run a head' a family support group for children with additional needs and their families.
- We saw a list of questions staff would ask the patient on admission which were written in several languages.
- Wherever possible mothers were not separated from their newborn baby and facilities were available for parents to be resident at the hospital with their child. For example, on the NICU there were bedrooms with en-suite facilities and a bedroom for parents to stay with their baby in the special care baby area. Where in-patient relative facilities were not available, they were offered a temporary bed or armchair should they wish to stay with their child.
- Staff explained that they tried to nurse male and female children and young people in separate bays from eight years of age upwards. We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow older children to be cared for by gender.
- A playroom was available in PAU for children and young people. It was equipped for primary aged children.
- There were no separate facilities for teenagers.
- A schoolroom and teacher was available during term time on the ward. Children who were inpatients for five days or more could access this service. Nursing staff gave an example of how the teaching staff at the hospital liaised with invigilators for a young person sitting their GCSEs.
- There was a parents' room available on Ward 130. As there was no parent's room on PHDU, they had access to the facilities on the paediatric medical ward.
- Parents told us they found the facilities to be poor, with uncomfortable seating, and cramped conditions.
- There were two 'rooming in' rooms available for parents in the neonatal unit. These contained two single beds, an armchair, a changing area, and space for cots. Staff explained that demand for these rooms was high and that they often had to 'juggle' things around to try to meet demand.
- A shower and toilet for parents was only available in one of the 'rooming in' rooms on the neonatal unit. There was seating available for parents in the neonatal sitting room and a kitchen area to make light snack and drinks.
- Two further sleeping rooms were available for parents on the neonatal unit. Both had double beds and were en-suite. One of these rooms had a wet room, which was suitable for parents with physical disabilities.

Learning from complaints and concerns

- The trust had a system in place for handling complaints and concerns; staff in the children and young people's service were aware of the procedure to follow.
- The Health Group included women and children's services and the complaints identified in the board reports reflected the two services as a whole. Given this, the trust was unable to show the number of complaints and trends as two separate figures.
- However, the monthly Paediatric Governance meeting minutes for December 2015, January and March 2016 showed that between November 2015 and February 2016 there had been five complaints in this service. The Patient Advice and Liaison Service (PALS) had received 33 comments, suggestions, compliments and requests for advice. Themes mainly related to outpatient appointments.
- The Quality report for March 2016 identified the action taken and lessons learnt from complaints. For example, a child had been discharged home with abnormal 'vital signs' (temperature, pulse and respirations). As a result, the trust wrote a policy which addressed the issues, including discussing concerns with the senior duty doctor, prior to patient discharge.

Services for children and young people

- Learning from complaints and concerns were disseminated to staff through bulletins, newsletters, emails, updates and meetings.

Are services for children and young people well-led?

Good

In 2015 we rated well–led as 'Requires improvement'. In 2016 this rating had improved to 'Good' because,

- Staff spoke positively about their managers and the culture of the trust.
- All staff were able to articulate the trust's vision and values.
- The Family and Women's Health Group had a strategic vision for the next three years.
- There were clear lines of responsibility and reporting to board level.

However:

- Not all incidents/near misses we reviewed had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt including safeguarding incidents. However, the trust had since changed its incident review processes and brought the responsibility for child safeguarding within the corporate team.
- There was not an effective system to identify and ensure that child safeguarding policies were reviewed and up to date.

Vision and strategy for this service

- The trust's vision was 'great staff, great care, great future' and all staff were able to articulate the trust's vision and values.
- We saw the Family and Women's Health Group had a strategic vision for the next three years. It aimed to provide the highest quality of care to patients and service users; be responsive to national and local priorities; committed to safety, clinical effectiveness and the efficient and economic use of resources across all services.
- The strategy also identified the vision was to deliver a five year plan of improvements in quality and safety of the care required to deliver key targets.
- Key objectives had been identified. These included a board approved plan for the relocation of children services which remained outstanding from the previous inspection in May 2015. This has meant there was an inability to give a joined up service due to separation of the paediatric surgical ward from other services; including the paediatric service on the 13th floor. Although the trust supported in principle the reconfiguration of the service, they had not identified when this would take place. This was due to the financial constraints of the organisation and other priorities taking precedent.

Governance, risk management and quality measurement

- The trust's Family and Women's Health Group oversaw the service specific management and governance arrangements of children's services.
- The trust was aware of specific risks for each Health Group, with each one having an individual risk register. For example, the trust register included the inability to deliver appropriate standards of care to children due to the environmental constraints of the 13th floor. The date the information was added to the register, review date, and the controls in place to mitigate any risks, were recorded.
- The children ophthalmology and dermatology division had identified eight risks including, the lack of junior doctors within the paediatric and neonatal services. The minutes of the meeting of the governance group who met monthly, showed the managers and trust board were aware of their local and strategic risk. They had systems in place for their review to keep patients safe.
- The trust had a Quality Improvement Overview Plan. The purpose of the plan was to define, at a high level; the overall continuing quality improvement journey the service was making and the improvement goals the trust would work towards over the next 8-12 months. It included the CQC requirements, recommendations, and longer-term objectives to improve quality and responsiveness across the organisation. A monthly progress report on the improvement plan was produced

and reported to the Health Group Board and the Operational Quality Committee. Actions from the 2015 inspection were included and monitored within this plan.
- At this inspection, we had concerns that not all incidents/near misses (including safeguarding incidents) had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt. The trust informed us that since April 2016 a new system had been introduced.
- There was not an effective system to identify and ensure that child safeguarding policies were reviewed and up to date.
- As part of the trust's quality improvement plan, they were strengthening their audits of incidents.
- The new system included the incident investigation officer reviewing the grading of the actual severity of the incident. They would carry out a further analysis/ investigation where required, to make sure the incident had been graded correctly. We were informed the incidents we reviewed, were before the new system was introduced and had not received the manager/ investigation officer review.
- The children, ophthalmology and dermatology division's monthly report March 2016, also showed the risks of the service were monitored, together with incidents, complaints, screening updates and performance.

Leadership of service

- Services at the trust were divided into four Health Groups, medicine, surgery, family and women's health and clinical support services. The Family and Women's Health Group was further subdivided into two divisions, both of which included aspects of children's services: Women's service division and Children, Ophthalmology and Dermatology division.
- Within the children's and young people's service there were clear lines of leadership and accountability. However, several of the staff were new in post and we were told the trust was restructuring their nurse management roles.
- For each shift, a band seven coordinator who managed the ward/ unit and was supernumerary to the nurse staffing numbers. This allowed them to provide support to the nursing staff and was the first line of contact when staff had staffing concerns.
- Staff confirmed they had good support from the ward manager and coordinators. They told us they were supported and the trust was a good place to work.
- We were told that a previously identified bullying culture was definitely improving with the appointment of the new Chief Executive.

Culture within the service

- We found there was a culture of openness amongst all the staff. Most staff were enthusiastic and spoke positively about the services they provided to children and young people.
- Most staff told us things had improved and felt they were able to raise concerns and would be listened to and supported by their manager.
- We observed staff working well together and there were positive relationships within the multidisciplinary team.
- We spoke with several staff on PAU and the outpatients department. They told us they had worked at the trust for several years and they had not seen any bullying behaviour. They told us their managers had always been open.
- Staff spoke about duty of candour and understood the need to be open and honest with families when things went wrong.
- The trust was open and transparent with families when things went wrong.

Public and staff engagement

- Staff on paediatric ward 130 were finalists in the trust 'Golden Hearts Awards' 2016, for the positive culture and team spirit category.
- We saw evidence that the service were seeking patient and relative feedback through family involvement groups and patient and family surveys.
- We heard how the patient representative group worked on projects in schools with pupils who had autism to prepare them for entry into hospital.
- Patients' relatives were involved and instrumental in the creation of a relatives/visitors sitting room, where they could make hot drinks on the paediatric surgical ward.
- The NHS staff survey results 2015 showed they scored 3.74 out of five for overall staff engagement.
- Staff told us their managers had a good relationship with their teams and they had an open door policy should they have concerns.

- Staff told us they were proud of the hospital choir. This was a multidisciplinary team of staff from across the four directorates who had come together to form the trust's choir.
- We saw in the March 2016 newsletter, all staff were invited to take part in a short anonymous questionnaire. It aimed at helping the trust understand how lessons were and shared across the organisation. The Risk team would then use the information to improve learning from incidents across the trust.

Innovation, improvement and sustainability

- Scenario training took place to support learning lessons from critical incidents. This was delivered both in ward areas and within the clinical skills facility within the hospital. They had also produced a DVD as an educational support tool for staff relating to incidents.
- Children and women's services were chosen as a pilot site for the **National Society for the Prevention of Cruelty to Children** film. It was being produced to help parents care for a crying baby and cope with the stresses of sleeplessness and crying.'
- The service used software that calculated the dose of emergency drugs for individual babies depending on their weight. The software was innovative and improved the safety of prescribing.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support, and mortuary services.

The trust provides services a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

Hull and East Riding Hospitals provided end of life care across a wide range of services, including surgical and medical wards (including wards for older people), accident and emergency, critical care and specialist services such as oncology at both Hull Royal Infirmary and Castle Hill Hospital that also incorporated the Queens Centre for Oncology and Haematology. In addition, the chaplaincy, mortuary and bereavement teams also provided care at the end of life.

The trust employed a Specialist Palliative Care Team; this included nine specialist palliative care nurses and four consultants. The Specialist Palliative Care Team (SPCT) worked Monday to Friday 8am to 6pm. There was provision across both main hospital sites. The team were based at Castle Hill Hospital and provided a daily in reach model at Hull Royal Infirmary.

During 2015, the trust had 2386 in hospital deaths. The Specialist Palliative Care Team received 1386 referrals; this included 1043 cancer referrals and 343 non-cancer referrals.

During our inspection we visited six wards at Hull Royal Infirmary where end of life care was being provided, we spoke with two patients and four relatives. We also spoke with 12 members of nursing staff, two doctors and eight porters. We visited the mortuary and bereavement service and spoke with four staff from these teams.

The last comprehensive inspection of end of life care services at the hospital was in February 2014, when we found the service to be good overall.

End of life care

Summary of findings

At the comprehensive inspection in 2014 we rated this core service as 'Good' overall. In 2016 the rating remained 'Good' overall because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents. Mandatory training across most services was above the trust targets. Medicines were prescribed and administered safely in line with policy and staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multi-disciplinary working across all teams. The trust had recently employed more staff to be able to provide seven-day specialist palliative care nurse availability. Consent to care and treatment was obtained in line with legislation and guidance.
- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and each patient's choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the SPCT were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

End of life care

Are end of life care services safe?

Good

In 2014 we rated safe as 'Good'. In 2016 this rating remained 'Good' because:

- Patients were protected from avoidable harm and abuse. Incidents involving end of life care patients were low in numbers. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents.
- All staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding.
- Mandatory training in most teams providing care at the end of life was above the trust targets however; in some teams, compliance with some subjects was lower than the trusts targets.
- The environments were fit for purpose and equipment was readily available.
- Medicines were prescribed and administered safely in line with policy.
- Staffing levels were appropriate for the services provided.

However we also found:

- Not all staff were up to date with mandatory training

Incidents

- All staff we spoke with told us that they were encouraged to report incidents and that they were confident in the use of the trust's electronic reporting system.
- Staff told us that they received feedback after reporting incidents and we saw lessons learned publications that were produced by the trust each month and disseminated to staff. We saw these displayed in some of the wards we visited.
- There were low numbers of incidents involving patients at the end of life across all core services. Information provided by the trust indicated that 30 incidents involving patients at the end of life had been reported between May 2015 and May 2016. All of these incidents were graded as low or no harm. These included incidents such as deterioration in a patient's skin condition and concerns raised regarding the transfer of patients care.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour.
- We saw that following incidents, in other services, the trust apologised to the patients involved and their families. There had been no incidents requiring duty of candour for patients receiving care at the end of life however staff told us about being open and honest and apologising if things went wrong.

Cleanliness, infection prevention and control (IPC) and hygiene

- All areas that we visited, that were providing care at the end of life, appeared clean and well maintained. This included ward areas, the mortuary and the bereavement team offices.
- Personal protective equipment (PPE) such as gloves and aprons were available in all areas. Hand wash stations were available in the main foyer area of the hospital and also in each ward. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side wards. We saw staff using appropriate PPE and washing their hands before providing care to patients.
- Within the mortuary, there was clear separation of clean, transitional and dirty zones. Cleaning schedules were displayed and in addition there was a separate category 3 (infectious diseases and forensic) room. In this room, we saw that each storage fridge had IPC warning signs in place.
- Staff completed IPC training as part of their mandatory training programme. The trust target for this training was 85%. Overall trust compliance with this was 73%; however, we found that only 43% staff from the SPCT were compliant with this training.

Environment and equipment

- Staff we spoke with told us equipment, such are syringe pumps and specialist mattresses, were readily available for patients. However, some staff referred to the 'bed

policy' and said that they were concerned that when patients were transferred between wards, they had to be transferred on to a bed belonging to the admitting ward rather than the beds being swapped. This meant that sometimes patients were transferred between beds. Staff told us that they were concerned that this could cause unnecessary pain or distress for patients.

- The trust used two types of syringe pumps. However only one type of device was used at this hospital. A palliative link nurse told us that they were the trainer for the pumps and as such provided training in the use of the pumps for other staff on the wards.
- We visited the bereavement office at the hospital. The bereavement offices were clean and tastefully decorated.
- The Human Tissue Authority (HTA) is a regulator set up in 2005 created by parliament; they are an executive agency of the Department of Health. The HTA regulate organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public.
- The HTA inspected the mortuary services for the hospital in September 2015 and deemed that the services provided by the hospital met the required standards for premises facilities and equipment.
- Maintenance and service records were kept for equipment, including fridges/freezers, trolleys, post mortem tables and the post mortem suite ventilation.
- The fridges in the mortuary had an electronic automated alarm system to alert staff if the temperature of any individual fridge rose above 12 degrees centigrade. Staff were available 24 hours per day in case of emergencies.
- The mortuary also had 96 fridges available, eight of which were bariatric. There were also freezers available for longer-term storage.

Medicines

- The trust had policies and procedures in place for the safe handling and administration of medicines. These included documents that related specifically to care at the end of life including the prescribing of 'just in case' medication boxes for palliative care and guidelines for the use of opioids in palliative care.
- The trust had a policy for the administration of medications via a syringe driver.

A member of the SPCT explained that syringe drivers were always prepared to contain 24 millilitres of fluid and run at one millilitre per hour over 24 hours to ensure a standard approach trust wide and therefore maintain patient safety.

- Staff we spoke with explained that if a patient was going home they had to take them off the syringe pump and would arrange for a district nurse to visit the patients home to set up a new pump. We had concerns about this however; staff explained that they gave the patient a subcutaneous dose of their medications to ensure that they remained symptom free until the community nurses could re-establish the syringe pump.
- The SPCT nurses were not non-medical prescribers however, they liaised with medical staff from the wards caring for patients at the end of life to ensure that medications were adjusted when needed. We witnessed this taking place during our inspection.
- We checked the medication administration charts for five patients receiving end of life care and found that all non-essential medications were discontinued as appropriate. We found that anticipatory medications were prescribed in line with evidence based best practice. This included medications for pain, shortness of breath, restlessness, nausea and respiratory tract secretions.
- In addition, we saw that medicines reconciliation had been completed on the medication administration charts.

Records

- We looked at the care records for five patients. We found that documentation completed by members of the SPCT was completed fully and consistently in all records. This included the patients' prognosis, symptom management and patients' physiological, social, spiritual and psychological needs.
- We saw comprehensive assessments of patients' needs and care plans in place to manage the risks. This meant that records were in line with national guidance and processes were followed which helped keep people safe however, we looked at ten food and fluid charts and found that these were not fully completed for any of the patients.
- Family involvement was clearly documented in the records reviewed.
- The trust used an intentional rounding tool; we saw that these were in place in all records we reviewed.

End of life care

- In line with policy and national guidance, we found that all, except one, do not attempt cardiopulmonary resuscitation (DNACPR) forms were signed by a senior clinician.

Safeguarding

- Staff told us that they completed safeguarding training as part of statutory mandatory training. The team members of the SPCT (medical, nursing and the MDT coordinator) were 86% compliant with vulnerable adults' level one and safeguarding children level two training. This was above the trust target of 85%.
- Mortuary and bereavement office staff were 100% compliant with vulnerable adults and safeguarding children training. This was above the trust target.
- The chaplaincy staff were 57% compliant with vulnerable adults and safeguarding children training which was below the trust target.
- Nursing staff, we spoke with about training told us that they had completed safeguarding training and were able to describe the process they would follow if they had a concern or needed to raise an alert.
- Staff also said that they knew how to access safeguarding policies and procedures via the trust intranet.

Mandatory training

- The trust target for completion of statutory and mandatory training compliance was 85%. Data showed overall compliance of 76% for the 14 members of staff in the SPCT; however, the team had newly appointed members of staff and staff who had returned after a period of absence.
- The team was above the trust target for major incident (100%), Fire training (86%) and Information Governance (86%) however, they were below target for Moving and Handling (71%), Safety (64%) and Resuscitation training (57%).
- Staff in the mortuary and bereavement service were 100% compliant with all training except for moving and handling which was 71%.
- Overall, the chaplaincy staff were 78.5% compliant with all training, which was below the trust target. Compliance for infection prevention and control training was 43%. Safeguarding children and vulnerable adults training compliance was 57%.

Assessing and responding to patient risk

- The trust used a recognised national early warning score tool (NEWS). These tools are designed to assist staff in the early recognition and response to a deteriorating patient.
- We saw these in use in all of the care records we reviewed however the forms did not always have a guide for staff to refer to in the event of a patient needing escalation response, except on one ward where we saw a laminated guide in the care record which was stored in the same section of the notes as the chart.
- In most of the records for patients receiving end of life care, we saw that ceilings of care were identified and documented. In one set of notes the ceiling of care was not documented however it was documented that the patient was not for escalation above ward level and not for admission to HDU/ICU.
- We saw that risk assessment tools had been completed in the records we reviewed. This included venous thromboembolism (VTE), falls, pressure area, malnutrition, moving and handling and IPC. When a patient was identified as at risk, we saw that a care plan was created.
- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw that the trust had a safety alert management flowchart. We also saw details of safety alerts displayed on some of the wards we visited.

Nursing staffing

- There were nine (6.5 whole time equivalents - wte) clinical nurse specialists and a multi-disciplinary team coordinator (0.7wte) in the SPCT.
- There were no vacancies at the time of our inspection and there had been no bank or agency use between June 2015 and May 2016. Sickness levels within the team were predominantly low, the average being 3% between June 2015 and May 2016. There was no sickness for seven of the previous 12 months. This meant there was continuity in the service that helped to keep patients safe.
- The SPCT nurses were available Monday to Friday 08:00 -18:00. Out of hours, staff could contact the local hospice for advice.

End of life care

- The hospice was also able to contact the regional on call consultant in palliative medicine for further specialist advice if required.

Medical staffing

- The trust employed four end of life care consultants (3.6 wte). The hospital had 1202 general, acute and critical care beds therefore this number was less than the national commissioning guidance for specialist palliative care which was one doctor per 250 hospital beds.
- The consultants worked across the trust and a local hospice.
- There had been no locum medical cover between June 2015 and May 2016. Sickness levels within the team were low. There was no sickness in the medical team in the previous 12 months except for November 2015 when sickness was 1.5%.

Other staffing

- The trust employed six chaplains; three were part time and three full time. In addition to this, there were 26 chaplaincy volunteers
- The mortuary was staffed by eight members of staff; six qualified anatomical pathology technologists (APT's), including the mortuary manager and mortuary supervisor, a trainee and a mortuary apprentice.

Major incident awareness and training

- NHS providers have a statutory obligation to ensure they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. We saw the trusts emergency preparedness, resilience and response (EPRR) business continuity plan 2015/16. This showed evidence of testing for staff available to respond with 30 minutes in the event of a major incident.
- Staff completed major incident training as part of the induction at the trust. A 100% of the SPCT, bereavement, mortuary and chaplaincy staff had completed this training.

Are end of life care services effective?

Good

In 2014 we rated effective as 'Good'. At the 2016 inspection the rating was 'Good' because:

- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patients were prescribed and administered pain relief in a timely manner.
- Information about people's care and treatment, and their outcomes, were routinely collected and monitored. This information was used to improve care.
- Staff providing care at the end of life were highly skilled and competent.
- There was evidence of multi-disciplinary working across all teams and also evidence of collaborative working with other providers and the local authority. Referral processes were straightforward and staff did not raise any concerns about these.
- The trust had recently employed more resources to provide seven-day specialist palliative care nursing availability. This was planned to be implemented from September 2016.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However,

- Although patients were assessed for risk of malnutrition, food and fluid charts were not always completed in line with policy. This meant that patients might not always receive appropriate support with food and fluids.
- The trust did not provide face-to-face access to specialist palliative care for at least the hours 9 am to 5 pm, Monday to Sunday and did not have any end of life care facilitators

Evidence-based care and treatment

- We saw that trust polices relating to care at the end of life had been developed based on national guidance such as that recommended by the National Institute for Health & Clinical Excellence (NICE).

End of life care

- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the trust had developed guidelines for end of life care. Staff did not use a pathway but used the guidelines to develop an individualised plan of care for patients receiving end of life care. This was called the guidance for the management of the dying patient.
- The specialist palliative care nurses we spoke with told us that the guidance was based on the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. The new approach focussed on giving compassionate care and to move away from processes and protocols. It recognised that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life and should be an integral part of personalised and proactive care.
- Information provided by the trust indicated that the SPCT managed patients on their caseload according to national and local guidelines as appropriate. Examples of these were the rapid discharge policy, the syringe driver policy, the Yorkshire and Humber palliative and end of life care groups: a brief guide to symptom management in palliative care, the DNACPR policy, NICE guidelines on opioids in palliative care, NICE guidelines on neuropathic pain and NICE guidelines on care of dying adults in the last days of life.

Pain relief

- We saw the results of an audit of the care records of 44 patients at the end of life, which was undertaken by the SPCT in 2015. This showed that 26 (59%) of the patients reviewed had all key drugs prescribed whilst 18 (41%) had some or none of the key drugs prescribed. There were 12 (27%) patients who had a syringe driver in place however, 20 (45%) patients had two or more injections in the previous 24 hours. This would suggest that a syringe driver should have been started or increased.
- We did not see reference to the guidance outlined in the 2015 core standards for pain management services within any of the trust documents that related to pain relief, however in the records we reviewed, where appropriate, we saw without exception, that patients at the end of life were prescribed anticipatory/ just in case medication in line with NICE guidelines. We saw from patients' records that pain levels were assessed regularly and patients we were able to speak with told us that their pain relief was managed effectively and that staff responded quickly when they requested painkillers.
- We observed an end of life care consultant discussing pain control with a patient and suggesting alternative pain relief methods including the use of heat packs, topical applications, unlicensed off-licence products that might have been appropriate and also acupuncture.
- In a trust survey of bereaved relatives, we saw that 100% of those surveyed said that they were satisfied or extremely satisfied with the comfort of their relative.

Nutrition and hydration

- An audit completed by the SPCT in 2015 highlighted a lack of documentation of discussions around nutrition and hydration at the end of life. It also highlighted the lack of documentation around regular mouth care making it difficult to ascertain the level of care given at the end of life to individual patients. This also indicated that the end of life guidance was not always adhered.
- We saw nutrition and hydration assessments in all of the care records we looked at. If patients were assessed as high risk of malnutrition or dehydration food and fluid charts were implemented.
- We saw that some patients were prescribed nutritional supplements and that these had been administered as prescribed.
- During our inspection, we saw staff performing mouth care for patients who were nearing the end of their life.
- Patients we spoke with told us that the quality of the food was good and that water jugs were replenished regularly as well as hot drinks and snacks being provided throughout the day.

Patient outcomes

- We saw an audit that had been undertaken in 2015 by one of the SPCT nurses. This audit highlighted areas of good and poor practice. It showed that the end of life guidance developed and implemented by the trust was not always adhered to. The outcome of this audit was that the end of life care guidance would be reviewed following the publication of the National Care of the Dying Audit in 2014. The team felt that the national audit

would provide further evidence of the care patients at the end of end of life and their relatives had received in the trust and would provide a benchmark of other trusts nationally.
- The End of Life Care Audit – Dying in Hospital 2015, showed the trust scored below the England average for three out of the five clinical key performance indicators however, they achieved five out of the eight organisational quality indicators.
- Wards where care at the end of life was provided contributed to the National Council for Palliative Care Minimum Data Set (MDS). The aims of the MDS are to provide good quality, comprehensive data about hospice and specialist palliative care services on a continuing basis. The data is used to inform service development, management, monitoring and audit. The information is also used for commissioning of services and development of national policy.
- The trust was not a CQC outlier in terms of any cancer related outcome measures.
- The mortuary team completed a full capacity audit each day.
- The trust did not participate in the gold standards framework.

Competent staff

- At the time of our inspection appraisal rates for the SPCT were 62.5%. In six of the previous 12 months, compliance with appraisals had been 100%. This had dropped due to sickness and newly recruited members of staff joining the team.
- Appraisal rates for the medical team were predominantly 100% between June 2015 and May 2016 however, this had dropped to 75% in September 2015 and May 2016.
- At the time of our inspection, the appraisal rates for the mortuary team were 87.5% and 100% for the bereavement team.
- Appraisals for the chaplaincy team were 83.3%.
- Information provided by the trust showed that the SPCT nurses had all achieved postgraduate qualifications in palliative care at English National Board, diploma, degree or masters levels.
- All of the medical team had trained as a Specialist Registrars in Palliative Medicine before joining the trust as consultants.
- A member of staff who had recently joined the SPCT told us that they thought that all of the specialist palliative care nurses had excellent communication skills and we witnessed this whilst observing the team providing care and support to patients and their families.
- We were told that most wards had a palliative care link nurse. Twice yearly seminars were held for these staff and the SPCT nurses told us that these sessions were well attended.
- All staff in the mortuary were competent at corneal retrieval for organ donation purposes. A report by the HTA in September 2015 deemed that the mortuary staff had worked at the establishment for a number of years and were motivated and experienced in their roles. They were well trained and had worked towards developing robust mortuary procedures.

Multidisciplinary (MDT) working

- The SPCT held an MDT each week on a Wednesday morning. This was held in the Queens Centre at Castle Hill Hospital. SPCT medical and nursing staff attended in person and attendance was recorded by signing a register. A member of the chaplaincy team also attended the meeting. The MDT co-ordinator collated attendance data.
- All new referrals to the service (both in-patient and outpatient) and ongoing complex patients were discussed at the MDT. The list was compiled by the MDT co-ordinator in conjunction with the team from the current caseload as documented on the electronic care record system. In April 2016, the team updated the MDT proforma to ensure that the recommendations of the NICE Guidelines on Care of dying adults in the last days of life, was included.
- In addition to the weekly MDT, the nursing staff from the SPCT also held a daily board round.
- The SPCT also had close working relationships across all wards and departments where care at the end of life was provided and also the local hospice.
- In addition to this, we also saw that staff attended the end of life discharge facilitation and patient pathway meeting. This was a multi-disciplinary meeting involving members of the trust team along with other local NHS trusts, the local hospice, local commissioners and the local authority.

- In their report in September 2015, the Human Tissue Authority reported that the mortuary staff had developed good working relationships with staff in other establishments including the coroner's office, visiting pathologists and local funeral directors.
- The chaplaincy service told us that they have multiple contacts within various faith communities including most religions and also secular, humanist and pagan associations.

Seven-day services

- The National Institute for Health & Clinical Excellence (NICE) guidelines state that palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.
- At the time of our inspection, the SPCT operated a five-day service from 08:00 – 18:00, Monday to Friday. New nursing staff had recently been recruited and a seven-day service was due to become operational in September 2016.
- Out of hours, staff could access specialist support from the local hospice, although staff on some wards were not aware this service was available.
- The SPCT provided an in reach service to Hull Royal infirmary and visited the hospital each day Monday to Friday.
- Hospice staff were also able to contact the regional on call consultant in palliative medicine, on behalf of trust staff, for further specialist advice if required.
- The trust chaplaincy team operated a seven-day service with an out of hours call out system in place.
- The mortuary operated a seven-day service including a 24 hour on call system. This included staff being available for relatives who wanted to see their relatives after they had died.
- The trust had seven day services for imaging, pharmacy and therapy services such as occupational and physiotherapists.

Access to information

- Staff on the wards we visited told us that they were able to access palliative and end of life care policies and guidelines on the trust intranet.
- The palliative care team had an intranet site, accessible to all staff electronically where current policies and information re palliative and end of life care could be accessed.
- We also saw palliative care resource folders on some of the wards however; on two wards we visited, some policies within these folders were out of date. This included the 'just in case' prescribing (valid until 2014) and the syringe driver guidance (valid until December 2014). We raised this with either the link nurse or a senior nurse on the wards.
- The SPCT had access to an electronic patient records system that is also widely used by general practitioners in the region. Staff were able to view and share end of life care patient details on the system. However, the SPCT also completed written documentation in the patients paper based care record, which was resulting in duplication of work.
- Staff in the mortuary were able to book appointments electronically with the registrar's office for bereaved relatives. However, most systems within the mortuary were paper based. Staff believed that more electronic systems would be beneficial.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- Patient or next of kin consent to share information was documented in patients care records. We saw this in 100% of the records we reviewed. In addition to this, we witnessed staff seeking consent before providing any care or treatment.
- During our inspection, we looked at eight; do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found all but one of these forms were kept in the front of the patients medical records, which was in line with trust policy.
- Six of the eight forms indicated that the patient lacked capacity. We could not find evidence of a mental capacity assessment in four of the patients' notes;

however, in four of the records we saw that a best interest decision discussion or meeting had taken place involving the patients' family. In one set of notes we looked at for a patient who lacked capacity, we saw that the patients' son had lasting power of attorney, for health and wellbeing. We saw that this was clearly documented.
- In all records, we saw documented evidence that a discussion had taken place with the patient or their relatives.
- 100% of the forms were signed and dated, however a senior clinician had not signed one form.
- This meant that predominantly the completion of DNACPR forms was of a high standard and in line with local policy and national recommendations.
- Staff completed training in consent, MCA and DoLS. Information provided by the trust showed that 79% of staff from the SPCT had completed this training. 100% of mortuary, bereavement and chaplaincy staff were compliant with this training.
- The trust had a mental capacity act, deprivation of liberty safeguards, consent and physical restraint policy and also a resuscitation policy (which incorporated DNACPR guidelines) to support staff.

Are end of life care services caring?

Good

In 2014 we rated caring as 'Good'. At the 2016 inspection the rating was 'Good' because:

- Feedback we received from patients was consistently positive about the way staff treated them.
- We observed a number of staff and patient or carer interactions during our inspection. We observed consistently caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involves them in planning their care.
- One family told us that the staff were 'exceptional' and that they were 'delighted' with the care their family member had received and the support had provided to the family.
- Patients and their families were supported emotionally. All staff were very responsive to the psychological needs, not only of patients but also those close to them.
- We saw an initiative that had been implemented by the bereavement team which we thought was outstanding.

Compassionate care

- We spoke to the relatives of a patient at the end of life who described the care provided as 'exceptional' for both them and their family member. They told us that they were 'delighted' with everything.
- Families and carers told us that staff always responded to any questions they had and always asked 'is there anything we can do for you?' We were told that staff provided tea and coffee at regular intervals without families having to ask.
- We saw ward staff and the SPCT being compassionate and caring to patients and their families. Staff were sensitive to the needs of the patients and their families.
- One family told us that staff had always made sure that their relatives' hair and nails were cared for and that they felt that this was really important to maintain dignity.
- In a 2015 externally collated survey of bereaved relatives, we saw that 100% of people surveyed were satisfied with the way in which the palliative care team respected patients' dignity.
- The trusts own 2015 bereavement survey showed that most (87%) bereaved relatives felt that their relative received a high standard of care. 9% of relatives disagreed with this. 4% did not respond to the question on the survey.
- The bereavement team had implemented an initiative to support bereaved relatives. They had displayed a notice, which said that they were aware that not everyone had the chance to say what they wanted to someone before they died. They provided a supply of cards and envelopes and invited people to write a message to their loved one, which the team then placed with the deceased patient. We felt that this was an area of outstanding practice.

Understanding and involvement of patients and those close to them

- We saw staff involving patients and families in decisions about care and that conversations with relatives were documented in patients care records.
- The trust provided the results of a service evaluation of bereaved relatives by the association for palliative medicine of Great Britain and Ireland (APM), which had been undertaken in August and September 2015. The

results of this were predominantly positive including 80% of relatives being satisfied or extremely satisfied with the availability of the palliative care team and 87% being happy with the way the family was included in treatment and care decisions.
- The trusts own bereavement survey in 2015 showed that 94% of relatives felt that their relative had been treated with dignity and respect at all times and 96% of relatives said that they found the information provided in the trusts bereavement pack useful.

Emotional support

- We saw staff providing emotional support to patients and their relatives during our inspection.
- In an externally collated bereaved relative's survey, conducted in 2015, we saw that 87% of relatives were satisfied or extremely satisfied with the emotional support provided by staff.
- A bereavement support group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- Following a death on a ward, staff completed a deceased transfer form, which was transferred with the patient to the mortuary. Ward staff advised relatives that they should contact the bereavement office. The bereavement office team then dealt with all aspects of care for the bereaved family. This included collecting a patient's belongings from the ward, ensuring death certificates and cremation forms were completed appropriately and in a timely manner and that families received help and support to contact the registrar's office.

Are end of life care services responsive?

Good

At the 2014 inspection we rated responsive as 'Good'. At the 2016 inspection it was rated as 'Good' because:

- Services were planned and delivered in a way that met the needs of the local population.
- All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. This included the mortuary service who were available operated a 24 hour service.
- Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and each patient's choice in relation to their preferred place of care where their care was delivered was achieved for high numbers of patients.
- The facilities and premises were appropriate for the services being delivered.
- We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- There were no complaints about the teams providing specialist end of life care, however when complaints were received about end of life care on generalist wards, senior staff from the Health Group and the SPCT were made aware and contributed to providing a response.

Service planning and delivery to meet the needs of local people

- Care at the end of life care was provided on generalist wards at the hospital, staff were able to refer patients to the SPCT if they needed advice and support to care for any patients with complex needs including symptom management. The team also provided training and education to the staff on the generalist wards and the majority of wards had palliative link nurses.
- Care at the end of life care was also provided in other departments at the hospital including the critical care units and the accident and emergency department that had a dedicated end of life cubicle.
- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families.
- The trust had a 'Preferred Priorities of Care' document which was completed for patients. We saw these in the majority of care records we reviewed. An audit provided by the trust showed that, between January and December 2015, 82% of 205 patients had their preferred place of care recorded in their care records.

Meeting people's individual needs

- The results of a recent trust survey showed that 100% of relatives were satisfied with the information they had been given about how to manage a patient's symptoms. In addition, 100% of relatives indicated that they were

satisfied or extremely satisfied with the palliative care team's response to changes in a patient's care needs and 87% indicated that they were happy with the speed at which symptoms were treated.
- However, within the same survey, only 50% of relatives who responded felt that their relative had enough choice about where they wanted to die however, 27% of relatives did not answer this question. 23% felt that their relatives did not have enough choice about preferred place of death.
- On all wards we visited staff told us that whenever possible end of life care patients would be cared for in a single room.
- The trust provided details of the interpretation/ translation services used. Staff we spoke with knew how to access the services as and when they were needed.
- The trust employed a learning disabilities (LD) liaison nurse who would be made aware of any patients with learning disabilities who were being cared for in the hospital. At the time of our inspection we spoke with the LD liaison nurse; however there were no patients with LD receiving end of life care.
- The trust used a dementia screening assessment and the butterfly scheme. Trust policies such as the dementia and delirium policies were available to support staff to care for these patients.
- Dementia training and education was not part of the trusts statutory or mandatory training. Three members of the SPCT had undertaken training in dementia.
- We observed a patient being moved from a main ward area, to an individual cubicle in one of the trusts critical care units, to maintain dignity at end of life. Experienced members of the nursing team transferred the patient. The relatives of this patient were fully involved in the decision to withdraw treatment and had been spoken to by the consultant responsible for the patient's care.
- In all areas we visited, we were told that relatives and carers of patients at the end of life would be offered open visiting.
- Not all wards had relatives' rooms available; however, there was an en-suite facility on one floor of the hospital.
- The bereavement office included a waiting area, with complimentary tea and coffee facilities. There was also a private room available for the bereavement staff to speak to relatives and carers in private.
- Staff on one ward told us that they would provide relatives with a reclining chair if they wished but that they did not have any folding guest beds; however, staff from this ward were due to meet with the estates team during the week of our inspection and were hoping to turn a room on the ward in to a family room with sleeping facilities.
- Chaplains were also able to conduct funerals on behalf of the trust if requested.

Access and flow

- Staff working on the wards and departments, providing care at the end of life, were able to access specialist support from the SPCT via a referral form. Staff we spoke with told us that the team were very responsive and usually saw the patients within 24 hours or sooner if required.
- During our inspection, we visited a ward with a member of the SPCT. Staff were about to refer two end of life care patients for support and advice. The SPCT nurse saw these patients at the time of the visit to the ward without having received a referral which was exceptionally responsive.
- The SPCT had seen a year on year increase in referrals from 689 in 2010 to 1,386 in 2015.
- The team had also seen a yearly rise in the number of referrals for non-cancer patients from 215 (18.1%) in 2013 to 343 (24.7%).
- In November 2015 and April 2016, snapshot audits of referrals to the SPCT showed that 98% of patients were seen within one working day of referral and 2% within 2 working days.
- The trust employed 5.35 wte chaplains (six people in total). This met the NHS Chaplaincy Guidelines 2015 Promoting Excellence in Pastoral, Spiritual & Religious Care. In addition to this, there were 26 chaplaincy volunteers. The role of this team was to provide religious, pastoral and spiritual care appropriate to the needs of individual patients. Referrals for spiritual care came from:
  - Patients themselves using the chaplaincy team phone number and email.
  - Staff recognising spiritual need in a patient and offering immediate support themselves or referring on to the chaplaincy team.
  - Carers of patients may refer to the chaplaincy service for support.
  - Community groups outside of the trust are able to refer their members for care to the chaplaincy team

End of life care

- The chaplaincy team used an electronic patient flow management software system that enabled them to alert colleagues to spiritual care needs for patients by a flag on the system.
- The trust had developed a 'rapid discharge' pathway to support ward staff to be able to organise a rapid discharge home for patients at the end of life. This was a checklist and aide memoire for staff, giving prompts to ensure they are able to organise care and services in a timely manner. Collaboration was sought with social services and the discharge team to support this and the SPCT also supported and facilitated if required.
- Data provided by the trust showed that 47% of patients were discharged to their preferred place of care on the same day, 35% were discharged the following day and 18% of patients were discharged 48 hours or more after the decision was made.
- The mortuary at the hospital was both a hospital and public mortuary. Senior staff told us that they provided care for 3000 hospital patients and 1000 deaths which had occurred outside the hospital, for example in people's homes or as a result of traffic accidents each year.
- We saw that mortuary capacity was listed as a risk for the mortuary service. Staff we spoke with in the service explained that when some of the elderly care wards had been transferred from Castle Hill Hospital this had increased demand for the service. In order to minimise the risk, staff had developed close working relationships with undertakers and were able, if necessary, to liaise with funeral directors to collect deceased patients. Staff explained that it was possible to transfer deceased patients to the mortuary at Castle Hill but that this option would only be taken with the coroners and families consent.

Learning from complaints and concerns

- There had been no complaints relating to the SPCT, mortuary, bereavement service or chaplaincy teams in the 12 months prior to our inspection.
- Information provided by the trust indicated that there had been two complaints involving patients who had died in the previous 12 months however further data received indicated that, between April 2015 and March 2016, 45 complaints involved a patient death.
- The most common clinical area for complaints involving a death was in oncology with nine complaints (20%). The majority of these complaints related to dissatisfaction over the way a patient was treated prior to their death.
- During our inspection, we discussed complaints with the Clinical Support Health Group senior management team and were told that they would be involved in any complaint that involved a patient at the end of life. We were also told that complaints were analysed for themes within the Health Group and where necessary the senior management team would be involved in the response to the complaint.
- We saw Patient Advice and Liaison service information displayed on the wards we visited.
- Following the death of a patient, the bereavement team offered support to relatives. This included asking relatives if they had any concerns with the care provided on the ward where their relative had died. Patient Advice and Liaison service leaflets were available in the bereavement office reception area and bereavement staff signposted relatives to this service if necessary.
- Staff we spoke to told us that complaints were shared with the team including the learning and actions. We saw this in minutes of team meetings we looked at.

Are end of life care services well-led?

Good

At the 2014 inspection we rated well led as 'Good'. In 2016 the rating was 'Good' because:

- All teams were aware of the trust vision and values. We saw these displayed during our inspection. In addition to this, we saw visions and mission statements for individual teams, for example, the mortuary and bereavement team and the chaplains.
- Whilst there was no trust end of life strategy, at the time of our inspection, the SPCT were working collaboratively with other providers and using the national End of Life Care strategy: New Ambitions document to benchmark and influence the care and treatment they provided to patients.

End of life care

- Robust governance, risk management and quality measurement processes were embedded in the teams and the Health Group. The Health Group had a Quality Governance and an Assurance Committee.
- The Health Group management structure was clear. Staff we spoke with told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board.
- We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- We saw examples of Innovation, improvement and sustainability.

However,

- At the time of our inspection, the trust did not have non-executive director (NED) for end of life care representation at board level.

Vision and strategy for this service

- All staff we spoke with were aware of the trust's vision and values. We saw these displayed in clinical areas. We also saw individual team visions and mission statements displayed.
- We saw the vision for the mortuary and bereavement service displayed in the reception area of the bereavement office. This was to deliver 'Specialist, high quality mortuary facilities and bereavement care'. Staff we spoke with were aware of and based their care around the service vision.
- The chaplaincy mission was to be available for those requiring spiritual care in the broadest sense of the word, to listen and be alongside those who may be experiencing loss, fear, distress or anxiety.
- We requested a copy of the trust strategy for end of life care but were told that the trust did not have a strategy. We were told that this was being developed and this was currently in draft stage. However; the SPCT were working collaboratively with other care providers and completing a gap analysis in relation to the national End of Life Care Strategy: New Ambitions document.
- In addition to this, the team had a specialist palliative care multi-disciplinary team operational policy (2016). This document outlined the aims, objectives and responsibilities of the team.

Governance, risk management and quality measurement

- The SPCT were part of the Clinical Support Health Group. The Health Group had a Quality Governance and Assurance Committee and also held End of Life Steering Group meetings.
- The SPCT produced an annual report, which highlighted any service developments, achievements and risks in terms of quality assurance.
- Operational policy meetings to discuss operational issues and service development within team were also held quarterly. We saw an action plan that had been developed to monitor compliance with the operational policy and service development.
- We saw the risk register for end of life care. There was only one risk highlighted which was in relation to mortuary capacity. Staff we spoke to about this were aware of the risk and could explain why the risk had arisen and the actions taken to mitigate the risk.
- Following an inspection of the mortuary services at the hospital, in September 2015, the Human Tissue Authority (HTA) found that all applicable HTA standards were assessed as fully met.
- The HTA also reported that all aspects of the mortuaries work was supported by ratified documented policies and procedures as part of the overall governance process.

Leadership of service

- The Health Group management structure included a medical director, an operational director, a director of nursing and a clinical director.
- Clinically there was a lead consultant and a lead cancer nurse; however, there was not a lead nurse within the SPCT.
- The trust met the recommendation to have a designated board member with specific responsibility for care of the dying: this was the Chief Medical Officer. There was also a lead clinician who was the Medical Director for the Clinical Support Services Health Group. However; there was not a non-executive director (NED) lead for end of life care on the trust board. We discussed this with the senior management team and were told that the director of nursing was progressing this.

End of life care

- There was a mortuary and bereavement services manager who was deemed by the Human Tissue Authority (HTA) to have a good understanding of the HTA Act and who worked to ensure improvements are implemented as required.
- There was a lead within chaplaincy service.
- All staff we spoke to told us that senior managers were approachable, supportive and visible.

Culture within the service

- We found that staff were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- The end of life care teams, including the SPCT, the mortuary and bereavement teams and the chaplains were described by the senior management team as having a 'unity of purpose', being passionate, pulling in the same direction, being proactive and providing fantastic care.
- We spoke with a newly appointed member of the SPCT who told us that they had been made to feel really welcome in the team.
- The medical and nursing staff from the SPCT told us that they had very good, close working relationships.
- The HTA reported that the mortuary staff have worked at the establishment for a number of years and were motivated and experienced in their roles. They were well trained and had worked towards developing robust mortuary procedures. The team was dedicated to ensuring that the dignity of the deceased was maintained and that relatives visiting the mortuary were treated sensitively.
- We spoke with three members of the chaplaincy team and found them to be warm, friendly and welcoming. Other staff commented that the chaplaincy service were excellent.

Public engagement

- The trust collated bereaved relatives feedback, on an ongoing basis, through the bereavement team and they used this information to improve the service for bereaved relatives by providing feedback to any areas where care fell below expectations.
- A bereavement group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- We found that staff from the SPCT listened to concerns expressed by relatives and were proactive in taking suggestions forward to improve the services provided for patients and those close to them.

Staff engagement

- Staff we spoke with told us that they were supported to professionally develop.
- Staff told us that they felt that communication between the team members and the information received from the trust was good.
- Compliments from patients and other services were discussed at the SPCT meetings.
- New staff told us that they felt supported by the team and a member of staff who had been on long term sick told us that the trust had been supportive.
- The chaplains provided an introduction to their service at the trusts induction for new members of staff. In addition to this, they also held a biennial spirituality day for staff. The aim of this was to raise awareness about staff wellbeing and coping strategies. There also ran spirituality in healthcare, spirituality in loss and spirituality in privacy and dignity sessions twice a year.
- The chaplains had 2700 contacts per year, of these 20% (540) were contacts with staff members.

Innovation, improvement and sustainability

- The SPCT operational policy outlined the responsible key clinicians for service improvement including research, audit, education, information and patient and carer issues.
- The SPCT were working collaboratively with other teams and care providers on initiatives such as:
  - Improving access to hospice care from the acute hospital through cultural transformation and
  - Improving specialist palliative care services to patients with non-malignant diseases through cultural transformation.
- Three of the SPCT nurses had been nominated for the trusts golden heart awards.
- Macmillan Cancer Support had recognised one of the SPCT nurses with a 2014 'Henry Garnett Award'.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) are the main hospital sites for the Hull and East Yorkshire hospitals trust and Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the HRI site. The trust also has several off-site locations delivering outpatient and diagnostic imaging services.

Between January 2015 and December 2015 there were 641,018 outpatient attendances for first and follow up appointments at the trust overall, including the off-site locations. In addition to appointments at the HRI and CHH sites, the trust ran outpatient clinics at the East Riding Community Hospital (ERCH), Westbourne NHS Centre and Bransholme Health Centre. In 2015, 5.3% of the trust's total appointments were at these locations, with 4% (27,984) at ERCH, 0.6% at Westbourne NHS Centre (4592) and 0.3% at Bransholme Health Centre (2547). We visited Westbourne NHS centre as part of this visit, but not the other two off-site locations.

Between May 2015 and April 2016, there were 704,483 attendances at the HRI and CHH sites; 404,580 (57%) of these were at the HRI site. The highest number of attendances at HRI was in ophthalmology, with 59,604 attendances during this12-month period.

Services at the trust were split into four Health Groups: medicine, surgery, family and women's health and clinical support services. Outpatient services were provided in each of the four Health Groups. Diagnostic imaging and pathology services were in the Clinical Support Services (CSS) Health Group.

During the inspection, we visited the following outpatient departments, clinics, and areas:-

- Ophthalmology
- Eye clinic
- Eye hospital
- Fluorescein angiography testing area
- Gynaecology outpatients
- Surgical outpatients
- Plastics outpatients
- Medical outpatients
- Audiology/ear nose and throat
- Neurology

We also visited all of the radiology areas, including nuclear medicine, the appointments and referral centre and histopathology.

From April 2015 to March 2016, the total number of investigations in all radiology modalities was 410,341. This was an increase of 13,172 compared to 2014/2015 and represented a 3.3% increase in demand.

Radiology at HRI had three general x-ray rooms, a CT (computerised tomography) scanner room and an ultrasound room on the ground floor of the main building adjacent to the accident and emergency department and fracture clinic. Radiology had three general x-ray rooms on the second floor. There was a PACS (picture archiving and communication system) reporting room on the second floor and a hot reporting room on the ground floor. There was an x-ray room on the first floor of the main building to support the Orthopaedic Outpatient Department (OPD). Rooms on the second floor supported inpatient, Outpatient

Outpatients and diagnostic imaging

and general practice (GP) patients. The radiology day unit had a shared waiting area with ultrasound and ultrasound had three rooms. The majority of GP radiology work was done at the CHH and community sites.

The MRI (magnetic resonance imaging) department was in a separate building and had three MRI scanners. Nuclear medicine was in the main building but was managed separately, within the clinical support services (CSS) Health Group.

We spoke with 45 members of staff in outpatients, radiology and pathology, including managers, nurses, radiographers, medical staff and administration staff. We also spoke with six patients. We reviewed paper and electronic patient records in outpatients and radiology and looked at other records such as audits, meeting minutes, policies and procedures. We also reviewed the systems for managing the departments including quality and performance information.

When we inspected this service in May 2015, the service was rated as good overall.

Summary of findings

At the inspection in 2015 we rated outpatients and diagnostic imaging services as 'Good' overall. The effective domain was inspected but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the services overall as 'Requires improvement' because.

- The trust was not meeting the national referral to treatment (RTT) standards for incomplete pathways. This meant patients were not always able to access outpatient services when they needed to. There were appointment backlogs and waiting lists in the majority of outpatient specialties, which totalled over 30,000 patient episodes at the time of the inspection.
- A cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery since the 2015 inspection and a previous never event in March 2015.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies in some outpatient specialties, and in radiology, there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.

Outpatients and diagnostic imaging

- The facilities and premises used to deliver services were of variable quality. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair.
- We found there was a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.
- There was inconsistency in the governance and management oversight in outpatients due to the clinics being split across the four Health Groups. The trust had recognised this and it was being addressed with a weekly Performance and Access (PandA) group, which reviewed all waiting lists, by speciality and an 'outpatient transformation project', which was running behind schedule. This project was to improve clinic utilisation, bookings processes and performance against national standards. We were also told that an overarching management post was to be developed.

However,

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway. Standard operating procedures and clinical validation had been agreed in early June 2016 and was ongoing at the time of the inspection. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action.
- At the last inspection, patients undergoing hysteroscopy within gynaecology outpatients were not completing consent forms. We found these patients were now completing consent forms as required.
- Outpatients and radiology had increased their capacity by running clinics out of hours and at the weekends, to cope with the increased demand and make sure patients had their appointments in a timely manner.

- Staff providing care and treatment to people in outpatients and radiology were very caring. Patients gave positive feedback about the care they received, and staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing deficiencies or those who needed an interpreter.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching outpatients risk register which meant there was a lack of cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- The trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

In 2015, we rated outpatients and diagnostic imaging services at HRI as 'Good' for safe. In 2016 we rated the safety of this service as 'Requires improvement' because:

- A cluster of eight serious incidents had been declared in outpatients across the trust, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- Some improvements had been made to the vascular dressings room in the surgical department, however these were not completed and the room was still not suitable for the purpose for which it was being used.
- There was variation in practice in the use of surgical safety checklists between outpatient specialties carrying out day surgery.
- There had been some improvements in the number of histopathologist and echo cardiographer vacancies since the last inspection, but there were still a number of vacant positions to fill.
- Staff vacancies in and across outpatient specialties were variable; there were regular unfilled duties for nursing and unregistered staff in ophthalmology, maxillofacial, medical outpatients and general surgery. In radiology, there were five vacant consultant radiologist posts out of an establishment of 33 and a high proportion of radiographer vacancies in general x-ray.

However,

- The majority of staff we spoke with knew how to report incidents and about learning lessons from incidents.
- Medicines were managed safely and kept securely, most departments had enough equipment to provide the safe care and treatment patients required and infection control practices were good.
- The trust had responded effectively to a serious incident reported within Radiology in December 2015 related to a failure to print 50,000 radiology reports. A further four serious incidents regarding specific patients had been reported relating to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- Staff were well supported for training, and the services were meeting the trust target of 85%. Mandatory training included safeguarding, infection control, information governance and major incidents.

Incidents

Outpatients

- The majority of staff we spoke with knew how to report incidents and about learning lessons from incidents. This was cascaded by email and, in some areas; the manager informed staff directly and/or left information in staff rest areas. The trust produced a monthly bulletin which included information and learning from incidents and never events.
- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 13 incidents reported in surgical outpatients and 18 in medical outpatients. No data was submitted for the other outpatient specialties.
- Staff in outpatient departments used Datix to report incidents. The band 7 sister in surgical outpatients, told us there were not many incidents reported within outpatients; incidents usually involved waiting times or cancelled clinics.
- The sister in surgical outpatients said a significant proportion of incidents reported were around patients becoming agitated and aggressive towards staff if their appointment was delayed. A zero tolerance initiative had been introduced due to a relatively recent 'spike' in these types of incidents; this included posters, leaflets and specific staff teaching sessions. This demonstrated a positive approach by the trust.
- In April 2016, a cluster of eight serious incidents had been declared in Outpatients, relating to patients that

had been lost to follow up and/or delays in diagnosis. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

- We found patients and their relatives had been contacted following the serious incidents and the requirements for the duty of candour had been followed in the majority. However, some patients and families had not been contacted about their serious incident investigations. These included patients with Alzheimer's disease and a patient who was admitted urgently to the intensive care unit.
- Representatives of the Outpatient management team told us outpatients had a duty of candour register. The medical director for the Family and Women's Health Group told us that patients who had suffered harm were always made aware and asked whether they wanted to see the investigation reports.
- When we reviewed the serious incident reports, we saw the panels discussed the duty of candour requirements and nominated a person who would be responsible for patient liaison.
- The medical director of the Family and Women's Health Group told us there had been a serious incident where the patient had been injected in the wrong eye. They said the procedure had been carried out by a locum.
- No 'never events' had been recorded by outpatient services. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Following never events in other areas of the trust, the trust had produced a training video and was in the process of delivering it to staff. Senior staff had undertaken 'human factors' training.
- However, we found a lack of awareness when discussing with outpatient staff the lessons learnt from the never events. Some staff could not tell us about the never events that had occurred at the trust.

Diagnostic Imaging

- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 160 incidents reported in radiology at the HRI site. Eight of these had been categorised as severity level 3 (moderate) or 4 (major) and one was categorised as 5 (catastrophic).
- A serious incident (SI) relating to the failure to print radiology reports had been reported in December 2015. The incident was detected when a consultant neurologist questioned why some radiology reports were taking so long to be sent to them.
- A root cause analysis investigation identified that the problem had been an issue for some time, with up to 50,000 radiology reports not being printed in the 12 months prior to the issue being identified. In addition to delayed printing, there were a high proportion of reports that had not been printed at all. For example, in the three months from June 2015, 20% of reports did not print. A sample from 2012 showed 4% of reports did not print at that time. However, all the reports were available electronically to anyone with authorised access to the systems and not all reports were routinely printed, the largest group being for ED patients where reports were read electronically.
- As a result of the incident the system had been changed so that all radiology reports were sent electronically both within the trust and to primary care and there was a mechanism in place which automatically monitored the opening of the reports and if action had been taken. Any exceptions were routinely reported and escalated to the medical director if required.
- Overall, seven SIs had been reported relating in radiology; four of which related to the printing issue and these were tracked with the commissioners at the monthly SI panel meeting to identify any more as they arose.
- Further investigation of the seven radiology SIs showed three were categorised as major, three as moderate and one as high. All seven patients involved experienced significant delays in diagnosis and/or treatment, which caused distress.
- Two never events had been declared in radiology since the last inspection, both involved wrong site / side surgery. Both never events occurred at the CHH site. The first occurred in October 2015 and the second in March 2016. There had also been a third never event, in March 2015, which had not been investigated at the time of the previous inspection.

- The two radiology clinical directors had made presentations to the trust's Quality Committee about the SIs and never events on 23 June 2016, entitled:
- Learning from recent radiology SI's
- Never Events in Radiology 2014/15 and 2015/16
- Staff told us that, following the two never events, all patients for interventional procedures had their skin marked, apart from a small number of exceptions. A new radiology checklist had been developed by the radiologists after the second never event occurred. This was because the form developed after the first never event was found to be too complicated; with 33 boxes and 55 questions for staff to complete. However, from reviewing this new radiology checklist we were not assured that it addressed the issue of a wrong site procedure being carried out.
- Radiology managers told us the radiology safety checklist was currently kept in the patient notes and was not scanned into the radiology information system (RIS). They said when the RIS was replaced, in November 2016, the forms would be scanned in. This meant it was currently difficult to audit the completion of these checklists.
- In nuclear medicine, staff told us incident reports went to the radiation protection supervisor (RPS) immediately. The RPS told us the originator would get feedback about the incident outcome.
- Radiology managers told us they monitored trends of incidents. They said the main incident type reported was extravasation incidents; however, these were lower than the national averages. Extravasation is when fluid leaks into the tissue, usually surrounding an injection site. The degree of injury experienced is variable.
- The number of radiation incidents requiring notification to external regulators was low. We reviewed the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) notifications from January 2015 to June 2016; there had been seven incidents notified in this period.

Cleanliness, infection control and hygiene

Outpatients

- The environment in most of the outpatient areas we visited was visibly clean, tidy and uncluttered. Surfaces and flooring were intact which aided effective cleaning. However, in audiology and surgical outpatient clinics we found environmental improvements, such as improved soundproofing (in audiology), were required.
- Cleaning staff followed cleaning schedules. For example, there were comprehensive cleaning checklists in all the ophthalmology clinical treatment rooms. We saw these were all completed as required and up to date.
- Alcohol hand rub was easily accessible within the departments and we observed staff and patients use it appropriately. We saw staff and patients had good access to hand washing facilities.
- We saw the processes for carrying out and recording cleaning of equipment each day were infection control compliant. For example, in audiology, we saw staff used ultra-wave cleaning for ear moulds.
- Mandatory training records submitted by the trust showed the majority of staff groups were up-to-date with infection-control training and were achieving the trust target of 85%.

Diagnostic Imaging

- All of the areas visited with visibly clean and there were effective systems and processes in place to reduce the risk of spread of infection. People were cared for in a clean hygienic environment.
- We saw there were hand gel dispensers available. Staff had access to appropriate personal protective equipment, such as gloves, and cleaning products.
- We saw appropriate handwashing notices in place, waste was segregated appropriately and flooring complied with current guidance for flooring in healthcare facilities.
- However, curtains in the recovery area of the interventional radiology day unit did not have the date when they had last been changed. Staff were unable to tell us when they were last changed or what the system was for replacing curtains. The sister said they thought it was, "About every six months." They said they might be changing to disposable curtains in this area.
- The radiology manager told us there was an electronic cleaning checklist used to record cleaning, however we were not shown evidence of this. We did observe cleaning checklists on each noticeboard in the general x-ray rooms, these were all completed and signed morning and afternoon.
- Mandatory training records showed the majority of radiology staff were up-to-date with infection-control

training, apart from administration and clerical staff whose percentage compliance was 45%. Medical staff compliance was 94%. This was against the trust target of 85% compliance.

Environment and equipment

Outpatients

- The environment of most of the outpatient areas visited was in good state of repair, clean and comfortable.
- The surgical outpatients' preparation room was in the process of being upgraded. At the previous inspection, the preparation room was not in an appropriate condition. During this inspection, steps had been taken to improve the environment of the room but it was only partly completed. Patients were still using the room, mainly for being weighed. At the previous inspection, this room had a sluice hopper and sink; these had been removed. However, wall plastering was exposed and there were many visible screw holes. This meant the room still was not an ideal environment for seeing patients in.
- The plastics outpatient department had three consulting rooms; the general environment of each of the rooms was sufficiently comfortable. However, the main desks in the rooms were dated; they were old tables with scratched and worn wooden tops.
- Staff reported there had been some investment in improving patient environments, after a long period of any requests being denied. For example, water fountains had been installed in outpatient waiting areas.
- In ophthalmology, we visited the ward and the outpatient department within the Eye Hospital; we found all areas in a good state of repair with large, light waiting areas. Equipment within the treatment rooms was appropriate, for example there were reclining chairs, ophthalmology equipment and vision test screens.
- The ophthalmology clinical treatment rooms all contained specific equipment checklists; we saw these were all completed as required and up to date.
- Ophthalmology staff told us equipment was managed and tested by the medical physics department, who kept track of service contracts. Breakdown of equipment was on the ophthalmology risk register.
- In ophthalmology, we reviewed comprehensive equipment management and medical estates records in the outpatient department within the Eye Hospital. We saw these documented the equipment number, location, manufacturer, model number, service and repair dates, and calibration dates. All records were up-to-date and included separate records for laser equipment and certificates of instrument accuracy.
- When we visited the gynaecology outpatient clinic, we found problems with the endoscopy scope cleaner; staff told us this machine broke down regularly. They said this had been a problem for about six weeks. They said they were only allowed six flexible scopes for each clinic but there were usually eight patients at each clinic. They said flexible scopes were much more comfortable for patients.
- They explained flexible scopes were sent off site and had not come back yet. If flexible scopes were not available, rigid theatre scopes had to be used.

Diagnostic Imaging

- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The radiology manager told us the department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out. A new CT scanner had been installed two weeks prior to the inspection.
- Staff in general x-ray told us the department had three DR mobiles and a DR machine in orthopaedics. They told us the department, "Does well with equipment replacement."
- A mobile MRI scanner (in a van) was in use when we inspected. The radiology manager explained this was because one of the department's three MRI scanners was not working.
- Appropriate personal protective equipment was available for staff to use in radiology. We observed radiology staff wearing specialised personal protective aprons; these were available for use within all radiation areas. Staff were also seen wearing personal radiation dose monitors; these were monitored in accordance with the relevant legislation.
- The nurses in interventional radiology regularly audited the condition of the bed and trolleys; staff told us if these were unsuitable, they were condemned.

- When we visited the nuclear medicine department in the main building we found the facilities were old and in need of updating. The radiation protection supervisors in this area told us working in this was a problem, as they shared facilities with cardiology.

Pathology

- The laboratory manager in histopathology told us their digital scanner was about to go live. A digital scanner creates a virtual or digital image of histological slides and provides a digital image for scientific analysis.

Medicines

- People were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines.
- Medicines storage and management was checked in all the outpatient and radiology departments visited. We found medicines stored securely and staff recorded fridge temperatures regularly as required. We saw historic written evidence, which demonstrated staff checked medicines fridges on a daily basis and temperatures were all within expected ranges.
- Room temperatures where medicines were stored were not monitored but we found air conditioning units were in use and the rooms felt cool.
- Controlled drugs were stored securely and recorded in the controlled drugs book. We reviewed the controlled drugs records in the outpatient department within the Eye Hospital and found these to be all correct, including historical records.
- Any auxiliary staff administering eye drops in the eye hospital followed the consultant prescription pathway. Some of the specialist nurses in ophthalmology had patient group directives in place for administering medicines, injections or drops.

Records

Outpatients

- People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate patient records were not always available.
- We observed patient notes were stored securely and away from areas accessible by patients. All of the patient notes we reviewed in outpatients were paper-based.
- However, staff in outpatient clinics reported to us, and we observed patients' notes were not always available. For example, we found 20-24% of notes were missing for medical retinal clinics in ophthalmology.
- If staff were unable to find a set of notes, this would be escalated and, following a second review by the supervisor, outpatient clinics would start a temporary set of notes for the clinician to record the consultation. These were taken to the clinic with an explanation of why originals could not be found.
- Following the implementation of a new computer system, staff no longer had to print off clinical correspondence, referral letters or results, as these could be viewed electronically. At the end of the consultation, the temporary" notes would go back to the medical records department to be reconciled with the originals. If medical records staff were unable to find the originals, then the "temp notes" would be made into an acute set of notes and an explanation would be added to the notes.
- In ophthalmology the intravitreal (injection) and emergency service used 'virtual notes'. Virtual patient records (VPR) help to reduce paper and streamline processes. Staff told us VPRs were used in order to get information back to the GPs in a timely manner. Staff said the system also reduced errors due to incorrect filing.

Diagnostic Imaging

- The radiology information system (RIS) was due to be replaced in November 2016. This would enable checklists and forms to be scanned into the patients' records.
- Radiology stored and viewed images on the departmental PACS (picture archiving and communication system).
- We found the records in nuclear medicine were well documented and evidenced on the departmental computer system.
- The radiology department had recently implemented an electronic reporting system. The radiology manager told us the majority of users, including GPs, received their results electronically.

Safeguarding

Outpatients

Outpatients and diagnostic imaging

- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology and medical outpatients were all up to date with training for vulnerable adults and safeguarding children.
- Most staff groups within these specialties had achieved 100% compliance against the trust target of 85% and dermatology was 100% compliant in all staff groups. Compliance rates for medical and dental staff were lower in some areas but were still meeting the trust targets. In ophthalmology, medical staff achieved 90.3% compliance in vulnerable adult training.
- The trust did not submit disaggregated mandatory training data for other outpatient areas.
- No safeguarding issues were identified during the inspection and staff were aware of their responsibilities and were able to describe what actions they would take they had concerns.

Diagnostic Imaging

- We saw there was a children's waiting area outside the fluoroscopy department. We asked the radiology manager about safeguarding training. They told us staff received mandatory training in safeguarding adults and safeguarding children and this training was all up to date. Radiology mandatory training records submitted confirmed what the manager had told us.

Mandatory training

- Staff received training and development appropriate to their roles and responsibilities.
- Ten mandatory training courses were available for all staff these included infection control, information governance, major incidents and safeguarding.

Outpatients

- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology, ENT, surgical outpatients and medical outpatients were all up to date.
- Senior nursing staff told us all training was done via the trust's HEY247 electronic system.
- In ophthalmology, staff told us on one morning or afternoon a month there were no clinics booked; this was to enable staff to attend training and development meetings.
- Staff in gynaecology outpatients told us mandatory training was done online and staff could check what training was required using the online system.

Diagnostic Imaging

- The radiology manager told us they monitored mandatory training of staff on a monthly basis and that all mandatory training for non-medical staff was up to date. Records submitted by the trust confirmed this.
- Mandatory training records were kept electronically and the radiology manager told us these records were reliable and kept up to date. The clinical leads in each area were responsible for managing training.
- In nuclear medicine, the radiation protection supervisor told us mandatory and statutory training was on a three-year cycle. They told the staff training was all up to date and new staff carried out their training during induction. Training records in nuclear medicine were kept on the computer's Y drive in the Department.
- Staff in general x-ray told us they were given time to do training and managers were supportive. They said some training could be done online out of hours.

Assessing and responding to patient risk

Plastics Outpatients

- We observed a patient being treated under local anaesthetic in the plastics outpatients' theatres. We were unable to observe the initial checks around the patient and documentation but we observed documentation being completed during the minor operation.
- The team was using a safety checklist but we noted the entire form had been completed before the start of the procedure; this included the final stage of the checklist, which should be completed after the procedure and just before the patient leaves the operating theatre.
- In addition, two members of the surgical nursing team were supposed to sign the checklist depending on their role during the procedure. Each checklist should have the signature of the 'scrub' nurse and circulating nurse. On the checklist we observed, there was only one signature from one nurse, this was not in-line with trust policy.
- During the procedure, swabs and sharps were used, including a blade, hypodermic needle and sutures. We

observed that staff did not count swabs or sharps prior to or after the procedure. The standard of practice within the outpatient theatre varied to that of the main operating theatres.

Gynaecology Outpatients

- We spoke with the specialist nurse who led on the colposcopy lists. During the colposcopy procedure, vaginal swabs were used on the majority of patients. The swabs were counted by the specialist nurse performing the procedure but the count was not witnessed by a second person.
- No documentation was used to record the number of swabs used or to confirm, between two people, that all swabs were accounted for after completing the procedure. According to a nurse who was present, not completing a witnessed swab count during colposcopy was in line with national practice.

Outpatients

- There were systems and processes in place for assessing and responding to patient risk to keep patients safe. For example, in ophthalmology, we saw there were warning lights outside the three laser treatment rooms and the two injection rooms.
- In the ophthalmology recovery room, there was a large reclining chair for patients to use while recovering from procedures. Staff told us some patients might feel dizzy or have blurred vision.
- Nursing staff in the outpatient department within the Eye Hospital told us the recovery room had been used for patients or visitors when they had collapsed in the department. They said the department's emergency doctor would be called first followed by the accident and emergency crash team if required.
- We checked the resuscitation trolleys in all eight outpatient areas visited. We found appropriate equipment was available and daily checks had been fully completed by staff as required. For example, when we inspected the resuscitation trolley in the plastics outpatient clinic, we saw it was suitably set up and daily checks were carried out as per policy; secure tags were placed on the draws of the trolley after each check to prevent people from removing equipment in non-emergency situations.
- We found a variation in practice between outpatient specialties carrying out day surgery. When we asked the medical director of the Family and Women's Health Group about staff conducting swab counts during surgical procedures, they acknowledged there was variation in practice between outpatient specialties carrying out day surgery. They confirmed ophthalmology carried out swab counts during procedures but some outpatient specialties did not.
- From speaking with staff in different outpatient specialities, some said the reason a swab count was not done was because the surgical incision was non-invasive/very small and a swab could not be lost in such a small cavity. Others confirmed they performed a swab count to ensure no swabs were left in a cavity and/or the theatre environment. A process of counting swabs between two members of staff provides assurance that all swabs are accounted for at the end of each surgical procedure.

Diagnostic Imaging

- The radiology department had three radiation protection advisers (RPAs) and each modality area had named radiation protection supervisors (RPSs). For example, there were four RPSs in interventional radiology. These gave advice on radiation protection when needed to ensure patient safety and minimise radiation risk. We reviewed the risk assessments for radiation protection.
- The RPAs and Radiation Protection Supervisors (RPS) had received appropriate training in line with IR(ME)R guidance. Staff told us the support given by the RPAs and RPSs was excellent.
- All of the staff in radiology had undertaken IR(ME)R training. Training was carried out by radiation physics staff who held the training records. Records of IR(ME)R training viewed during the visit and submitted after the visit confirmed these were all complete as required.
- We spoke with the two radiation protection supervisors (RPS) in nuclear medicine. They told us about the ARSAC (Administration of Radioactive Substances Advisory Committee) licence holder and vetting of referrals. We reviewed the list of people who were competent to vet nuclear medicine referrals. Routine vetting was done following a protocol; anything else was referred to the ARSAC licence holder. We reviewed an example of a referrer's authorisation for vetting and found that it was appropriate.
- WHO safety checklists were being used in both interventional radiology departments. The monthly

audit of their completion was fed back to the multidisciplinary teams. We observed a checklist being filled out in interventional radiology; this was completed correctly.

- We reviewed an audit on the use of the WHO surgical checklist in interventional radiology from November 2015. The results of the audit for the period undertaken demonstrated 93% compliance. The only negative score was a signature missing in two of the 30 checklists audited. This was identified at HRI and fedback to the staff concerned; thereafter there had been 100% compliance.
- In interventional radiology, all procedures, apart from nerve root blocks, had a WHO checklist and the radiology safety checklist. These were completed by staff in the consenting rooms and were checked in theatre by a second nurse before the procedure was carried out. Once in the theatre the whole team checked the radiology checklist as a surgical pause (huddle). The patient was also spoken to during this check, which was led by the nurse.
- We observed notices on display in patient waiting areas, asking patients whether they could be pregnant.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited.
- We observed a 'Pause and Check' notice in one interventional radiology theatre, from the Royal Society of Radiographers. Staff told us use of the pause and check within the rooms was a new initiative following the two recent never events. They said all of the questions were now asked in the room with the whole team and the patient present.
- Contrast media for use in nuclear medicine were securely locked behind a door with a key pad. Staff told us there was a continuous supply of isotopes and we saw evidence of double-checking injections as per the local protocol.
- Radiology equipment had routine quality assurance tests to check radiation exposure levels. Any trends or increases in exposure were reported to the RPS for investigation.
- We checked the resuscitation trolleys in all of the radiology areas visited, the majority of the records of checks performed were complete. The ultrasound department shared a resuscitation trolley with the radiology day unit.
- However, in the CT scanner room opposite the emergency department, we found staff had not completed the resuscitation trolley monthly checks for seven out of the previous 12 months. When we asked the radiology manager who was responsible for carrying out these checks they told us it was the radiographers working in that area. However, when they asked the radiographers they said the resuscitation team also used that trolley and that team was responsible for restocking the trolley This lack of clarity over roles and responsibilities for checking and restocking the trolley in this room meant there was a risk that vital equipment may not be available for a patient when they needed it,
- We observed that the CT scanner room adjacent to the accident and emergency department had the doors wide open onto a public corridor. This meant members of the public could access this room, as it was not kept secure.

Staffing

Outpatients

- Staff told us there were not always enough qualified, skilled and experienced staff in outpatients to meet people's needs. Staff in most of the outpatient departments we visited were very busy.
- Information submitted by the trust following the inspection, showed that between 21 March 2016 and 18th of April 2016 the difference between planned and actual hours for registered staff in ophthalmology was 18% less than planned, in maxillofacial it was 29%, in medical outpatients 43% and in general surgery outpatients 10%.
- For unregistered staff in the same period, the difference between planned and actual was 27% less actual hours in ophthalmology, 52% in maxillofacial, 19% in medical outpatients and 22% in general surgery outpatients.
- Senior nursing staff in ophthalmology told us the service was expanding and recruitment was ongoing. At the time of the inspection, there was 60 WTE staff in the Department these were a mixture of skills and grades. They told us staff numbers were due to increase to 68.6 whole time equivalent (WTE) staff. The medical director of the Family and Women's Health Group told us the staff headcount in ophthalmology outpatients has increased from approximately 14 to 75 over the past 10 years.
- Ophthalmology had six WTE band three ophthalmic support workers and 14.09 WTE band two staff. Senior

nursing staff told us the Eye Hospital had recently recruited to four additional intravitreal nurse practitioner posts. There was a band five clinical liaison officer and a band two assistant clinical liaison officer.

- There were 11.25 WTE qualified nurse practitioners in ophthalmology and they were developing the band six staff to become nurse practitioners. The nurse practitioner role had supplemented medical staff numbers to help address problems meeting the timings required for patients' repeat intravitreal injections.
- They told us two band six nurses would be recruited to work as first assistants in theatres and band two technicians were being advertised for. The department had just recruited three WTE band five staff.
- A new role had been identified in ophthalmology for a data support analyst. Finance to fund this role had recently been approved and recruitment was about to start.
- The sister in ophthalmology told us they felt optimistic about recruitment and staffing in the department. They told us that, on a day-to-day basis, it was difficult to fully staff across the external clinics. This was due to absences including various types of leave and long-term sickness. Sickness in the department was being managed according to the trust policy.
- Ophthalmology did not use any agency staff, gaps in the rotas were covered by their own staff working flexible shifts and additional hours.
- The outpatient department within the Eye Hospital had recently recruited to four additional Intravitreal Nurse Practitioner posts staff told us this would enable 12 additional injection lists to run each week.
- In the gynaecology clinic, we found staffing levels had been reduced; staff were very busy and told us the work was stressful. However, they said staff could claim overtime and all staff did overtime if it was needed.
- Staff in audiology told us they were currently short of staff, due to three staff leaving. One audiologist assistant was due to start in August 2016, and a band five post was being advertised.
- Senior nursing staff in general medical outpatients told us their staffing was up to establishment. They had identified additional money for 16 hours a week for a qualified nurse. The sister felt staffing levels were safe, long-term sickness was covered internally and no agency or bank staff were used.
- At the time of the inspection, surgical outpatients had two band seven sisters. One of the band seven sisters was retiring imminently and a band six nursing post was being advertised to fill the band seven gap.
- Due to the recent (1st June 2016) restructure between plastics (moved to the Family and Women's Health Group) and surgery, staffing was under review. The band seven sister was awaiting a decision around future staffing numbers under the new structure.
- In surgical outpatients, demand for plastics clinics had increased, particularly over the past year. Despite the increased patient throughput and workload, staffing numbers had remained the same; staff were working to full capacity and described the staffing as 'tight'. Clerical support and room space was also 'tight'.
- No agency nurses were used in surgical outpatients, but an auxiliary bank nurse was used each day. Extra sessions relied on the good will of staff; who claimed overtime or lieu time.
- Outpatients had daily safety huddles, these identified staffing levels and work allocation for the day.

Diagnostic Imaging

- The radiology manager told us radiographers managed by the radiology service also worked in the 'cardiac catheter labs.' However, this service was not managed by radiology.
- The radiology manager told us the trust offered relocation packages for radiographers. There were a significant number of vacancies in radiology at the HRI site at the time of the inspection. For example, in general x-ray there were 9.5 WTE vacancies, out of an establishment of 56 WTE. In CT, there were 3.1 WTE vacancies out of an establishment of 24 WTE, in MRI there were 1.5 vacancies out of an establishment of 19.
- There were no vacancies in interventional radiology or ultrasound at the time of the inspection and no agency staff were used in these areas. Radiology nurse staffing was up to establishment at HRI. Data submitted by the trust following the inspection confirmed what staff had told us.
- The radiology manager said the department had used agency staff but these were not always available.
- The radiation protection supervisors in nuclear medicine told us there were six band five technicians, four band six radiographers and two band seven radiographers covering two sites.

Outpatients and diagnostic imaging

- Radiology supervisors and managers stayed in their own areas and band five radiographers rotated between sites. Some staff in CT and MRI rotated between the HRI and CHH sites.
- Staff in general x-ray told us there were rotas for staff to work extra hours at night and out of hours. This was due to the current staff shortages, they said staff put in their availability and shifts were always covered.
- The radiology managers told us there was low staff turnover and good staff retention in the department.

Pathology

- The histopathology laboratory manager told us they had increased the number of advanced practitioners in the department, they now had three band sevens and the business case had been submitted for a fourth. These staff carried out 55% of the macro dissection in the department. A band 8a specialist scientific lead was also being trained to do reporting.

Medical staffing

Outpatients

- Senior nursing staff and some outpatient specialties told us there were problems with medical staff recruitment, for example, senior nursing staff in ophthalmology told us medical staff were 'stretched.' However, clinics were rarely cancelled and clinics were moved around to accommodate patients.
- In surgical outpatients, the plastics department had a 10-week consultant rota. A registrar and middle grade doctor supported the consultant. No problems were reported in terms of medical cover for plastics outpatient clinics.

Diagnostic Imaging

- There were two vacancies for vascular radiologists and two new consultants in the vascular team. The department was advertising for a musculoskeletal radiologist. There were 4.9 WTE radiologist vacancies out of an establishment of 33 consultant positions. The radiology manager told us there was a national shortage of consultant neuro-radiologists. At the time of the inspection there were two full-time radiology consultants working in neuro-radiology.
- The radiologists had four separate specialist on-call rotas; neuro-radiology was one in five, interventional radiology (non-vascular) was one in four, CT was one in seven and vascular was one in six. This represented a high 'out of hours' commitment for the radiologists. When we asked the clinical directors whether they felt this was sustainable in the long term, they thought it was.
- Two radiologists worked remotely for the service, mainly reporting results.

Pathology

- The histopathology laboratory manager told us there were three vacancies for consultant histopathologists, there had been five vacancies a year ago. This meant there were three vacancies out of the establishment of 13 WTE. They said they had taken on a speciality doctor and once they had passed their 'MRC Path' exam, they would become a substantive consultant. The advanced practitioners in the department were supporting the consultants with macro-dissection.

Major incident awareness and training

- Major incident training was one of the mandatory training courses for all staff at the trust. Data submitted by the trust showed 94.3% staff in the trust had completed this training.
- The radiology department had a major incident policy which staff were aware of.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain is inspected but not rated. We last inspected the effective domain in May 2015. At the 2016 inspection we found: -

- The issues from 2015 around consent in hysteroscopy had been rectified. Consent procedures were observed in ENT and ophthalmology and there was a new consent process in interventional radiology theatres.
- Care and treatment was delivered following national and/or local guidance or best practice.
- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas,

nurse led clinics and expanding use of extended roles. There was high use of advanced practitioners, including in histopathology, specialist nurses and reporting radiographers.
- Services were moving towards seven-day working, many clinics were working extended days and weekends.

However,

- We found issues with document and version control for procedures in radiology. We found uncontrolled paper copies in circulation. This meant there was a risk staff were not following the current procedure.
- The systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the National Institute for Health and Care Excellence (NICE) quality standards relating to frequency and reviews.

Evidence-based care and treatment

Outpatients

- Patients' needs were assessed and their care and treatment was delivered following national and/or local guidance or best practice.
- However, the systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the NICE quality standards relating to frequency and reviews. For example, in gynaecology outpatients, the target wait time for patients with postmenstrual bleed was two weeks. Staff told us these patients needed to be seen urgently and the department was not meeting this target.

Ophthalmology

- In ophthalmology, there was a triage checklist used by staff that showed patients with urgent symptoms were referred appropriately to clinical or medical staff.
- Staff in the bookings centre told us they followed trust policies and procedures for clinic booking. Staff had desktop guidance for each specialty, which covered access plans, timeframes and clinics.
- Nursing staff in the outpatient department within the Eye Hospital told us they had been auditing their OCT (optical coherence tomography) images since August 2014. They said this audit was ongoing and linked with glaucoma monitoring clinics.
- Audiology staff told us they were meeting the key performance indicators (KPIs) for hearing screening. For example, 90% of patients had a hearing screen completed within four weeks of raising concerns.

Diagnostic Imaging

- The external July 2015 MPE inspection report for compliance with the Ionising Radiation (Medical Exposure) regulations (IR(ME)R) 2000 in interventional radiology theatres showed good compliance with the regulations and no major areas of concern.
- Internal audits of compliance with radiation regulations showed good compliance.
- Radiology had an approved plan for clinical audit; this was discussed at the monthly radiology management team governance and strategy meeting.
- We found document and version control in radiology required improvement. For example, we found there were no dates on flowcharts and there were no lists of printed copies of documents in circulation in clinical areas, no electronic document control system and no way of knowing whether the document in use was the most up to date version.
- When we looked at the '2016 Radiology Checklist,' which was available in radiology clinical areas, we found there was no date of issue and no review date. The radiology manager told us all departments were using this document.
- We found there was no audit of the completion of the safety checklists at the end of each session / day. An audit of checklist completion had been approved by the trust; however, this was not due to start until August / September 2016.
- An x-ray radiographer told us they had carried out an audit of lead markers. They told us they were going to repeat this audit to see whether there had been an improvement.
- Radiation protection supervisors in interventional radiology told us they had started carrying out radiation protection audits in May 2016.
- There was a comprehensive quality assurance programme for all of the ultrasound machines; these were tested weekly, monthly or annually.
- In ultrasound, there was a peer review audit, which checked 5% of all scans; sonographers audited each other's work. There were also radiology discrepancy meetings and monthly audit meetings in ultrasound.

- The radiology management team told us the results of audits were presented at radiology team meetings. They said reporting radiographers sent out teaching emails to staff telling them about the results of the audits.

Patient outcomes

Outpatients

- Between December 2015 and March 2016 between 82.3% and 91.4% of cancelled outpatient clinics were cancelled within six weeks of the appointment date. The main reasons for cancellation of clinics were not provided by the trust.
- The follow up to new rate was similar to the England average from September 2014 to May 2015, ranging between 2.22 and 2.37 follow-ups per one new appointment.
- The ratio then dropped below the England average, falling to a low of 1.33 in August 2015. This was mainly due to a drop in Castle Hill Hospital's follow up rate.
- The trust had a low (better) follow up to new rate (2.0) between September 2014 and August 2015, compared with other trusts.
- The trust did not provide information relating to the percentage of patients waiting over 30 minutes to see a clinician.

Diagnostic Imaging

- The radiation protection adviser's annual report for 2014 showed patient radiation dose audits had good compliance with the local and national diagnostic reference levels, and had continually improved.
- The radiology manager told us the reporting radiographers carried out the radiation dose audits.

Pathology

- All of the pathology departments at the trust were accredited. The United Kingdom Accreditation Service had inspected histopathology in September 2015; the laboratory manager told us this was a surveillance visit and compliance was maintained.

Competent staff

Outpatients

- Appraisal data submitted by the trust showed the majority of staff groups in the four Health Groups were compliant with the 85% target. However, in medicine all staff groups had compliance rates below 85%. The data did not show figures for staff working in outpatients separately. Staff told us appraisal was done via the trust's HEY247 electronic system. Staff we spoke with all told us their appraisals were up-to-date.
- In ophthalmology, one band two support worker described their four-week induction to us. They told us they had been observed and tested before being signed off as competent to carry out eye tests and administer eye drops to patients.
- In ophthalmology, one band six junior sister spent their time managing the department and training staff in additional skills. Staff told us nurses were given opportunity to develop specific skills. For example, one band six nurse carried out high skill level procedures in glaucoma and a business case had been put forward for her to be upgraded to band seven.
- At the outpatient department within the Eye Hospital, staff told us there were four nurse practitioners with ophthalmic roles; they performed intravitreal injections at the HRI site. There were also nurse led diagnostic clinics such as fluorescein angiography and photodynamic therapy.
- Auxiliary nursing staff at the outpatient department within the Eye Hospital were undergoing training and development. Eleven had achieved NVQ level three, nine were currently working on their care certificate and two were undertaking research training, to support research in the department.

Diagnostic Imaging

- Records were kept of consultant's registration / qualifications and robust systems were in place to record ongoing continuing professional development (CPD) with the Royal College of Radiologists (RCR). This was relevant to each consultant's practice, as part of the appraisal and revalidation process.
- Consultants were required to participate in appraisal annually and submit evidence of CPD to the Trust's database system, where copies of the evidence were stored. These were confidential to the consultant and the responsible officer (and their deputies). There was an automated system of alerts, including reminder letters from the Chief Medical Officer. There was a separate database of satisfactory completion of the RCR CPD.
- Radiology staff received equipment specific training and managers kept separate records for new equipment

used by the radiologists i.e. in the new interventional rooms. Staff we spoke with told us they were trained and competency assessed on all the equipment they needed to use.

- We saw there was a good induction programme for agency staff working in radiology, which covered all departments including nuclear medicine. Cleaning staff working in nuclear medicine were given a certificate following their induction to the department.
- Radiology had a number of extended roles for radiographers for example, one radiographer in MRI specialised in knees. There were also reporting radiographer roles, these included musculoskeletal, abdominal, chest, and CT colonoscopy. Some radiographers did forensic work and the ultrasound service was sonographer led.
- Some radiology nurses working in nuclear medicine had been trained to refer patients attending the prostate clinic for a bone scan. The ARSAC licence holder had signed to allow these staff to make these referrals. We checked the ARSAC licences during the inspection and found these to all be in order.
- A reporting sonographer working in ultrasound told us they had been trained to perform musculoskeletal joint injections.
- The radiology management team told us the president of the Royal Society of Radiographers had visited the department recently and was impressed with the number of extended roles for staff.
- Appraisals were up-to-date in all the radiation departments, including nuclear medicine. The RPS in nuclear medicine told us staff went through their competency framework during the appraisal.
- There was a radiology nuclear medicine e-learning programme, organised by the RPA.
- The radiology manager told us there was a training budget within the department and staff had not been refused any request for training, as long was as it was required for their role. There was a separate training budget for the radiologists and external companies financially supported the department for training.

Multidisciplinary working (MDT)

Outpatients

- Staff in the majority of outpatient clinics visited told us they worked well with other teams. For example, staff in audiology told us they had good contact with local education facilities.
- However, one of the serious incidents declared in outpatients, showed there were communication problems between different MDT meetings. The patient was on two different pathways of care, with no communication between the two teams.

Diagnostic Imaging

- We found good examples of internal and external MDT working in radiology.
- The nurses working in ultrasound told us they worked closely with the nurses in the radiology day unit. They said there was good support from the day-care team for staff in the ultrasound area.
- One support worker in radiology had worked closely with the 'Pioneer Team Academy' to create radiology link nurses on all wards. The aim was to improve communication between radiology and nursing staff, improve the patient experience and reduce lost scanning time. Their executive sponsor was the Chief Executive of the trust. They told us the idea had been well received by nursing staff of various bands, and feedback was, "better than I could have hoped for."
- The radiology clinical directors told us the neuro-radiologist who worked remotely for the department from Scotland regularly visited the Department and attended spinal MDT meetings.
- The radiology management team told us their service was critical to many of the other departments in the hospital. They said they maintained good working relationships

Pathology

- The laboratory manager in histopathology told us the department had set up a formal working relationship with Sheffield NHS foundation trust. They said they were the first two trusts in the country to do this in histopathology. There was an established neuropathology network between the Hull laboratories and Sheffield NHS trust.
- The laboratory manager told us they were about to start using a digital scanner for MDT meetings. This meant

microscope slides could be shared and viewed interactively from anywhere, using the Internet. The lead consultant histopathologist told us the digital scanner would speed up reporting.
- The lead consultant in histopathology told us they generally met their MDT agreements, but not the Royal College of pathology key performance indicator recommendations.

Seven day Services

Outpatients

- Staff in the majority of outpatient clinics we visited, told us they held evening and weekend clinics to keep up with the backlog. When we met with the outpatient management team, they confirmed this.
- For example, ophthalmology outpatient clinics were open from 8.30am to 6pm Monday to Friday and there were clinics every Saturday.

Diagnostic Imaging

- The radiology manager told us the service was unable to further extend the working day or increase capacity across seven days due to the finite number of radiologists and radiology support staff.
- Radiology worked extended days, usually from 8am to 6pm. For example, the CT on level two in the main building was open from 8am to 6pm for inpatients and outpatients. Out of hours there was a 24-hour service in CT, which was staffed by one CT radiographer in the evening and overnight with support workers in the evenings.
- The MRI department was open 12 hours a day, seven days a week.
- The radiology day unit was open from 8am to 6pm and no patients stayed there overnight. Staff told us urgent patients were 'imaged' there out of hours, but did not stay on the unit.
- The radiology management team told us that 'out of hours' neuro intervention provision was currently on the risk register. This was because they were unable to offer a 24-hour seven-day week service.

Pathology

- The histopathology laboratory manager told us the department was looking at moving to extended working days.

Access to information

Outpatients

- Trust data submitted prior to the inspection showed that 1% of patients were seen in outpatients without their full medical record being available. Missing clinical information can result in delays or disruptions to patient care and a potential risk of harm.
- However, we found there was a high proportion of missing notes in the intravitreal service outpatient clinic we observed during the visit. For example, the 28 June 2016 afternoon list had 10 sets of notes missing out of 49 patients due to attend the clinic. This meant 20% of the notes were missing. On the 27 June 2016 (the previous day), there had been 21 sets of notes missing and 87 patients were on the clinic list. This meant 24% of the notes were missing.
- When we asked staff what was being done about this, they told us lists of missing notes were passed on to the clinical performance meetings. Representatives of patient groups and administration/bookings staff attended these. They said the audit of missing notes had resulted in more staff being employed and a new case note system was introduced in June 2015. Staff said they were starting to see improvements as a result of this.

Diagnostic Imaging

- Staff in radiology told us the intranet site was easy to use to access the information they required.
- The radiology management team told us that the radiology information system (RIS) was due to be replaced in November 2016. They said the new system would feed into the electronic patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff with spoke with in outpatients and radiology understood the relevant consent and decision-making requirements of legislation and guidance. Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information submitted by the trust showed overall compliance rates of 87.6% for MCA training and 86.8% for DoLS training.

Outpatients

Outpatients and diagnostic imaging

- Staff in ophthalmology outpatients told us patients for laser treatments were consented separately for each procedure; these were usually patients with diabetic retinopathy.
- We visited the gynaecology outpatients department where there was a regular hysteroscopy and colposcopy list. At the previous inspection we found that consent procedures were not being accurately followed for the hysteroscopy list. At this inspection the issues around consent had been rectified. We reviewed the notes of five patients who had attended a recent hysteroscopy list and consent had been completed accurately.
- Staff told us written and verbal consent was obtained from patients for all minor operations and hysteroscopies in the gynaecology clinic. Completed consent forms were kept in patient notes.
- Staff told us consent forms were not used for colposcopies; they said verbal consent was obtained from the patient for these procedures. When we asked the outpatients' management team about consent for colposcopy, they told us they had reviewed the national information available and found that 90% of trusts carrying out colposcopy did not obtain written consent. They accepted that this was a potential clinical risk.
- In the plastics outpatient department, we noted one patient had signed their consent on the day of the procedure; there was only one patient signature. This did not follow the two-stage consent process. Three copies of the consent form were in the patient's notes; the patient had not been given a copy.
- The patient administration manager in the appointments and referral centre told us they sent patients text message reminders about their appointments. However, patients could choose to opt out of this.

Diagnostic Imaging

- In interventional radiology and fluoroscopy, we observed a patient giving their consent for a procedure. The interventional radiology manager explained that patients were consented when the nurses carried out a nursing pathway assessment.
- A reporting sonographer working in ultrasound told us non-interventional procedures used verbal consent and written consent was used for interventional procedures, such as joint injections.
- A consent audit had been carried out in interventional radiology theatres in March 2016; this showed more than 80% adherence to the trust patient information policy (which covered consent). No actions were required.

Are outpatient and diagnostic imaging services caring?

Good

At the 2015 inspection, we rated the outpatients & diagnostic imaging services as 'Good' for caring. At the 2016 inspection the rating remained 'Good' for caring because:

- Staff treated people with respect, and respected their privacy and dignity.
- Feedback from patients and relatives about the care received was generally good.
- People understood the care and treatment choices available to them and staff gave them appropriate information and support about their care treatment.
- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.
- Staff in the MRI department in radiology told us they used neuro-linguistic programming (NLP) for patients that had claustrophobia. They gave an example of a patient who had previously needed intravenous sedation when having an MRI scan, who could have the scan without sedation after the NLP sessions with staff.

However,

- In some of the radiology waiting areas we observed privacy and dignity issues, however, senior staff were aware of these problems.

Compassionate care

Outpatients

- We observed positive, friendly interactions between staff and patients in all of the areas visited.
- We spoke with six patients during inspection, they were all happy with the service. One patient commented that the staff were "pleasant" and another described three nurses they had seen in the department as, "All brilliant."

Outpatients and diagnostic imaging

- Friends and family test results for outpatients at the trust were good, with 94% of those surveyed saying they would recommend the service. However, response rates over the six months from December 2015 to May 2016 were low, ranging from 2.9% in December 2015 to 5.3 % in April 2016.
- Senior nursing staff in general medical outpatients told us they identified patients who may need additional care while they were waiting for their appointment by using a laminated card, which was put at the front of the notes. This alerted staff to offer refreshments, toileting, alternative seating and pressure area care. Staff we spoke with felt this had been very successful, although it had not been audited.
- In one of the treatment areas we saw staff documented the time they administered drops to patients on a 'patient board. 'We noted that the patients' initials were used, rather than their full name. This respected peoples' privacy.
- All of the outpatient areas we visited had water fountains; some also had refreshment machines and televisions for patients to use.

Diagnostic Imaging

- We found the staff in radiology were excellent; they were very caring. We observed courteous and respectful interactions between staff and patients in all of the areas we visited.

Understanding and involvement of patients and those close to them

Outpatients

- Patients and relatives we spoke with were all happy about the information provided relating to their care and treatment. We observed and staff told us, that staff introduced themselves.
- Staff in ophthalmology outpatients told us patients could choose where they would prefer to wait for their transport home; some preferred to wait in the reception foyer.
- The bookings process appeared to give patients a choice about their preferred hospital site or location.
- However, most of the patients we spoke with, told us their preferences about location or time of appointment had not been taken into account. When we asked the patient administration manager about this, they told us that giving patients a choice of appointments was difficult to manage.

Diagnostic Imaging

- In nuclear medicine, all visitors to the Department were given copies of the local rules and radiation information and advice.
- In fluoroscopy, we observed a patient being prepared for a procedure. Two staff explained procedure to the patient, including the risks and benefits.

Emotional support

- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.

Outpatients

- Staff in ophthalmology told us one member of staff was always available to stay with patients if the clinic was running late, after 6pm. Staff told us no patients would be left unattended and waiting for transport, there would always be a member of staff to accompany them.

Diagnostic Imaging

- We saw there was a counselling room in the interventional radiology department.
- A radiographer in the MRI department in radiology told us they had been trained to use neuro-linguistic programming (NLP) for patients that were claustrophobic about having MRI scans. They related an example of a patient who had previously needed intravenous sedation when having an MRI scan, who could have the scan without sedation after the NLP sessions with staff.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

In May 2015, we rated the responsive domain as 'Requires improvement'. At the 2016 inspection the rating remained as 'Requires improvement' because:

Outpatients and diagnostic imaging

- The trust was not meeting the national referral to treatment (RTT) standards for incomplete pathways. This meant patients were not always able to access outpatient services when they needed to. There were appointment backlogs and waiting lists in the majority of outpatient specialties, which totalled over 30,000 patient episodes at the time of the inspection.
- The appointment booking process was variable across services, specialties and sites. There were capacity and demand problems in the majority of outpatient clinics visited.
- The quality of facilities and premises used to deliver services were variable. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair. For example, staff in audiology told us there had been a flood two years ago and that the damage was still not fixed.

However,

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway. Standard operating procedures and clinical validation had been agreed in early June 2016 and was ongoing at the time of the inspection.
- The histopathology reporting backlog had improved significantly since the last inspection, from 820 twelve months ago to 120 at the time of this inspection.
- There was a telephone triage in ophthalmology by a qualified nurse, which improved the service for patients as it screened out issues that could be dealt with by nursing staff.
- Gastroenterology held evening clinics for 16-18 year olds between 5pm-9pm. This meant they did not have to miss school.
- We found many examples of nurse led clinics and there was an increasing use of nurse practitioners in ophthalmology.
- Feedback from audiology staff was positive; they said they were meeting targets.
- The bookings centre had dedicated staff dealing with cancer referrals and extra 'initiative clinics' were being used to help reduce the backlog. For example, one of the orthopaedic consultants had recently offered five Sunday dates for clinics.
- Staff in neurology clinics offered drinks and pressure area care to their patients if they had mobility problems and a long wait, for example patients with multiple sclerosis.

Service planning and delivery to meet the needs of local people

Outpatients

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway.
- Senior nursing staff in ophthalmology told us follow-up appointments for patients were restricted by the lack of space and lack of doctors to run the clinics. They said a growing elderly population and an increasing demand for services such as macular degeneration exacerbated capacity issues.
- Staff in the booking centre told us outpatients were sent a text reminder one week before their appointments, apart from oncology patients. When we asked the patient administration manager whether the use of text messages had improved the DNA rates, they said they were not aware this had been looked at. However, they said it had increased the cancellation rates but were unsure why.
- The quality of facilities and premises used to deliver services were variable. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair. For example, staff in audiology told us there had been a flood two years ago and that the damage was still not fixed.
- We saw the audiology department's waiting area was located in a corridor near to a mixed specialty reception. We saw there was limited space and the hearing rooms and testing rooms were losing their soundproofing and were visually not appropriate. Curtains had been put up to minimise the glare from the soundproofing, staff told us patients may feel dizzy in this room so they tried not to use it.
- Gastroenterology had introduced a pilot clinic for 16 to 18-year-olds; this ran from 5pm to 9pm and had been

successful. This reduced the time lost in education, as it was after school. Staff told us they were hoping to expand this across other specialties and thus increase the attendance of young adults at clinics.
- Ophthalmology and dermatology ran virtual clinics; this meant patients did not require a face to face consultation at each appointment.
- There was work ongoing as part of the sustainability and transformation plans (STPs) for the larger geographical area with other health and social care partners to address the capacity and demand issues with ophthalmology.

Diagnostic Imaging

- We saw the waiting areas in radiology in the main building were too small for the number of patients using them. We observed chairs on the corridors outside the waiting rooms.
- In the main building, there were no dedicated waiting areas for patients on trolleys or beds and the areas were not easily accessible to wheelchair users.

Access and flow

Outpatients

- Between April 2015 and March 2016, the trust's referral to treatment (RTT) performance was consistently worse than the England average and the national standard for incomplete pathways. The operational standard is that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. The trust was performing clinical validation for patients that had breached the 18-week RTT standard in order to prioritise appointments for those most at risk.
- The trust had an agreed trajectory with the local Clinical Commissioning Groups (CCGs) and NHS Improvement (NHSI) to meet the standard by March 2017. The trust was meeting the current individualised local standard between April and June 2016. The revised trajectory in April 2016 was 84%; the trust achieved 86% and in May 2016 the trajectory was 84.9% and the trust achieved 87%.
- The trust position relating to the RTT and cancer national standards was improving. The improving cancer position meant the majority of cancer targets were being delivered. The RTT trajectory had improved overall for 2015/16 when compared with 2014/15. There were specific challenges in some areas, and a recovery plan had been agreed for 2016/17.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between Q1 2014/2015 and Q4 2015/2016.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since Q3 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in Q1 and Q2 in 2015/2016.
- The 'did not attend' (DNA) rate was mostly higher than the England average between September 2014 and August 2015. The DNA rate ranged between 7.1% and 10.2% at trust level, compared with the England average of between 6.6% and 7.7%.
- The DNA rate at Westbourne NHS Centre was over 10% in all but two of the 12 months between September 2014 and August 2015. In August 2015 it reached 20%. We asked staff about the high DNA rates for the neurology follow-up clinic at Westbourne NHS Centre on Wednesday mornings. None of the staff we asked about this could explain the reason for this.
- On 22 June 2016, there was an outpatient follow-up backlog of 29,968 patients. This was the number of patients on an access plan who were overdue a follow-up. The largest individual specialties follow-up backlogs on this date were: - ophthalmology 8,117, ENT 1,032 and plastic surgery 1,369.
- A further backlog report dated 27 June 2016 showed there were 30,431 patients overdue for their appointments on that date, 6,702 of these were over six months overdue and 2, 898 were 12 months overdue.
- An 'outpatient waiting list backlog report' was run every day. The patient administration manager said these reports helped bookings centre staff know where to focus their work.
- Members of the outpatients' improvement team told us cardiology had a large backlog. Data provided following the inspection showed cardiology had the largest backlog in the Medicine Health Group; 2,092 on 22 June

2016. They said they were looking at ways to reduce the DNAs, cancellations and new to follow-up ratios by increasing activity and slot utilisation. They were also looking at clinic productivity.

- The medical director for the Family and Women's Health Group told us there were long waits for appointments in some specialties, due to a shortfall in capacity. They told us there were problems with the additional slot issues (ASI) list; they told us patients were not meant to be on the ASI list for more than four days but this was not always achieved.
- There was follow up slippage in outpatients or patients with chronic diseases and long-term conditions. In some specialties, there was evidence this had led to patient harm. For example, ophthalmology patients with wet macular degeneration needed regular injections every four weeks. The capacity and demand problems meant these patients were often not seen until between six and eight weeks. Staff and managers told us some patients vision had deteriorated because of this.
- We asked the patient administration manager about booking rules, they told us staff in the appointments and referral centre did not work from booking rules. However, members of the outpatients' improvement team told us different specialties had their own booking rules.
- Staff told us, and we observed long waits in some outpatient clinics, for example, staff told us patients regularly waited for up to two hours in oncology clinics. However, when we visited the audiology department, we saw appointments were running on time.
- The Sister in general medical outpatients told us neurology saw approximately 1,500 patients per week and ran large clinics. Senior nursing staff in general medical outpatients told us they were concerned about the long waiting times for patients in the clinic and when waiting for transport. This included patients with multiple sclerosis and other neurological problems such as motor neurone disease.
- One patient in surgical outpatients told us they were under multiple consultants and they had to travel to different trust locations for the varying outpatient appointments. The patient's appointment was 3pm, running 20 minutes late.
- A second patient told us they had needed to alter their follow-up appointment and the department was accommodating about this. Their appointment was at 3.30pm and they were called in to see the doctor on time.
- Another patient in plastics outpatients told us the clinic they were attending was running 35 minutes late. They said the nurse in the clinic was keeping patients informed.
- The patient administration manager told us they held regular RTT meetings with the business managers in each specialty. They said some business managers were responsible for more than one specialty. They discussed additional slot issues (ASIs) and holding lists, which were lists of patients that there was no appointment slot for.
- They explained some specialties were worse than others; for example, upper gastrointestinal, neurology and paediatrics were worst. In trauma and orthopaedics, some areas were better than others. We asked about the serious incidents, which had been declared in outpatients, they confirmed these had occurred because patients had not had their planned appointments.
- When we asked the patient administration manager why some individual specialties, such as cardiology, booked their own appointments they told us cardio thoracic services and cardiology had always booked their own appointments. However, cardiology staff told us that when the central bookings team had booked their appointments, clinics slots were left unfilled.
- The patient administration manager told us they were looking at centralising appointment bookings for all specialties. They felt this would improve quality and consistency. They said East Riding Community Hospital appointment bookings were done centrally and that worked well.
- In the central bookings centre, we found there were dedicated staff assigned to booking clinics for patients on the cancer two-week wait pathway. They told us they followed the patient through from initial referral to checking the patient had attended their appointment.
- If patients did not attend for their cancer appointment, staff followed a process to contact them and rebook. If the patient did not want to rebook or was not contactable after two phone calls, then staff contacted the initial referrer and informed them.

Outpatients and diagnostic imaging

- Staff in the booking centre told us there were regularly extra clinics, called initiative clinics. They told us one of the orthopaedic consultants had recently offered five Sunday dates for clinics.

Ophthalmology

- Referrals to ophthalmology came from GPs, opticians and accident and emergency. Existing patients could also self-refer.
- Senior nursing staff in ophthalmology told us there were not enough doctors to reduce the waiting list in ophthalmology for follow-up appointments.
- There was a telephone triage service 24 hours a day, seven days a week. This was run by specialist band six nurse during the daytime and doctors on the ward overnight.
- There was a one-stop clinic for patients needing an injection. Staff told us each patient had a full assessment at each appointment in order to monitor any changes
- When we visited ophthalmology, we noted that the medical retinal clinic was running on time on the afternoon we visited; however, staff told us that in the morning that day, it was running between 60 and 90 minutes delayed.
- Staff told us patients appointments were only cancelled 'occasionally'. They said patients would never be cancelled on the day, they would pre-inform the patients.
- The only exception would be laser treatments where treatment would not be safe if case notes were not available.
- Staff told us that if a patient turned up on the wrong day or at the wrong location then they would try to see them if possible.
- In the ophthalmology outpatient clinics, we saw large whiteboards documented any waiting times for appointments. They also informed patients which doctors were on duty. The names of the nurses on duty were also displayed on these boards. The nurse covering that area kept these updated.
- The medical director for the Family and Women's Health Group told us ophthalmology workload had increased by 30%. They said staff were working extended days and Saturdays to cope. They told us there was an ophthalmology business case to increase the footprint of the area available by a third. In addition a business case was being developed to increase the staffing.
- They said patients with wet macular degeneration needed regular injections every four to twelve weeks. They said the department did 9,500 of these injections a year and the waiting time had drifted to between six and eight weeks in 2015. Some patients' vision had deteriorated by the time they were seen, and some had suffered moderate harm. The trust told us they had introduced "Treat and Extend", which meant delays in injection appointments varied between zero and two weeks for urgent treatments. They said ophthalmology services had been opened at the Castle Hill site, because there were a limited number of injection rooms at the HRI site.
- They said patient administration gave real-time feedback monitoring the slippage and the lists were subject to regular scrutiny. However, retinal screening was picking up patients with problems and the department was unable to follow this up with a timely appointment.
- Nursing staff in the outpatient department within the Eye Hospital told us they ran two glaucoma-monitoring clinics each week and had introduced virtual clinics; they said these had reduced the backlog and waiting times.

Diagnostic Imaging

- The operational plan for 2016/2017 showed there had been a 5% annual increase in demand across all of radiology.
- The percentage of patients waiting over six weeks for a diagnostic test was consistently better than (below) the England average between April 2014 and March 2016. We saw the majority of breaches for six-week imaging appointments occurred in MRI; these were due to issues relating to sedation and general anaesthetic and 'cardiac capacity'.
- The radiology management team told us their DNA rates were low and they were keen to implement text message reminders. For example, the DNA rate in ultrasound was 5.6%. They said the DNA rates in paediatric ultrasound were higher and they were investigating the reason for this.
- Information provided by the trust showed that the mobile MRI scanner was used on eight days during March 2016. At the time of the inspection, the mobile MRI scanner was in use full-time in order to reduce breaches in the timeliness of MRI imaging.

- Staff in ultrasound told us their appointments generally ran to time.
- In interventional radiology, patients could be assessed for day case procedures by telephone.
- If plain films were not reported within six days, these were outsourced. This ensured patients got their results in good time.
- The department used two radiologists who reported flexibly and remotely; one in Scotland and one in Portugal.
- The radiology clinical directors told us consultant radiologists could have PACS (picture archiving and communication system) installed at home; this enabled them to do their reporting remotely.
- We asked the radiology clinical directors about reporting backlogs. They told us there had been a backlog of 64,000 plain films a year ago; this had reduced to 8,000 at the beginning of April 2016 and 2,500 on 30 June 2016. The demand for plain film had increased 1% annually.

Pathology

- The histopathology laboratory manager told us the reporting backlog in May 2016 was 773 specimens. On 29 June 2015, 870 cases had not been reported within 28 days and on 30 June 2016, 110 cases had not been reported within 28 days. This showed there had been a significant improvement in the past 12 months. The laboratory manager told us no patients had come to any harm due to delays in reporting results.
- Histopathology had rapid processing for needle core biopsies, the laboratory manager told us these were processed within four hours.
- The histopathology department had a service level agreement with an external company to outsource reporting for routine work. The turnaround time in the tender was for 90% of diagnostic reports to be reported within five days of collection.

Meeting people's individual needs

Outpatients

- In ophthalmology, we saw yellow and black signage, which clearly directed patients with any visual impairment to the correct areas(s). A specialist team carried out eye tests for children, there were also specialist staff caring for and treating patients with dementia, additional needs or communication problems. Staff told us there was always a specialist paediatric qualified nurse on duty.
- We saw there was plenty of room to manoeuvre wheelchairs in the ophthalmology waiting areas. There were four toilets available in the main waiting area, one of which was wheelchair accessible. There were handrails and an emergency alarm in this wheelchair accessible toilet.
- In the ophthalmology orthoptist area, there was a separate waiting area for children with books, toys, small seats and age-appropriate wall prints. This area was separate from the adult waiting areas.
- There were no separate toilets for children in ophthalmology; there were baby-changing facilities in the wheelchair accessible toilet. Audiology was located in a small area but we saw it was able to accommodate patients in wheelchairs.
- However, in surgical outpatients, the doors entering in to the department were not automatic. We observed three people in wheelchairs struggling to open the doors and wheel themselves through at the same time.
- The trust had a dementia strategy but staff training in dementia awareness was not mandatory. Staff in audiology told us they allowed extra appointment time for patients with dementia or learning needs. They said staff in the department had attended dementia awareness training.
- Interpreters were available; if these were required, they were arranged prior to the clinic appointment. Secretaries informed the department if a new patient had any additional needs.
- Staff in the bookings centre told us that, in addition to booking clinics, they booked 'advocacy.' This included additional support for patients with learning needs, hearing deficiencies or needing an interpreter. If face-to-face interpreters were not available, they would check with the clinic to see whether they could use the language line at the patient's appointment.
- Staff transferred inpatients from the main block to the MRI department on trolleys or hospital beds; staff wheeled these across the car park. At the time of the inspection, there were works taking place in the car park areas, and staff transferred patients to the MRI department by ambulance on a temporary basis. The

radiology manager said there were covers available for use by patients on a bed/trolley and there were plans to locate the next MRI scanner to be installed in the main hospital building.
- In ophthalmology, we visited the ward and the outpatient department within the Eye Hospital and found there was no sign at the reception desk asking patients to wait back from the desk to reduce the chance to overhear conversations. Eight patients were queuing to use the reception desk when we visited this small reception area. This meant private conversations between patients and reception staff may be overheard.

Diagnostic Imaging

- In nuclear medicine, the radiation protection supervisors told us staff training in dementia and equality and diversity was not mandatory.
- A reporting sonographer in ultrasound told us patients with learning difficulties or physical difficulties would have a nurse escort. They confirmed dementia training was not compulsory for staff working in the area.
- In the radiology day unit, we saw there was segregation of male and female patients in separate bays.

Learning from complaints and concerns

Outpatients

- Data submitted by the trust showed there were 166 complaints about outpatients in the 12-month period from April 2015 to March 2016; this represented 26% of the 646 complaints received by the trust. Seventy-one (43%) of these related to patient care.
- The highest number of complaints were received by the outpatient fracture clinic (15), followed by elective orthopaedics (10) and ophthalmology (10). Cardiology outpatients had eight complaints and plastics outpatients had six complaints.
- The patient administration manager told us they did not get as many complaints as they would expect. They told us they did not record verbal complaints from patients or relatives.

Diagnostic Imaging

- Radiology had received eight complaints in the same period, two of which related to patient care.

Pathology

- Pathology at Hull Royal infirmary did not receive any complaints this 12-month period.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

When we inspected this service in May 2015, we rated the well led domain as 'Good'. At this inspection, we rated the well-led domain as 'Requires improvement' because:

- The effectiveness of the leadership, governance, culture and support for outpatient services had varied between the four Health Groups and visibility of the leadership was variable. There had been no overarching governance structure or cohesive management oversight in outpatients, but this had recently been addressed and was being developed.
- The trust, for some time, had not been achieving the national indicators for referral to treatment and urgent cancer treatment and current outpatient capacity did not meet the demands on the service. There were appointment backlogs and waiting lists in outpatients, especially in ophthalmology. The trust was working with the local commissioners (CCG and NHSI) to improve this.
- The ongoing backlog position was being monitored and addressed at senior management level; however, staff we spoke with in outpatient clinics were unaware of what was being done to improve the situation. Staff in outpatient clinics were unaware of their own waiting list positions and backlogs.
- There were high numbers of complaints about outpatients. The overarching system for capturing and managing issues and risks within outpatients was under development. This meant that at the time of the inspection there was limited management oversight of incidents, risks, audits, quality and patient safety about outpatients.
- Since the 2015 inspection, outpatients had declared eight serious incidents and radiology had declared seven. There had also been two never events in radiology. There was a lack of assurance that the lessons learnt from some of the serious incidents in both services and never events in radiology had been embedded to ensure no further incidents occurred.

However:

Outpatients and diagnostic imaging

- The trust had a vision and strategy and staff were aware of this.
- Management, leadership and governance were good overall in radiology and pathology. Radiology and pathology had risk registers in place.
- The Clinical Support Services Health Group had operational plans and an outpatient improvement team was working on a two-year plan for the outpatient specialties. There were plans to appoint an outpatient matron or manager.
- The trust was aware of the problems in outpatient services and had plans in place, agreed with commissioners and NHS Improvement to make improvements to achieve the national standards. The lack of an overarching governance structure or management oversight in outpatients had recently started to be addressed by the weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient transformation project' was also in progress, which was running behind schedule. This project aimed to improve clinic utilisation, bookings processes and performance against standards.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching outpatient risk register which did not allow cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- Staff reported positive culture changes at the trust, especially relating to the historical bullying issues. A more positive ethos had led to change in staff morale; staff told us they were well supported by their local line managers and there were positive comments about the new trust board.
- There were good examples of innovation in radiology, ophthalmology and pathology.

Vision and strategy for this service

- The trust had developed its five-year strategy following wide consultation; this was approved at the Trust Board in April 2016.

Outpatients

- We saw the 'HEY Improvement Portfolio' included an outpatient transformation project. The project overview document showed this work had started in August 2015. This was to review the overall outpatient management structure, operational policies and processes.
- When we reviewed the directors report from 25th of April 2016, we saw the project was categorised as 'at risk 'and was currently running four weeks behind schedule. Goals included clearing the outpatient follow-up backlog and improving customer service. Work streams in oncology, cardiology, cardio thoracic and orthopaedics had commenced. The project had an agreed project overview document, rollout schedule and key performance indicators. Weekly performance against the KPIs was being monitored.
- Staff knew about the trust vision and told us there had been staff events related to this. However, some staff told us the events had been publicised at too short notice for staff to attend.
- Representatives of the outpatients' management team told us they felt there was a positive culture change happening within outpatients. For example, services were moving to seven-day working and extended days. Staff were going through consultation at the time of the inspection. Any new staff employed had seven-day working as part of their contract. Many procedures were being done as day cases and non-theatre nurses were carrying out procedures.

Diagnostic Imaging

- The CT and MRI operational plan for 2016/2017 showed services were working towards seven-day working, expanding radiography reporting and expansion of the CT colonography (CTC) service.
- The radiology manager told us radiology was part way through a three to four-year programme of retrofits of all rooms in the main building. Radiology had a clear strategy for equipment replacement; the plan was to have digital radiology (DR) equipment installed across all areas.
- Radiology staff we spoke with knew about the trust vision and values and the radiology equipment replacement programme.

Governance, risk management and quality measurement

Outpatients

- Each of the four Health Groups had a number of outpatient services within it. The Family and Women's Health Group included dermatology ophthalmology, plastic surgery and ENT. The Medicine Health Group included general medicine, cardiology and neurology.

The Surgery Health Group included neurosurgery, head and neck, urology and general surgery. The Clinical Support Health Group included audiology, oncology and clinics for allied health professionals.

- There had been limited overarching governance and management oversight of the outpatient departments. Recent changes were starting to address this including the PandA meetings and the work of a transformation board. There had been variation in the management of and support for outpatient specialities across the Health Groups.
- At the time of the inspection there was oversight of governance at trust level and a project overview document and outpatients' action plan was in place. The aims of which were:
    - To quantify, as a priority, by specialty, the number of patients that had passed their outpatient follow up date;
    - To have a standard approach to validating these patients;
    - To develop trajectories for the reduction and elimination of follow up backlogs and;
    - To clinically review these patients to quantify if any had had experienced harm.
- Some action plan target dates were overdue.
- There were trust-wide performance and access (PandA) meetings every week to review and monitor waiting lists. These meetings were led by the chief operating officer and had started a few weeks before the inspection. We were told these meetings provided assurance and oversight; and that attendance lists and action notes were taken.
- There were significant concerns relating to appointment backlogs and waiting lists in outpatients, especially in ophthalmology, which had not been addressed since the last visit.
- There was an outpatient project steering group, which met every month. We reviewed the notes from February 2016 meeting. We saw agenda items included consultant annual leave, clinic slot utilisation, hospital cancellations and project updates.
- Risks identified within the Health Group risk registers reflected the main areas of concern. These specifically included ophthalmology, dermatology and a composite risk relating to specialties within the Medicine Health Group regarding a number of overdue appointments outstanding in respiratory medicine, endocrinology, diabetes, cardiology, neurology and rheumatology. There was no overarching outpatient risk register.
- There were no overarching outpatient governance or quality meeting minutes submitted and there was no discussion recorded of risks, risk management, governance or quality monitoring at the outpatient project steering group meeting.
- Outpatient managers told us there were regular weekly operational meetings between patient administration, business managers and divisional general managers.
- The trust had introduced a new patient IT system to improve the tracking and monitoring of patients including those who were on waiting lists. Outpatient managers told us there had been many issues with the new IT system, and the transition from the previous computer system and this meant there had been some double counting and cleansing of the data had been required . They said this meant that data collated following the changeover to the new computer system had not always been reliable.

Diagnostic Imaging

- Data provided prior to the inspection showed radiology was aware of the departmental risks and kept up-to-date with compliance against regulations. Their most recent medical physics expert (MPE) and RPA reports were very good, and clearly identified any issues that needed action.
- We saw some evidence of identifying and learning from serious incidents and never events. The two radiology clinical directors had made presentations to the trusts' quality committee about the SIs and never events on 23 June 2016, entitled: 'Learning from recent radiology SI's' and 'Never Events in Radiology 2014/15 and 2015/16'. We saw evidence of actions taken and changes made to practice.
- For example, radiology had undertaken a look-back exercise with the commissioners to check for harm from serious incident relating to the non-printing of reports incident. A new monitoring system alerted staff if radiology reports had not been viewed and/or actioned; this could be escalated to the medical director for action.
- We reviewed the radiology risk register and saw a number of risks related to ageing equipment. The department was well aware of this issue, and had a

rolling equipment replacement programme to replace all the computerised radiology equipment and digitise all of the rooms. There were also issues with the RIS and PACS information systems and plans were in place to replace these.

- The radiology management team told us the department was collaborating with neighbouring trusts in the area to undertake regional insourcing. This is where critical work within the region is assigned using local resources, rather than outsourcing it. This should be more cost effective and helps maintain control.
- Eight trusts were undertaking a joint procurement of a new PACS system. They said they would be able to manage capacity and demand better when the new radiology information system (RIS) was installed.
- Two of the consultant radiologists shared the clinical director role in radiology; one for governance and one for information technology. The radiology manager and section leads in each modality area supported them
- The radiology management team told us there was 'excellent in-house governance' in radiology. For example, in 2015, 2,050 ultrasounds were peer-reviewed and this work had been nationally recognised. They said they were proud of their work and maintaining the safety of patients.
- We reviewed minutes of the radiology management team meetings and radiology governance and strategy meetings for February, March, and April 2016. We saw these discussed serious incident investigations, business cases, workforce planning and departmental risks.
- The trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- The two reporting radiologists who worked remotely for the department visited the department regularly and understood the local discrepancy and governance policies.
- The radiology management team told us the departmental spend on outsourcing reporting was significant. They said they had to balance the finances against the turnaround times for results. They said the trust executive team were supportive and recognised their challenges.

Pathology

- Pathology Governance Committee Meeting minutes showed that the quality systems were discussed and reviewed in these meetings. Agenda items included audits, risk assessments, and corrective and preventive actions (CAPA).

Leadership of service

Outpatients

- There was limited trust-wide overarching operational management of outpatient services and each of the Health Groups offered different levels of management and clinical support. Staff talked of plans to get all outpatient services into one structure, and the appointment of a matron for outpatients. However, we did not see any documentary evidence to confirm this.
- The leadership in the four Health Groups had changed recently. Each of the Health Groups had a medical director, director of nursing, and operations director. These were supported by matrons, apart from the Surgery Health Group, which had a divisional nurse manager.
- There was an outpatients' transformation project board and representatives of each of the Health Groups attended this. This reported to a trust transformation board; weekly performance against key performance indicators was monitored.
- Most staff told us their local managers and matrons were supportive but there was limited contact with their senior managers.
- Staff in surgical outpatients had previously had 'time out' days for the nursing team and senior staff. This helped staff get to know each other better. We were told that this 'time out' no longer took place.
- Staff felt the trust board was introducing positive changes. They reported feeling more supported and there was a feeling of mutual trust. Staff were generally enthusiastic, positive and optimistic.
- Senior nursing staff in ophthalmology told us the executive team had not visited the department recently.

The head of nursing had visited the surgical outpatients unit recently, staff told us this was seen as constructive. However, they commented that senior staff could get to know junior nurses better, and have more visibility.

- Staff in gynaecology outpatients told us the department had recently lost two managers; they said this had been very stressful. Two departments had combined, including the consultant staff.

Diagnostic Imaging

- We found competent staff managing the radiology areas we visited and staff we spoke with told us the leadership and support in the departments was good. We found nuclear medicine was a very well led department.

Culture within the service

- Staff we spoke with were aware of the requirements of the duty of candour. They knew about being open and honest with patients and families when things went wrong and some were able to give us examples of when they had done this.

Outpatients

- Staff had heard of and/or attended the PaCT (bullying awareness) training. Staff acknowledged the history of bullying in the trust and reported that things had improved recently. They said the PaCT training was good.
- The outpatients' management team told us they felt the bullying culture had changed, there was additional support to staff, and PaCT training was available. They said outpatients had good working relationships between staff and departments.
- The sister in surgical outpatients told us the culture across the surgical division and the trust as a whole was much more open. They felt the 'fear factor' about being open and honest had now gone.
- The sister in ophthalmology told us they were very confident in their staff, and they had good support from the consultants and business support.
- However, staff in ophthalmology told us they rarely saw the matron for the service. They added that the matron covered multiple services and was contactable if needed.
- Staff in gynaecology outpatients told us they were proud of their department, everyone worked together, and things were improving. They said the department had a very positive culture and there was more stability than in the past.
- Staff in nuclear medicine had a good team and provided a good service. They were very open and honest.
- From our observations in the bookings centre, we found a very close friendly atmosphere where staff were supported by their managers, who were working close by. Staff told us they were encouraged to put forward suggestions for better or different approaches to their work.
- Representatives of the outpatient management team told us that serious incident investigations were more supportive to staff than they had been in the past. They said the new Chief Executive 'set the tone.'

Diagnostic Imaging

- Radiology staff we spoke with were generally positive about culture within the department and told us the team was very supportive. However, some staff told us they would like more training opportunities and one support worker told us they felt morale was still very low in radiology.
- The radiology management team told us they felt the culture in the department was good. They said they had involved the trust's 'anti-bullying Tsar' when there had been issues with bullying. They said the staff survey results for the department had shown an improvement.
- The lead consultant in histopathology told us they felt the atmosphere at Hull had changed for the better over the past year. They said there was a supportive management structure.

Public engagement

Outpatients

- The friends and family test results for outpatients for the six months between December 2015 and May 2016 showed consistently good results but the response rate was consistently low.
- For example, the average percentage of respondents who would recommend the service was 94.2% and the average response rate was 4.2%. In May 2016, there were 2,304 responses from a total eligible of 48,928; of these respondents 94% would recommend the service and 1% would not.

Outpatients and diagnostic imaging

Diagnostic Imaging

- The Friends and Family test (FFT) results for the radiology day unit (RDU) were good; recent scores for people who would recommend the service were reported as 4.89 / 4.9 out of 5.
- We were not provided with any national friends and family test data for other radiology services.
- We were not provided with any evidence to show that the general departments actively sought feedback from patients.

Staff engagement

Outpatients

- We found the visibility of managers within services was variable. Some staff saw their manager at least once a week and reported they were very approachable. One member of staff said they would not hesitate to contact their manager if they needed to. However, staff in plastics outpatients reported that they had not seen a matron for "a considerable period."
- On 1 June 2016, plastics moved to the Family and Women's Health Group. They told us the senior management team felt this was a better set up in order to manage the service effectively. Surgical outpatients were in the Surgery Health Group. The sister told us they had not been involved in any of the decision-making related to this restructure.
- Student nurses told us they were asked to give feedback about the clinical area they had worked in, but did not always hear anything back. For example, one student nurse completed the 'you said we did' evaluation but received no feedback. They said they found this disappointing and didn't know whether any action had been taken to improve things or not.
- In ophthalmology, the sister told us staff meetings were held, but, "not as often as they would like." They said information was disseminated to staff by emails, a communication book and staff meetings. We looked at the meeting minutes from 26 April 2016 and saw 40 staff had attended, from a wide range of job roles. The agenda for the meeting included: governance, audits, accessing diagnostics, missing notes and broken equipment.

Diagnostic Imaging

- There was a radiology newsletter, this was available to staff on the trust's intranet.
- In nuclear medicine, one of the radiation protection supervisors showed us the trust intranet. This appeared to be a useful resource for staff to use.
- Staff in general x-ray told us there were monthly staff meetings. They said if they were unable to attend the meeting they were emailed the minutes.

Innovation, improvement and sustainability

Outpatients

- The sister in ophthalmology told us she had won the Bayer ophthalmology honours UK outstanding ophthalmology nurse award in December 2015.
- Nursing staff in the outpatient department within the Eye Hospital told us the International Glaucoma Association had awarded the Department an innovation award for their glaucoma monitoring work.
- A band five registered nurse working in the outpatient department within the Eye Hospital had been awarded the 'Golden Heart' trust award for her work mentoring and supporting staff and students in the department.

Diagnostic Imaging

- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.
- The Chief Executive of the Society of Radiographers attended a meeting between nursing staff and a support worker in radiology to discuss creating radiology link nurses on all wards. As a result, they wrote an article for the Society of Radiographers magazine, to be published in the summer of 2016.
- A reporting sonographer told us the British Medical Ultrasound Society (BMUS) had taken on at Hull ultrasound audit and it was presented at a national conference. This was an accolade for the ultrasound department.

Pathology

- A strong multi-disciplinary team managed sudden unexpected death in infants and children (SUDIC) cases at the establishment, working under detailed procedures in a chain of custody manner. The dedication of the team had recently won them an award, recognising their commitment to quality.

Outpatients and diagnostic imaging

- The laboratory manager in histopathology told us their digital scanner was about to go live. A digital scanner creates a virtual or digital image of histological slides and provides a digital image for scientific analysis. This digital scanner would enable co-working with histopathology in Sheffield.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal for their training courses.
- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health needs.
- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital.
- The responsiveness of the Specialist Palliative Care Team (SPCT) in relation to acting on referrals.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones
- The International Glaucoma Association had awarded the ophthalmology department an innovation award for their glaucoma monitoring work.
- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology.
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that planning and delivering care meets the national standard for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- The trust must review the process for categorising incidents, including safeguarding incidents relating to children, to ensure effective investigation and lessons learnt.
- The trust must ensure that staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- The trust must ensure learning from never events is further disseminated and lessons learnt are embedded.
- The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment, and; that the escalation procedures are audited for effectiveness.
- The trust must ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- The trust must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- The trust must ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.

Outstanding practice and areas for improvement

- The trust must ensure that records of the management of controlled drugs are accurately maintained and audited within A & E.
- The trust must ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.
- The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- The trust must ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- The trust must ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol).
- The trust must ensure the effective use and auditing of best practice guidance such as the "Five steps for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- The trust must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The trust must review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- The trust must ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient and maternity services.
- The trust must ensure that there are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).
- The trust must continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.

Action the hospital SHOULD take to improve

- The trust should continue to improve the access and flow within the hospital, including reducing the number of patients who are medical outliers on other wards.
- The trust should ensure nursing staff have the correct skills to work specialist areas, specifically within medicine.
- The trust should ensure ward sisters/charge nurses have dedicated time to carry out their management duties.
- The trust should review the provision of rehabilitation after critical illness in line with national recommendations (Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation After Critical Illness).
- The trust should strengthen formal mechanisms to obtain patient and relative feedback within critical care and other services.
- The trust should ensure that all policies, guidelines and pathways on the trust intranet are up to date, especially within maternity.
- The trust should ensure that all members of the Specialist Palliative Care Team are fully compliant with all mandatory training.
- The trust should consider appointing a non-executive board member with responsibility for end of life care and an end of life care facilitator.
- The trust should consider developing a Trust end of life care strategy.

Outstanding practice and areas for improvement

- The trust should ensure the facilities and environment used by audiology are appropriate for patients' needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014: Need for consent.** **How the regulation was not being met: There was no policy or protocol in maternity services for staff to assess a young person's (under 16 years of age) understanding using guidance such as Gillick competencies and therefore ability to consent to a proposed treatment. The trust must:** 1. ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.** **Care and treatment was not always provided in a safe way for patients. The trust must:** 1. ensure that planning and delivering care meets the national standard for A & E; meets the referral-to-treatment time indicator and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits. Regulation 12(1)

This section is primarily information for the provider

Requirement notices

2. review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt. Regulation12(2)(b)
3. ensure that staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns. Regulation 12(2)(a) & (b)
4. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b)
5. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b)
6. ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services. Regulation 12(2)(c)
7. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy, especially within A&E. Regulation 12(2)(g)
8. ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient. Regulation 12(2)(g)
9. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)
10. ensure that records of the management of controlled drugs are accurately maintained and audited within A & E. Regulation 12(2)(g)
11. ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services. Regulation 12(2)(i)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA (RA) Regulations 2014. Safeguarding service users from abuse and improper treatment.** **How the regulation was not being met: Some safeguarding guidelines were out of date, not all staff were trained to the required level 3 for safeguarding children, and the computerised record system did not identify adults who may pose a risk to children. The trust must:** 1. ensure that systems and process are operated effectively to prevent abuse of service users, specifically in relation to children. Regulation 13(2)&(3)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 HSCA (RA) Regulations 2014. Meeting nutritional and hydration needs.** **How the regulation was not being met: Some patients' food diaries and fluid balance chart were not fully completed therefore it is not possible to monitor whether their needs were being met. The trust must:** 1. ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulation 17 HSCA (RA) Regulations 2014. Good governance.

How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The trust must:

1. ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol). Regulation 17(2)(a)
2. ensure that orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a)
3. ensure the effective use and auditing of best practice guidance such as the "Five steps for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)
4. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).
5. ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
6. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient and maternity services. Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014. Staffing. How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. The trust must:

This section is primarily information for the provider

Requirement notices

1. ensure that there are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically ensure critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012). Regulation 18(1)
2. continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour. Regulation 18(1)

Hull and East Yorkshire Hospitals NHS Trust

Castle Hill Hospital

Quality Report

Castle Road
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Tel: 01482 875875
Website: www.hey.nhs.uk

Date of inspection visit: 9 June, 28 June – 1 July and 11 July 2016
Date of publication: 15/02/2017

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Hull and East Yorkshire Hospitals NHS Trust operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham. Castle Hill Hospital has cardiac and elective surgical facilities, medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT), a breast surgery facility and outpatients as well as the Queen's Centre for Oncology and Haematology. In total, the trust has approximately 1,300 beds and 7,400 staff. The CHH site has over 600 beds. The trust provides services for a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull and 342,200 in the East Riding of Yorkshire.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. We inspected the five core services delivered from CHH which were medicine, surgery, critical care, end of life care and outpatients and diagnostics. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

We rated CHH overall as 'Requires improvement'; the safe, effective, responsive and well led domains were rated as 'Requires improvement' with caring rated as 'Good. There had been improvements made for referral to treatment times (RTT); whilst the trust was not achieving the national standard it was meeting the local trajectories agreed with commissioners and NHS Improvement. Surgery services had improved. End of life care remained 'Good' across all domains. However, there was deterioration in the ratings overall for critical care from 'Good' to 'Requires improvement'. Outpatients and diagnostics had improved in some areas and deteriorated in others which changed the rating from 'Good' in 2015 to 'Requires improvement' overall.

Our key findings were as follows:

- The trust reported and investigated incidents appropriately and the previous backlog had reduced. However, staff in some areas could not tell us about lessons learned or changes to practice.
- The trust had effectively responded to a serious incident reported by Radiology in December 2015 related to a failure to print 50,000 radiology reports. A further seven serious incidents regarding specific patients had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- A backlog of 30,000 patient episodes/appointments had been identified by the trust prior to the inspection. There had been eight serious incidents declared in outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- Staff were not always assessing and responding appropriately to patient risk. The trust used a National Early Warning Score (NEWS) to identify deterioration in a patient's condition. We saw some examples of when escalation of a deteriorating patient had not happened in a timely way and some staff were unclear about what to do if a patient's score increased (indicating deterioration). The trust was aware of this and was putting actions in place to improve this.
- Falls risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in the patient records, which may have resulted in a failure to identify patients at risk of malnutrition. We also found poor compliance with the completion of fluid balance charts.
- Nurse staffing shortages were evident across the majority of medical and surgical wards and Board reports indicated that safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators.
- There were also some gaps within the medical staffing, especially within critical care.

Summary of findings

- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2 which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016 which was similar to the England ratio (100) of observed deaths and expected deaths.
- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb). This meant that deaths within these areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable, what lessons could be learnt and actions were then put in place.
- Although medicines were stored and administered appropriately, we found gaps and errors in the recording of medicines administration and in the monitoring of checks of controlled drugs which had been a concern at our 2015 inspection.
- Leadership had improved. There was a clear vision and strategy for the trust with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork.
- Feedback from patients and relatives was positive. We saw good interactions between staff and patients. Staff maintained patients' privacy and dignity when providing care. Caring within medicine had improved.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks, if required, during the day.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited.

We saw several areas of outstanding practice including:

- The urology service had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award for their training courses and had been asked to write an article for a national nursing journal.
- The responsiveness of the Specialist Palliative Care Team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement team initiative of providing cards for relatives to write messages to their loved ones.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

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

Importantly, the trust must ensure that:

- Planning and delivery of care meets the national standards for the referral-to-treatment time indicators and eliminates any backlog of patients waiting for follow ups with particular regard to longest waits.
- Learning from Never events is further disseminated and lessons learnt are embedded.
- Staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- Staff have the skills, competence and experience to provide safe care and treatment especially for patients requiring critical care services.
- Staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.

Summary of findings

- Staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.
- Staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- Patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- Review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- Outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- Medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- There are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

In addition there were areas where the trust should take action and these are reported at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Requires improvement 	We rated medical care services as 'requires improvement' overall because: • We found the trust had not addressed some issues raised from the comprehensive inspection in February 2014, for example: low nursing and medical staffing levels. The planned nurse and medical staffing levels were not consistently achieved and this impacted on the capacity of the medical wards. • Systems and processes were not completed consistently such as control checks of fridge temperatures and controlled drugs. Medication administration was not always completed and we observed gaps in medication charts that were not accounted for. • Audits were not always completed within the timeframe set by the trust when standards were not at acceptable levels. The trust 3G audit identified that nutrition standards were not always met and food charts were not always fully completed which would indicate if further referrals were needed. These were not highlighted as risks on the medicine risk register. • Some staff did not possess the specialist competencies that were required for specialist wards. • The trust was not achieving specific outcome targets, such as primary percutaneous coronary intervention (PPCI) • We observed nurse and medical leadership on the wards however ward managers were not always allowed to remain supernumerary due to nurse staffing levels. However: • The trust had addressed some of the issues raised from the comprehensive inspection in February 2014, for example: the lack of available beds that led to long delays in accessing and treatment, frequent bed moves and the disconnect between the executive team and the

Summary of findings

wards. A local improvement plan was in place and, at the time of inspection, targets were being achieved to meet the 18 week referral to treatment national indicator.

- The majority of patients and relatives felt involved in their care and thought staff were compassionate about the care they provided. Staff felt proud of the care they delivered and enjoyed working at the hospital.
- We observed patient centred multidisciplinary team working.

Surgery

Requires improvement

In 2015 we rated surgical services at CHH as 'inadequate'. At the 2016 inspection we rated surgical services at CHH as 'requires improvement' overall because;

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective.
- We had concerns over the effectiveness of the 'Five steps to safer surgery' checklist, from our observations it was apparent this process was not embedded as a routine part of clinical roles.
- From medical notes we reviewed and staff we spoke with, we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. Nursing staff did not always complete accurately the falls and dementia risk assessments. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.

Summary of findings

- Patients were not always able to access services for treatment in a timely way; the trust did not meet national performance standards for treatment and cancer standards.

However;

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dietitians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI) we carried out, showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- The trust had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

Critical care

Requires improvement

We rated critical care as 'requires improvement' because;

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified risks to the service that were not on the risk register. We were concerned about the out of hours medical cover at CHH and the impact of the trust's reconfiguration of services. There was a lack of recognition of this or forward planning from the Health Group management team or executive team to mitigate the risks.
- Controls for some of the risks that had been identified were limited and unsustainable and

Summary of findings

there was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action on some of the risks on the risk register.

- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts to cover CHH. Some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place which was not in line with guidelines for the provision of intensive care services (2015).
- Junior medical staff that worked on ICU2 out of hours did not have skills in tracheostomy and epidural management.
- Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units.The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the cardiac arrest and transfer team which meant they may not always be immediately available or on site.
- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015). Patients did not have access to formal psychology input following critical care.
- The service had limited formal mechanisms for collecting patient or relative feedback.

However,

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

- There was clear nursing and medical leadership on the units and in the critical care outreach team and it was clear that staff had confidence in the units' leadership.
- We observed patient centred multidisciplinary team working.

End of life care

Good

The last comprehensive inspection of End of life care services at the hospital was in February 2014, when we found the service to be good. During this inspection we rated this core service as 'good' overall because;

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and managers shared the learning from incidents. Mandatory training across most services was above the trust targets and medicines were prescribed and administered safely in line with policy and staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multidisciplinary working across all teams. The trust had recently employed more resources to provide seven-day specialist palliative care nursing availability. Consent to care and treatment was obtained in line with legislation and guidance.
- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the

patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and patients' choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.

- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the Specialist Palliative Care Team (SPCT) were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatients and diagnostic imaging services as 'requires improvement' overall. [KK1] We rated the safe and responsive domains domain as 'inadequate', the well-led domain as 'requires improvement' and the caring domain as 'good'. The effective domain was inspected but not rated. This was because we are currently not confident we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

- Radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further six serious incidents regarding specific patients had been reported, of which three related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.

Summary of findings

- In addition, a cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should. Three of these serious incidents were at the HRI site and six at the CHH site; all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery and a serious incident was declared in December 2015 due to 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents related to printing errors, being declared by the time of the inspection.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies for nursing and support staff in some outpatient specialties, and in radiology there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.
- Outpatients and radiology had increased their appointment capacity by running clinics out of hours and at the weekends, to cope with the increased demand and ensure patients had their appointments. However, there were ongoing concerns about the trust not meeting national standards for referral to treatment and urgent cancer treatment. However, a plan was in place and locally agreed trajectories, agreed with

commissioners and NHSI were being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action to review any issues.

- Staff providing care and treatment to people in outpatients and radiology were caring. Patients gave positive feedback about the care they received and we saw staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing impairment or those who needed an interpreter.
- The facilities and premises used to deliver services were good. The environment in all of the areas visited was in good state of repair, clean and comfortable and sufficient well-maintained equipment was available.
- We found there were a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.
- Outpatient services were split between the four Health Groups, meaning there were different levels of management and clinical support for each service. There was no outpatients risk register. Risks were identified on risk registers of Health Groups; however, this did not allow a cohesive oversight. There was also limited evidence of outpatient audits and quality monitoring.
- There was inconsistency in the governance and management oversight in outpatients due to it being split across the four Health Groups. This was starting to be addressed with the setting up of a weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient transformation project'

Summary of findings

was also in progress, but this was running behind schedule. This project's aims included improving clinic utilisation, bookings processes and performance against standards. We were also told that an overarching management post was to be developed.

- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme in which all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Castle Hill Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Castle Hill Hospital

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 as a result of a merger between Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. It operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham.

The trust provides a range of acute services to the residents of Hull and East Riding of Yorkshire area, as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire, and Hull Royal Infirmary is a Major Trauma Centre for the region and Castle Hill Hospital has the regional Queen's Centre for Oncology and Haematology. The trust also provides other clinical services, mainly outpatients at other locations within the Hull and East Riding of Yorkshire area, for example the Freedom Centre in Hull and East Riding of Yorkshire community hospital in Beverley.

The trust provides services a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

Kingston Upon Hull Unitary Authority scored significantly worse than the England averages for 21 of the 32 indicators in the 2015 Area Health Profiles. The city had the highest long term unemployment of any local authority in England. It also scored particularly badly for smoking prevalence, smoking-related deaths, deaths from cancer among under-75s and female life expectancy. The city scored significantly better than the England average for incidences of malignant melanoma and TB. The cancer mortality rate in Hull (360.8 per 100,000) is significantly higher than the England average (285.4 per 100,000). By contrast East Riding of Yorkshire Local Authority scored significantly better than the England averages for 14 of the 32 indicators in the area health profiles. The area scored significantly worse than the averages for three indicators: smoking status at the time of delivery, recorded diabetes and deaths and serious injuries on roads. In the 2015 Indices of Multiple Deprivation, Hull ranked as the third most deprived local authority in England. On the other hand the East Riding of Yorkshire was ranked the 195th most deprived local authority in England.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. The trust has been inspected a number of times previously and a summary of the regulatory breaches is provided below.

The inspection in May 2015 was a focused inspection which did not look across the whole service provision; but focused on the areas defined by the information that triggered the need for the focused inspection including the previous inspection in February 2014. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services inspected. At CHH we inspected domains in surgery together with outpatients and diagnostic services. The overall rating for CHH and the Trust was Requires Improvement. The Trust was found in breach of the

Detailed findings

Health and Social Care Act (Regulated Activities) regulations 2014. These included: Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs), and Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good governance) and Regulation 18 (Staffing).

At the first comprehensive inspection in February 2014, using the Care Quality Commission's (CQC) new methodology, HRI and CHH were found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 22 (staffing) and 23 (staff support). Additionally HRI was also found in breach of regulation 15 (premises).

Hull Royal Infirmary was inspected in June 2012 and October 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication). In December 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

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Our inspection team

Our inspection team was led by:

Chair: Robert Aitken: NHS non-executive director and former government lawyer.

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The inspection team consisted of two inspection managers, 18 CQC inspectors and 24 specialists including; an adult safeguarding specialist, an A&E doctor and nurse, a critical care doctor and nurse, two end of life nurses, a maternity doctor and midwife, a medical doctor and nurses, outpatient doctor and nurse, paediatric doctor and nurse, surgery doctor and nurse, radiographer, a junior doctor, two student nurses and two trust-wide specialists.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspected the following core services during the inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostics

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations

Detailed findings

included the local Clinical Commissioning Groups, NHS England, NHS Improvement, Health Education England, Healthwatch, various medical Royal Colleges and other stakeholders.

We held two public engagement stalls prior to the inspection to hear people's views about care and treatment received at the trust; one at HRI and the other at CHH. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended these events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, and allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients,families and staff from ward areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

At CHH we inspected medicine, surgery, critical care, end of life care and outpatients and diagnostics. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

Facts and data about Castle Hill Hospital

Castle Hill Hospital is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at East Riding of Yorkshire Community Hospital in Beverley and some outpatient services in other locations.

Castle Hill Hospital has cardiac and elective surgical facilities, medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT) and breast surgery facility and outpatients. It has the regional Queen's Centre for Oncology and Haematology. Critical care is provided in two units, which support the cardiology and cardio-thoracic services. There are no accident and emergency services at this hospital: these are provided at Hull Royal Infirmary (HRI).

By April 2015, the majority of the medical beds at Castle Hill Hospital had moved to the HRI to bring together acute medicine and care of the elderly onto the one site.

The trust had 1,294 beds at the time of the inspection of which: 1,162 were available for general and acute care, 77 for maternity and 40 for critical care. The trust's management structure was based on four Health Groups: Surgery, Medicine, Family and Women's Health and Clinical Support along with the corporate functions.

As of 1 April 2016 there was 6,979 whole time equivalent (WTE) staff in post against an establishment of 7,620 WTE. Of these, 956 were medical (against an establishment of 1010); 2,778 were nursing (against an establishment of 3,066) and; 3,245 were other (against an establishment of 3,544).

The medical staff skill mix had similar percentages to the England average with 37% being consultants compared with 39% nationally; 5% were middle career compared with 9% nationally; specialist registrars were 40% compared with 38% nationally and junior doctors were at 18% compared with 15% nationally.

The financial data for 2015/16 included:

- Revenue: £526 million
- Full Cost: £534 million
- Deficit: £8 million

The types of activity at the trust for 2015/16 was:

- Inpatients: 119,751
- Outpatient (total attendances): 694,981
- Accident and emergency attendances: 121,963*
- Attendances to minor injuries unit: 13,414*

*W/c Monday 30 March 2015 to w/c Monday 21 March 2016

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good
Overall	Requires improvement

Information about the service

Castle Hill Hospital is part of Hull and East Yorkshire Hospitals NHS Trust. Medical care was provided across two sites in the trust with Castle Hill Hospital providing cardiology, oncology and haematology services. Acute medical services including older people's care was provided at Hull Royal Infirmary.

Between January 2015 and December 2015, there were approximately 65,000 medical episodes of care carried out in this trust with approximately 27,000 at this hospital site. Day cases accounted for 76% of all episodes, emergency admissions 13% and elective admissions 11%.

Medical services were managed within the Medicine Health Group and Clinical Support Health Group. The cardiology department at Castle Hill Hospital was a tertiary referral centre covering a local population of 550,000 with a total catchment area of 1.2 million. The trust provided primary percutaneous coronary intervention (PPCI); this allowed the ambulance crew to transfer a patient straight to the cardiology department when the cardiac monitor readings met a specific criteria. Cardiac procedures were held in the cardiology catheter laboratory and 11 beds were available for overnight stay Monday to Friday. There was also a 12 bedded cardiac monitoring unit (CMU) which managed level 2 patients and two general cardiology wards (wards 26 and 28) with a total of 43 beds. There was also an infectious diseases ward (ward 20) with a total of 19 beds.

Castle Hill Hospital provided inpatient care in the Queen's Centre for Oncology and Haematology building. There were five wards at the Queen's Centre (ward 29 to ward 33) with four of them being dedicated to the care of cancer patients and the other being specifically for rehabilitation. There were 112 beds in total with 99 of them being for cancer patients and 15 for rehabilitation. Wards 30 through to 32 were primarily oncology wards and 33 was primarily the haematology ward; ward 33 also incorporated a high dependency unit. Ward 33 also cared for teenage and young adults between 18 and 24 years of age in a specific area of the ward.

During the inspection we looked at 23 patient records, 25 prescription charts, spoke with 11 patients and relatives, and 31 staff including doctors, nurses, therapists, care support workers, ward managers, matrons, administrative assistants and student nurses. We also attended two multidisciplinary team meetings. We visited all the cardiology areas – ward 26, 28, CMU, cardiac catheter laboratory and 5 day care unit. We also visited ward 29 rehabilitation ward, ward 20 infectious diseases and wards 30, 31 and 33.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. Before the inspection, we reviewed performance information from, and about the trust. We also carried out unannounced inspections on 9 June 2016 and 11 July 2016.

A comprehensive inspection of medicine at Castle Hill Hospital was carried out in February 2014, where safe, responsive and well-led were rated as requires improvement. Areas of improvement were identified that

Medical care (including older people's care)

the hospital must take action for including: ensuring sufficient numbers of suitably skilled staff were in place across medical wards particularly at nights and weekends. The hospital needed to ensure suitable arrangements for on call and junior doctors to be appropriately supervised and not responsible for multiple pagers across different areas. Both effective and caring domains were rated as good. In April 2015 following a reconfiguration of services and transformation of the acute medical care pathway, wards were moved from Castle Hill Hospital to Hull Royal Infirmary. These services were then followed up within the Hull Royal Infirmary CQC inspection in May 2015.

Summary of findings

In 2014 we rated medical care services as 'Requires improvement' overall, this rating was unchanged in 2016 because:

- Planned nurse and medical staffing levels were not consistently achieved and this impacted on the capacity of the medical wards.
- Systems and processes were not completed consistently such as control checks of fridge temperatures and controlled drugs. Medication administration was not always completed and we observed gaps in medication charts that were not accounted for.
- Audits were not always completed within the timeframe set by the trust when standards were not at acceptable levels. The trust failed to meet the nutrition and hydration standards set by the trust. These were not highlighted as risks on the medicine risk register.
- Some staff did not possess the specialist competencies that were required for specialist wards.
- Patient outcome performance data was variable with some being below the national average, for example the primary percutaneous coronary intervention (PPCI) target was not consistently met.
- We observed nurse and medical leadership on the wards however ward managers were not always allowed to remain supernumerary due to nurse staffing levels.

However:

- The trust had addressed some of the issues raised from the comprehensive inspection in February 2014, for example: the lack of available beds that led to long delays in accessing and treatment, frequent bed moves and the disconnect between the executive team and the wards.
- The majority of patients and relatives felt involved in their care and thought staff were compassionate about the care they provided.
- Staff felt proud of the care they delivered and enjoyed working at the hospital.
- We observed patient centred multidisciplinary team working.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

In 2014 we rated safe as 'requires improvement'. In 2016 this rating was unchanged because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example there were still staff shortages within nursing and medical staff.
- Some audits for specific wards remained below the trust standards for infection control.
- Systems and processes were not completed appropriately such as control checks of fridge temperatures and controlled drugs.
- There were gaps in medication administration and no review of competency for registered nurses administering medication.

However we also found:

- Staff understood their responsibility in reporting incidents and were encouraged to complete these.
- When errors occurred, the trust reviewed the process and lessons learnt were implemented.
- Staff understood their role and responsibility in safeguarding children and adults.

Incidents

- There were no never events reported in medical services between May 2015 and April 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between April 2015 and April 2016, there were 5180 incidents reported for the Medicine Health Group across the trust. The Medicine Health Group included emergency medicine, general medicine, elderly medicine and specialist medicine divisions. The majority of these incidents resulted in no harm or low harm however, 78 caused moderate harm, 18 caused severe harm and four resulted in patient death.
- There were 27 serious incidents reported for medicine between May 2015 and April 2016. Serious incidents are incidents that require further investigation and reporting. The most prevalent incident types were slips, trips and falls (nine), pressure ulcers (seven) and sub-optimal care of the deteriorating patient (six).
- There had been two serious investigations into the care of patients receiving PPCI where patients were diverted to the emergency department at Hull Royal Infirmary due to inconsistencies regarding the patient's ECG readings and then back to cardiology at Castle Hill Hospital. As a result of the second incident the referral form was being redesigned by the trust to ensure the same consistency was maintained.
- Serious incidents were all investigated. We looked at examples of incidents, which had been investigated and found that staff had completed a thorough root cause analysis and action plans completed. The trust held meetings to review the serious incidents reports.
- Mortality and Morbidity meetings were held monthly. We saw minutes of the renal department mortality and morbidity meetings, which showed discussion of each case with learning points and actions identified to prevent reoccurrence.
- The trust produced a monthly lessons learnt bulletin, staff positively commented on this during the inspection and this was provided to all staff. The lessons learned newsletter was circulated electronically every month and was available on the intranet for sharing with the ward teams.
- Staff understood how to report incidents using the electronic reporting system and identified a positive incident reporting culture. However, they told us that they would not routinely report short staffing concerns as this was highlighted within the daily safety brief completed by the trust.
- Most staff received feedback about incidents and gave us examples of incidents and changes that had occurred as a result.
- We observed information displayed on ward 26 following a recent drug incident surrounding venous thromboembolism prophylaxis dose. As a result of the incident, staff now double checked the dosage.
- Incidents were investigated at a ward level and fed back to staff individually and at ward meetings. However we

did hear how incidents were not generally shared between wards and team meetings were not always regular. Therefore learning may not have been provided to staff early.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke with understood the principles of the duty of candour however more junior members of staff were not knowledgeable.
- The incident reporting system had a mandatory field for duty of candour. We reviewed a root cause analysis following a serious incident which resulted in patient harm and saw that staff had followed the policy correctly.
- The trust had a 'Being Open when Patients are Harmed Policy' which set out the process for duty of candour. We observed the policy and flow chart displayed in ward areas.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), catheter and urinary tract infections (CUTIs). Between March 2015 and March 2016, staff reported 50 pressure ulcers, 22 falls with harm and 20 CUTIs in medical services across both hospital sites.
- Patient safety thermometer data showed that between March 2015 and October 2015 there was an upward trend in the prevalence of new pressure ulcers reported. There was then a downward trend in prevalence from January 2016 to March 2016. There was also a downward trend in the prevalence of falls from April 2015 to March 2016. The prevalence of urinary tract infections in patients with a catheter fell in April 2015 and May 2015, since then the rate has been fairly stable. Overall this showed an improving picture for harm free care.
- On inspection we observed safety thermometer information displayed. On ward 31 it was confirmed in May 2016 the ward had provided 100% harm free care.

Cleanliness, infection control and hygiene

- We observed a patient undergoing a coronary angiograph. This is an invasive procedure involving insertion of instruments in to the patient's blood stream; it is a procedure carried out under sterile conditions. The 'scrub' team consisted of the medical consultant and healthcare practitioner; both of whom wore a sterile single patient use surgical scrub gown and sterile gloves.
- During the inspection one staff member highlighted to a colleague that they were not adhering to the correct infection control standards and requested that they re-scrub and put on a fresh sterile gown and gloves.
- The trust aimed to undertake monthly hand hygiene audits. We reviewed hand hygiene audits from April 2016 to June 2016.Ward 26 submitted that in April 2016, 76 hand hygiene observations were recorded with 100% compliance. No other data was submitted for the remaining two months. Other cardiology wards did not submit any data. The trust highlighted that there was a reduced compliance regarding the completion of audits. As a solution from July 2016 an alternative audit tool will be implemented across all the clinical areas.
- During our inspection we saw ward cleanliness audit findings on ward 26 which showed 95% and 99.3% compliance for May 2016.
- We observed staff using appropriate personal protective equipment when completing clinical tasks. Staff complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- Hand washing facilities were available at the front of all ward areas and signage to remind people the importance of handwashing. Handwashing basins and hand wash gel were available at various locations throughout the wards.
- On ward 33, the results from an infection control audit showed they had not been meeting infection control standards and were in a red category of less than 80% compliance. They did not meet the criteria in eight areas which included 85% compliance in hand hygiene training and commodes were visibly clean and identified as clean with tape in place. At this level the ward required to be re-audited within three months; the ward was re-audited and the standards had improved to a good category of 89 – 94.9% compliance.
- On ward 30 there were nine areas where the standard was not met such as information was not cascaded from

the infection control link practitioner to the ward staff, waste was not managed and segregated appropriately and infection control risk assessments were not carried out on admission and documented.
- Information submitted by the trust identified that wards 28 and 32 met all the criteria of the infection control standard.
- Each ward had an infection control link practitioner, part of their role was to cascade information to the nurse in charge and team. Evidence was presented that this occurred on four out of five wards areas.
- We observed clinical waste and domestic waste were appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- We saw patients were nursed in side rooms or allocated bays. Some patients were nursed in isolation following infection control procedures to ensure cross infection was eliminated; this included the appropriate use of personal protective equipment (PPE). Some patients were receiving chemotherapy and appropriate infection control measures were in place. We observed staff using PPE, washing their hands or using hand gels when entering and leaving side rooms and allocated bays.
- Equipment was identified as being clean by using the cleaning assurance stickers.
- Patients were cohorted on ward 20a with positive Clostridium difficile infection; this practice was to discontinue in July 2016 and patients would be managed on their individual wards. A patient management pathway was in place that staff were aware of. Review meeting were held daily and weekly to discuss all patients with the infection.
- Staff completed infection prevention and control training as part of their mandatory training programme; the overall compliance was 73% which was below the trust's target of 85%. Although some individual staff groups received 90% or above such as medical staff in infectious diseases, the lowest compliance was estates and ancillary with 42.9%.

Environment and equipment

- Most of the wards were in spacious, new buildings specifically designed for specialist services although ward 20 was in an old block building surrounded by empty ward areas. The environment surrounding ward 20 was old fashioned however there were plans to move out of there soon so no further adaptations were being completed. Medical staff commented that ward 20 was geographically far away from all the other wards and this took time for medical teams to reach a deteriorating patient.
- Wards had identified areas to keep equipment such as mattresses, hoists and ward areas appeared clean and well maintained. Bed areas were spacious and in some areas, four bedded areas allowed for six cubicle spaces although only four were ever used. Many of the wards had day rooms and other rooms for patients to use.
- The cardiology unit was around seven years old; the environment was in a good state of repair and a suitable layout.
- The unit had recently purchased two new echocardiograph machines and the third existing machine was functioning well; service contracts were in place with the manufacturer.
- The unit had two cardiac analyser machines which were due for renewal; a business case had been submitted for two new cardiac analyser machines.
- Resuscitation equipment was available on all of the wards; records indicated that these were checked on a daily basis and ready for use.
- Equipment was checked and had been serviced correctly and dates recorded. Ward 33 has a transplant bay of five cubicles; these were all hepafiltered, serviced annually and monitored as part of maintenance schedule.

Medicines

- All patients had a drug administration record. Within the record it allowed for the prescriber to identify the patient's allergies and VTE assessment. There was also a record of any omitted medication and a numbered scale to identify the reason why the medication was omitted.
- We checked drug administration records on 25 patients; on ten occasions we saw that medication was not signed for by a registered nurse or any indication to why it may not have been given. One of these was a low molecular weight heparin, which can be used for prophylaxis or treatment of deep vein thrombosis or pulmonary embolism. We asked if the medication had been administered, but staff could not confirm if the medication had been given; the patient was also unable to confirm. This meant we could not be assured that patients were receiving all the medications they needed.

- We observed that allergies were recorded and VTE assessments were completed. Some staff identified that the VTE assessment needed to be completed online also, therefore staff were duplicating the information. All the records were legible, signed and dated, on one occasion a new drug dosage had been written over the original dose rather than rewriting the medication.
- We also observed a chemotherapy prescription chart completed in full and in accordance with local policy.
- We saw antibiotics had been prescribed as per trust guidelines in the prescription charts we reviewed. Start dates were recorded and the rationale for why antibiotics needed was recorded.
- We observed two medication rounds. One staff member was interrupted during the medication round by another staff member. The appropriate patient checks were completed, however during one of the observations the staff member signed for the administration prior to giving the patient the medication. The staff member stated this was their common practice. We raised this with the trust and the ward manager; we visited the ward the next day and the ward manager advised us appropriate steps had been taken. There was no mechanism in place to review the competency of registered nurses administering medication.
- We observed the checking of a controlled drug and insulin dose with two staff members in line with trust policy.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked cabinets. Expiry dates were checked and the stock was rotated appropriately.
- Controlled drugs were appropriately stored with access restricted to authorised staff.
- We found that daily checks for controlled drug medication were not always completed. On ward 32 there were 71 occasions since January 2016 where the check had not been completed including one gap of seven consecutive days; this was not in line with trust policy and meant that robust safety checks were not in place. When the check had not been completed it normally stated it was 'not checked due to ward demands'.
- In documents provided by the trust, concerns had been raised in January 2016 at the Safe Medication Practice Committee. This highlighted that staff were not following the procedure to complete controlled drug books and it was agreed to complete an audit. An audit was completed over a three month period from October 2015; ward 20 had compliance of 100% for October and November 2015, 93% for December. Ward 32 had compliance of 61% in October 2015, 50% in November 2015 and 45% in December. Further monthly audits were carried out; wards 29 and 30 completed checks 100% in months February 2016 to June 2016. Ward 32 remained the lowest ward to complete the checks with 45% in March 2016, this steadily increased over the months with 80% in June 2016.
- We checked the fridge temperature records on four of the wards and found there were gaps in the daily recording of the fridge temperature records; this was not in line with the trust policy. On one ward the fridge temperature was recorded out of range consecutively for 13 days in a row and there was no evidence of escalation. We discussed this with the ward staff who took steps to address it. This meant that drugs may not have been stored at the correct temperature required.
- One of the medication fridges on ward 30 was for chemotherapy drugs; this was faulty and not in use. This had been reported several times. The chemotherapy drugs were stored in the other medication fridge appropriately.
- We found on some wards detailed flowchart instructions of what to do in the event of out of range temperature readings.
- We found the appropriate risk assessment and patient agreement had been completed for patients who were self-medicating.
- A lessons learnt approach was taken with drug errors, incidents were reported, investigated and a staff completed a piece of written reflection. On ward 30, a monthly audit of medication cards was completed by the staff.
- An audit was undertaken of the administration of daltaparin following the administration of an injection to the wrong patient. The audit was completed over an eight week period from November 2015 which included four patients on wards at Castle Hill Hospital. At each intervention the nurse was assessed as administering the correct medication and adhering to the appropriate personal protective equipment (PPE).
- National Institute of Clinical Excellence (NICE) guidance recommends in an acute setting, medicines reconciliation should be carried out within 24 hours. The trust submitted a trust wide medicines reconciliation

audit for three months from April 2016. In April 2016, 66% of medicines were reconciled within 24 hours, this increased to 77% and 76% on consecutive months. The trust target was 80% compliance; this was not met for the three months.

Records

- Care plans were spilt into care bundles which related to certain risks such as nutrition, skin care, falls care bundle which included bed rail assessment and moving and handling assessment. The care bundles were generic assessments with an area for individualised care to be added for each patient. We observed that individual care planning was completed.
- Intentional rounding was in place for each patient. This was a document where staff completed regular checks with patients at set intervals carrying out scheduled tasks or observations such as pain, positioning, comfort, checking call bells and drinks were within reach. We saw that these were used and appropriately completed.
- The majority of medical and nursing notes were paper records and were stored securely on the ward. Each ward also used a patient electronic board which also had patient information stored.
- We reviewed 23 sets of patient records, which represented a sample of the services we visited. Most of the records we reviewed were completed appropriately in line with professional standards, with relevant risk assessments and descriptions of staff interaction with the patient.
- Nutritional assessments were partly completed on the patient records that we observed. The trust used a validated nutritional screening tool on the wards to identify adults who were malnourished. The daily food chart identified how much food had been consumed at each mealtime, and a rag rating was given to the amount of food eaten. For example, if none or only a quarter of the meal was eaten, a red indicator was given or if the whole meal was eaten a green indicator was given. The totals were to be added up to identify the overall malnutrition risk to the patient and if a referral to a dietitian was needed. We observed that this part of the food chart was not always completed to identify the malnutrition risk to the patient. Three records had not been fully completed, these included food chart scores that were not always completed. One of these patients had been identified at a high risk for nutritional intake, but the risk was not completed for three days.
- On ward 30 staff had highlighted improvements were needed and were working towards improving the documentation. A quality assurance audit was completed every month; in June 2016 this highlighted issues with skin integrity assessments that staff were working on. Staff had been involved in the process to ensure record keeping was understood and improvements developed.
- Staff completed information governance training, with an overall compliance of 85%. Most staff groups within the medical care services achieved over the trust target of 85% with some achieving 100%. The lowest compliance was for medical staff in infectious diseases who achieved 64%.

Safeguarding

- The trust had policies and procedures for safeguarding children and adults at risk. Both polices were in date and required to be reviewed in December 2016. This included guidance on local safeguarding pathways and contact details. Staff were aware how to access these on the intranet.
- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- Patients with safeguarding concerns were documented as part of the trust daily safety brief based at Hull Royal Infirmary. We attended one of the daily safety brief meetings whilst on inspection and this confirmed that staff from Castle Hill Hospital contributed and were part of the safety brief.
- Staff completed safeguarding children and vulnerable adult training which both exceeded the trust target of 85%. Most staff groups within the medical care services achieved over the trust target with some reaching 100%. The lowest compliance was for medical staff in cardiology who achieved 73%.

Mandatory training

- The trusts mandatory training programme included infection control, fire safety, information governance, resuscitation, moving and handling training, major incident training, safeguarding children, vulnerable adults, mental capacity act and safety training. The trust target for mandatory training was above 85%.
- Most staff groups within medicine fell below the trust target of 85% for resuscitation; these included healthcare assistants, medical staff and nursing staff

from most wards areas. The lowest compliance was healthcare assistants and other support staff in cardiology at 37.5%. Healthcare assistants and other support staff on ward 20 were the only area to obtain 100% compliance.

- Overall compliance was below the 85% target for conflict resolution and fire safety although for some individual groups compliance was improved. For example, the healthcare assistants and other support staff groups in cardiology and infectious diseases compliance was 100% for conflict resolution and fire safety.
- Other mandatory training met the 85% target such as moving and handling, safety, and major incident training.
- Training was either completed face to face training or online for certain subjects.
- Some staff commented that training was not often cancelled; bank staff worked on the ward to allow permanent staff to attend training.
- Training was reviewed every month and staff were aware it was their own responsibility to book on training courses. During the inspection, training on ward 30 was at 83% compliance which was much improved for the ward, although this was just under the trust's target of 85%.

Assessing and responding to patient risk

- The catheter laboratory unit used the WHO checklist. We observed a patient being checked by staff before entering the procedure room; this included, but was not limited to, checking the procedure, site, allergies and consent. Other appropriate checks were conducted with the patient and the staff team within the procedure room.
- During our observations of the coronary angiography, we noted that surgical swabs, sutures, hypodermic needles and a surgical blade were used during the procedure. We noted that these items were not 'counted out' between two members of staff before, during and after the procedure. We also noted that a 'sticky' surgical pad was not used during the procedure to prevent sharps from accidently being moved and/or lost during procedures. At the end of the procedure, some swabs remained on the surgical trolley which were placed in to a bin and some swabs remained on the sterile sheet on top of the patient; these were collected up along with the sterile sheet and but in the bin together.
- The critical care outreach team covered both hospital sites, providing care 24 hours a day seven days a week. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them through the National Early Warning Score (NEWS) referral system. The team supported patients nursed on wards with tracheostomies and delivered Non-invasive Ventilation (NIV) outside of critical care.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care. Medical areas used a paper system to record the score.
- The trust submitted audit data for three months from April to June 2016 which measured NEWS compliance. It measured whether the patients NEWS had been calculated correctly and whether appropriate action been taken. Twenty patients per month were audited. The audit showed 100% compliance for most areas, although some wards did not submit any data for some months. In April 2016, on ward 33 the audit showed only 25% had appropriate action taken and documented response to the NEWS score. This had increased to an average of 97% for May and June 2016.
- Staff on ward 33 ward had completed simulated NEWS training following an incident where a NEWS score was not escalated appropriately. Staff thought the training was valuable and this had improved the understanding of the policy and escalation.
- We observed on one patient a NEWS score of seven was escalated and actioned appropriately.
- One patient's care plan identified that the patient was refusing their medication at times; this had been appropriately recorded on the drug administration record. However, the issue was not escalated to medical staff in line with the policy.
- All patient falls were reported and investigated. The trust Falls Committee held monthly meetings and was attended by a Medicine Health Group representative, multi-disciplinary team (MDT), risk and safety representative, consultant in elderly care and the director of nursing. Staff could identify some of the reasons why patients had fallen, for example one patient was advised not to mobilise independently, however the patient mobilised without supervision and fell. This was reported and appropriately documented.

- One patient was identified on the falls care bundle as requiring assistance; this should have triggered a multi-factorial assessment to be completed; however on this patient it was not completed.
- Wards had access to pressure pads, alarms and high risk patients were moved to more visible areas.
- There was no falls team at Castle Hill Hospital and when one to one supervision had to be provided this was provided by the ward staff. Staff involved family and provided one to one nursing when needed. It was highlighted on the trust's risk register regarding the unavailability of staff at short notice to provide one to one care. Security staff could be used for exceptional covering or if patients were wandering into other patient areas.
- An e-learning package had been developed on falls prevention.

Nursing staffing

- The trust used the Safer Nursing Care tool to determine patient acuity. This was translated to the safety brief giving the number of patients and their acuity. The trust aimed for staffing ratios of 1:8 on general medical wards and 1:2 on CMU; however, this was reviewed on a twice daily basis at the safety brief in line with acuity. This enabled the organisation to respond to areas and provide additional staff where needed.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the trust's risk register. A monthly nursing and midwifery staffing report was collated for the trust board identifying key risks for specific wards. Controls put in place by the trust to reduce the risk included a clear escalation process and discussion at the safety brief meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and retention of staff. The trust was working with the local university in securing permanent positions for newly qualified staff. In September 2016, 74 nurses were due to commence employment with the trust.
- Staff shortages were evident across the majority of wards and the trust's safer staffing levels were not met. On six of the wards, during our inspection, none met the actual planned level of registered nurses or health care staff; these included specialist areas such as oncology, haematology, rehabilitation, neurology and cardiology. Staff were aware how to escalate their concerns regarding staffing.
- We reviewed staff fill rates for the trust and these were not always met. In March 2016 on ward 33 the average fill rate for registered nurses was 57% alongside 78% for healthcare staff. These figures were the same for April 2016 and May 2016. The ward had been below the staff fill rate target of 80% since April 2015. The figure had improved to 80% fill rate for June 2016.
- On ward 33 there were 5.5 whole time equivalent (WTE) vacancies for registered nurses. Ward 32 had provided the ward with an extra registered nurse for a six month period. The vacancies had been filled with student nurses that completed their course in September 2016. The ward also had 2.4 WTE vacancies for health care staff. Bank staff were used to cover vacancies and occasionally agency staff were used. However, due to the complexity of the patients on the ward skill mix was not always maintained. Staff were required to look after patients requiring chemotherapy and transplant-related needs, therefore specific skills were required. The ward manager was expected to work in the planned numbers of staff more than the allocated allowance due to the staff shortages. This was confirmed in the safe staffing report where the supervisory charge nurse capacity was below 19% for 10 months with the exception of 2 months where the capacity was 35% and 42% in August 2015 and May 2016.
- We reviewed the nurse staffing on ward 29 from 1 April 2016 to 9 June 2016. The number of registered nurses on a day shift was under the planned number 59 days out of 70.
- We reviewed the nurse staffing on ward 28 and CMU; the electronic off duty identified which shifts remained uncovered to meet the planned staffing numbers required. We looked at a period of two weeks and on all three shift patterns; early, late and nights at least one shift was not covered. Many vacancies had been filled with student nurses, for example we were informed on four wards that vacancies had been filled with student nurses that were due to qualify until September 2016.
- Information submitted by the trust showed the Medicine Health Group had 42.3 whole-time equivalent (WTE) nursing vacancies from their 772.69 WTE establishment.

Medical care (including older people's care)

- Board reports from January 2016 to March 2016 identified that staff turnover was high on wards 28, 30, 31, 33.
- The Medicine Health Group used bank and agency staff to improve staffing levels. Information submitted by the trust showed the usage ranged between 12.2% and 0.2% for registered nurses. Ward 29 used the most bank and agency; the highest month was June 2015 at 12.2% this reduced slightly in other months and fluctuated, raising to 7.9% in March 2016.
- The service lead for echocardiography described how the numbers of newly qualified echocardiographers was limited; this made recruiting new staff challenging.
- Wards worked well and supported each other with staffing although at times it was difficult to move staff due to the actual planned levels of all the wards.
- Planned hours for Allied Health Professional (AHPs) staff in March 2016 for the Medicine Health Group, were 842.0. However the actual hours completed were 504.5 leaving a deficit of 337.5 hours. Planned hours for unqualified staff was met at 280 hours.
- Within the cardiology catheter laboratory one staff member was due to leave their post and the vacancy had already been filled.
- Staff on the wards often completed extra shifts to reach the required levels and ward managers commented how well their staff were at covering the extra shifts. Often the same bank staff were used to provide continuity to the patients and bank staff.
- Some wards had over recruited to non-registered staff to compensate for registered nurse shortfalls. However not all the medical wards at Castle Hill Hospital had discharge facilitators or ward hygienists. Staff, where the extra staff had been employed, felt positive about the roles.
- We observed a nursing handover where clear information was provided and plans were made for discharge. Staff completed and updated an electronic handover sheet. Staff felt the handover was beneficial for receiving up to date information. Wards had implemented a pre-recorded handover between the day and night staff to ensure maximum staff numbers remained on the ward during shift transition. This was followed up by a bedside summary.

Medical staffing

- The medical staffing for the Health Group was made up of 28% consultants, 5% middle grade, 39% registrars and 28% junior doctors. The percentage of consultants was lower than the England average and the percentage of junior doctors was lower than the England average. The proportion of middle grade doctors and registrars was about the same as the England average.
- We examined the medical staff rota and talked with consultants and junior doctors. There were two junior doctor vacancies in cardiology. Bank and locum staff had only been used in August 2015 and March 2016 which covered 2.3% of the total bill spent. Staff confirmed that minimal locums had been used and they felt overstretched and stressed in the work they were expected to complete. Junior doctors felt supported by the medical team and felt that staff were experienced to provide assistance.
- In minutes provided by the trust, one of the main financial pressures was the amount spent on agency junior doctors on ward 29. Bank and agency money were used every month for the neurology speciality, for example, the highest bank and agency use was 34.1% in the month of June 2015. The amount fluctuated over several months and more recently in March 2016 the usage was 7.2%.
- All staff completed an induction including locum staff.
- There was consultant cover during the day from 9am to 5pm. Staff commented that consultants would sometimes come in on weekends to complete a ward round. There was cover for the rapid access chest pain and consultants covered on call for the PPCI.
- The trust had highlighted on the risk register the lack of senior medical cover on ward 29 where at times there was no senior input into patient care. This was caused by a consultant working single handedly with no clear cover in place from the trust. In addition patients were not being seen by a senior member of the medical team on a daily basis as the trust expected. Controls had been put in place to minimise patient harm, these included referral to RMO3 doctor when senior medical input required and review by neurology consultant.
- Staff commented that they felt medical staffing on call was not effective; one example given was in January 2016 where a junior doctor was carrying three bleep monitors to manage. This was reported as an incident. At weekends, the junior doctors and middle grades managed the majority of hours.
- Medical staff sickness was low with the highest percentage at 1.5% in August 2015.

Medical care (including older people's care)

Major incident awareness and training

- The trust had a major incident and business continuity plan. Policies were also accessible for winter plan, escalation plan, severe weather and pandemic flu.
- Staff explained how to access the major incident and continuity plans on the intranet and an awareness of their role.

Are medical care services effective?

Requires improvement

In 2014 we rated effective as 'Good'. In 2016 we identified concerns which meant the service was rated 'Requires improvement' because:

- The trust's own ward-based '3G' audits were not always acted upon and completed in the timeframes agreed.
- Some staff did not possess specialist competencies required for the medical ward they were on.
- Patient outcome performance data was variable with some being below the national average, for example the primary percutaneous coronary intervention (PPCI) target was not consistently met.

However we also found:

- Patient's pain control was managed effectively.
- Multidisciplinary teams worked together to understand and meet patient's needs.

Evidence-based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. The trust followed NICE guidelines for patients with spinal cord compression.
- Staff demonstrated an awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward. We reviewed clinical guidelines on the intranet. Of the three that we reviewed, all had an identified author/ owner and all had review dates.
- The trust had an ongoing monthly audit programme for safe care, which included tissue viability, fluids and nutrition, observations and documentation. The results of these audits were combined in the Safe Care Summary Report.
- The pharmacy team completed audits on the wards looking at compliance with fridge monitoring, 24 hours controlled drug checks and resus trolley checks to ensure patient safety was maintained.
- The trust participated in national audits such as percutaneous coronary interventional procedures, heart failure, myocardial ischaemia national audit project and COPD audit.
- We asked staff in the cardiology laboratory about national bodies that provided best guidance for cardiology practice and whether benchmarking audits had been conducted against national standards; there was lack of certainty around this. The service manager mentioned three national bodies, but audit information was limited. The three bodies mentioned were the British Heart Rhythm Society, British Cardiovascular Society and The Registration Council for Clinical Physiologists.

Pain relief

- We observed staff respond to patient's pain requests promptly and effectively and patients commented their pain was managed well.
- Nursing staff used and documented an evidence based pain score to assess patient's needs. We saw from patients care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- On reviewing 25 prescription charts, 23 patients were prescribed pain relief on the 'as needed' part of the prescription chart. This allowed the patient to receive medication for pain relief quickly to alleviate their symptoms.

Nutrition and hydration

- We observed a patient menu folder that was for each patient. Staff commented that they had seen an improvement in patients selecting foods rather than the usual menus.
- Staff had completed training to support patients who had difficulty in swallowing. The dietitian and speech and language team provided assistance when needed.
- Protected meal times were in place. We observed a meal time and saw that patients were encouraged to sit in the dining area for their meals. Drinks were provided at meal times and between meals; we observed that drinks were placed within patients' reach.

- Assistance was offered to patients during mealtimes. Patients who were known to require assistance with meals were identified at nurse handover. A nutrition board was observed in one office with information about patients with special dietary requirements and comments regarding assistance needed.
- A breakfast club was in place on ward 26 for all patients, assisted by therapists and nursing staff.
- Staff on ward 29 told us about 'take 5' which was an initiative which staff undertook in regards to malnutrition. This included screening and weighing patients twice weekly, including a more specific assessment for patients that had been identified as a moderate or high malnutrition risk. A new nutrition section had been included on the patient discharge letter which highlighted their nutritional care whilst on the ward.
- Two wards did not meet the 3G audit for the nutrition and hydration standard set by the trust. We asked the trust to submit the last two nutritional audits. Ward 28 received 78% in the nutrition audit which the trust had rated as an inadequate scoring. For ward 33, in June 2015, the ward did not meet the required standard for nutrition and hydration with 47% and an inadequate rating. We were informed on inspection that the dietitian came to work with staff to improve the score. The audit was reviewed next in December 2015, where the score increased to 57% and remained an inadequate score. The same actions were not being met in both audits, such as food charts not totalled and necessary action taken and the patients weight was not monitored appropriately to their nutritional risk. This means we could not be assured that patients received adequate monitoring.
- The trust identified that audits should be reviewed in three months when a ward received an inadequate rating. The nutritional audits for ward 33 were not reviewed within this time period.

Patient outcomes

- PPCI is a surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart. The performance for PPCI identified the percentage of patients that receive PPCI from the patient's initial phone call for help to the procedure within 150 minutes; the target is 90%. From April 2015 to April 2016 the standard was not met for six months with the lowest being 84.8% in September 2015. Four months were consecutively below 90% from December 2015 to March 2016. It was recognised that the trust was working closely with other organisations and actions were in place in regards to the PPCI target.
- In the National Diabetes Inpatient Audit 2015, the trust was in the upper England quartile for eight of the 18 indicators. However, the trust was in the lower England quartile for prescription errors (31.4%) and although between the upper and lower quartiles for medication errors, it was still worse than the England median.
- For the period January 2015 to December 2015 the average length of stay for this hospital was shorter than England for elective care. However, data showed it was longer for clinical oncology and clinical haematology. For non-elective care, the average length of stay was longer than the England average, particularly in medical and clinical oncology.
- In the National Audit of Percutaneous Coronary Interventions the trust performed well in the audit, better than the national average for two out of three indicators.
- Castle Hill Hospital performed well in the Heart Failure Audit 2013/14. The hospital scored better than the England average for all the in-hospital care indicators. It also performed better than or the same as the England average for all but one of the seven discharge indicators.
- We saw that when performance was below the standard required in national audits, an action plan was formed and documented.
- From December 2014 to November 2015, risk of readmission at this hospital was higher than expected for elective clinical haematology and non-elective cardiology.

Competent staff

- Overall compliance with appraisals for the Medicine Health Group (across sites) for 2015 to 2016 was 79.9%. This had improved over the past two years where compliance had been 68.7% and 74.9%. Staff on two wards confirmed they had received an appraisal and the ward managers identified that 100% of appraisals had been completed. One staff member identified within their appraisal that they required more support with information technology and they had completed a computer course.

- Preceptorship packages for new members of staff were in place and they were allocated an amount of supernumerary time in order to progress with competencies.
- Nursing staff were required to complete further competencies packages for specialised skills and were assessed to identify competency levels. On ward 33, only 35% have completed the extended skills competencies. This was highlighted within the Medicine Health Group's risk register where controls were added to reduce the risk to patients; such as limiting patient numbers, offering overtime and the use of bank staff for non-specialised care.
- An intrathecal competency register was available and observed on the ward wall. Staff completed competency updates annually.
- Staff felt the specialist registrars offered training and support and the trust had a good focus on training. The senior medical team offered structured teaching sessions to junior doctors which had been effective. They were due to roll out training to other medical grades.
- Junior medical staff commented that training was excellent. A junior doctor commented how their request to fully experience the stroke pathway was supported by gaining experience during the rotation to experience patient flow from acute care through to rehabilitation.
- Therapists had developed competencies for ward based rehabilitation staff of all grades to support patient care.
- Wards provided placements for student nurses.

Multidisciplinary working

- We saw good examples of multidisciplinary team (MDT) working during our inspection. All wards carried out daily board rounds and weekly multidisciplinary meetings. We saw examples of staff interacting, both formally and informally, to discuss patient's care between teams and seek advice from colleagues. Therapist had an individualised activity plan for each patient which fed into the MDT meeting.
- Staff spoke positively about close MDT working and felt they had good working relationships.
- We observed a MDT meeting on ward 29 where all staff contributed equally and discussed the ongoing care of patients. Staff talked about how to transfer and mobilise patients, precautions to take and equipment to use. Also discussion around discharge planning and care packages was observed. We also observed a board round on ward 30 and 33 where all staff attended and provided an overview of the patient's care.
- Goal setting meetings were in place for patients on one ward within two weeks of admission and then according to individual progress.
- Staff had access to specialist services in order to provide care to patients. We were informed that ward 31 had forged strong links and partnerships with specialist MacMillan colleagues to support patient transition into the community.

Seven-day services

- Further work on the acute medical pathways is underway as part of the Urgent and Emergency Care Programme. In addition, changes had been made to junior medical rotas to increase doctor presence at weekends and overnight.
- Physiotherapy teams offered a seven day service across the wards; four physiotherapists were available at the weekend plus an on call service out of hours.
- Nurse practitioners worked out of hours and helped support staff on the wards.
- Consultant cover was provided via on call for the wards from 9 am to 9 pm.
- Pharmacy staff were available seven days a week including bank holidays. The on call pharmacist could be called outside opening hours for any urgent emergency items or advice. Clinical Pharmacy services were provided to the vast majority of wards throughout Monday to Friday with a selected service to key admission areas at a weekend.
- Imagining services were available on the site Monday to Saturday plus on call the rest of the time for urgent and emergency work.
- The cardiac catheter laboratory was open Monday to Friday plus on call the rest of the time for urgent and emergency care needs.

Access to information

- The trust used the same electronic patient board on each ward. This allowed for up to date information to be stored and informed the nursing handover record for staff. Staff could complete electronic referrals and record the pathways patients were on. The trust used three IT systems, some staff found this inefficient and slow to work at times.

Medical care (including older people's care)

- By using the trust's intranet, staff had access to relevant guidance and policies. Staff we spoke with were aware of how to access policies and were advised to look on the intranet for the latest version. All staff had access to an email account and could access the intranet from home through a secure system.
- Staff were able to access blood results and x-rays using electronic results services.
- Medical and nursing records were accessible on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated an understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Some staff were more confident with the process as they worked in areas where more patients were admitted that required a DoLs in place.
- The DoLs protocol was on display on some of the wards.
- We looked at the paperwork for a patient with a DoLS in place; this was appropriately completed and reviewed.
- We observed staff obtaining verbal consent and giving an explanation prior to completing a procedure. Patients we spoke with also said that staff asked for consent prior to delivering care.
- The electronic computer system identified any patient that had a DoLS in place.
- We reviewed two sets of patient's notes whilst in the cardiac catheter laboratory. In both cases, consent for the procedure did not follow the trust policy on two stage consent. On one patient's consent form, the patient had signed for the procedure on the day; there was no signature prior to the day of surgery. On the second patient's consent form, there was the patients' signature from the pre-assessment clinic but no signature on the day of the procedure. The second patient did have a copy of their consent provided.
- Staff completed mental capacity act training with an overall compliance of 88%. Most staff groups within the medical care services achieved over the trust target with some reaching 100%. The lowest compliance was for medical staff in cardiology who achieved 73%.
- Staff completed DoLS training with an overall compliance of 87%. Most staff groups within the medical care services achieved over the trust target with one area reaching 100%. One of the lowest compliances was medical staff in cardiology who achieved 76%.

Are medical care services caring?

Good

In 2014 we rated caring as 'good'. This remained as 'Good' in 2016 because:

- Feedback from patients and relatives was positive.
- Staff maintained patients' privacy and dignity when providing care.
- Patients and relatives told us that staff kept them informed of their treatment and progress and involved them in decision making.
- Staff were proud of the care they delivered to patients on their wards and enjoyed working there.
- Patients and families told us that they received compassionate care and that staff went above and beyond to provide individual care.

Compassionate care

- The Friends and Family Test response rate for this hospital was higher than the England average from March 2015 to April 2016. There were good test results across all wards, these included some months where 100% of families and friends would recommend the medical ward they had received care. The lowest month was July 2015 on ward 31 where 83.3% would recommend the care they received.
- We observed that most wards displayed the most recent Friends and Family Test information as well as cards and letters received from patients.
- All patients and relatives spoke positively of the care they received. Patients described staff as being very helpful and supportive of their needs.
- We observed staff interacting with patients on the wards in a caring and compassionate manner. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We observed that staff respected the privacy and dignity of patients. Staff were sensitive in the way they discussed aspects of the patient's care with them.
- We visited CMU that could be a mixed gender bay area in line with Department of Health guidance due to the level of patient care that was required. Patients were

asked on admission their preference and moved to a single cubicle where requested and appropriate. At the time of inspection there was no mixed sex accommodation within CMU.
- We checked eight patient bed areas on one ward and all the patients had access to nurse call system and drinks.

Understanding and involvement of patients and those close to them

- Patients commented that they felt involved in their care and described being included in the decision making about treatments they received.
- Rehabilitation goals were discussed and agreed with patients and their families at goal setting meetings. We saw evidence in the records where patients and their relatives had been involved in the decision making about their care and treatment.
- In one of the ward areas the day room was decorated with banners and football memorabilia for a long stay patient who was an avid football supporter.
- Patients were encouraged to bring in personal belongings to make the patient feel more comfortable. We viewed some of the rooms and observed personal pictures and belongings.
- We observed staff involving patients in their care in a way they could understand.

Emotional support

- We observed staff interacting with patients and relatives in a supportive and reassuring manner.
- We heard good examples of staff providing additional emotional support to patients. For example, one staff member went shopping with a patient to buy clothes and a wig to allow the patient to attend the wedding. The staff member also agreed to take the patient to the wedding.
- On one of the wards, staff told us that they served meals in the dining area to support social interaction and prevent isolation however staff respected the individual choice of the patient of where to eat their meal.

Are medical care services responsive?

Good

In 2014 we rated responsive as 'Requires improvement'. In 2016 this has improved and was rated as 'Good' because:

- People knew how to raise concerns and the process to follow.
- Services were planned in a way to meet the needs of the local population.
- Patients' individual needs were met such as interpreters and support for people with disabilities.

However we also found:

- A local improvement plan was in place and, at the time of inspection, targets were being achieved to meet the 18 week referral to treatment indicator.

Service planning and delivery to meet the needs of local people

- The trust worked closely with local Clinical Commissioning Groups (CCGs), stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- The teenage and young adult's area was designed with facilities for patients of that age and supported by the Teenage Cancer Trust.
- The Queen's Centre was designed to hold various other services to be close together, including support groups and a patient information centre.
- Quiet areas were available on ward areas we visited to enable patients and relatives to be somewhere more private.

Access and flow

- Data for the period April 2015 to March 2016 showed that overall the trust was not meeting the 90% standard for the percentage of patients receiving treatment within 18 weeks of referral. The percentage achieved by the trust was worse than the England average. By speciality, the worse area was cardiology at 71.8%.
- The management team were aware of the failure to meet the referral to treatment targets and had agreed an improvement plan with the local CCGs to work towards achieving this. There was an agreed trajectory for improvement and the trust was currently ahead of trajectory.
- Information regarding bed moves between March 2015 and February 2016, indicated that across medical services for Castle Hill Hospital, 46% of patients had no moves, 34% were moved once during their stay, 12%

were moved twice, 5% three times and 3% of patients were moved 4 or more times. There were 58 patients moved wards after 10pm from October 2015 to March 2016.

- At Castle Hill Hospital from January to December 2015, the average length of stay was shorter than the England average for elective care, but longer than the average for non-elective care. Elective clinical oncology and clinical haematology and non-elective cardiology, clinical oncology and medical oncology had longer than average lengths of stay.
- Some patients had direct access to the wards; this reduced the time patients needed to be in other departments.
- Due to the complex patient clinical needs on ward 29, access was needed to intensive expert speech and language therapists. However, it was highlighted on the trust's risk register that there was a lack of specialists and there was a risk that patients were not able to meet their rehabilitation potential. Control measures were in place, for example, the head of the department oversaw the clinical practice of a graduate on the ward.
- We asked all the medical teams regarding medical outliers who confirmed that it was rare to have medical outliers on their wards.

Meeting people's individual needs

- Visiting hours on some of the wards were flexible to meet the needs of the patients and their condition.
- There was a range of clinical nurse specialists who supported patients in a range of different settings.
- Hospitality rooms were available for relatives to stay which were easily accessible.
- Patients said they were offered a choice of food and regularly offered drinks. Patients were offered alternative choices to the food menu and were provided with snacks during the day.
- Face to face interpreters were available and there was access to a language line for rare languages. There was also access to British Sign Language (BSL) interpreters.
- Staff informed us they had recently had to use the service for patients and relatives who spoke Russian and Polish.
- A clinical psychologist and learning disability specialist nurse supported those patients with particular needs. Staff were aware of the learning disability passport and how to access this. Patients with learning disabilities were highlighted as part of the safety brief to identify if further support was required. We observed this element within the safety brief during our inspection.
- The learning disability liaison nurse provided training for staff and the trust was planning to facilitate a mental health and learning disability study day in July 2016. Online training was also available.
- The wards areas were spacious and accessible for people with limited mobility and who used a wheelchair. Wheelchairs were available within the areas, when required and disabled toilets were available.
- One patient with physical disabilities could not use the nurse call system due to problems with their hands. The unit contacted engineering and the buzzer was adapted for their needs. Therapists were very flexible to meet the needs of those patients who required additional support.
- In the last 12 months there had been no mixed sex breaches reported by the Medicine Health Group. CMU was a mixed sex area due to the level of patient need, however where possible they tried to maintain the same sex in each bay area. At the time of inspection males patients were in the bay areas and female patients were in the cubicles.
- The trust had a dementia strategy. Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This is a national scheme that teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- Wards had dementia friendly signage and were decorated accordingly. Some staff took on a dementia friendly role and felt passionate about this responsibility; this included encouraging others to learn more about dementia. Wards had access to activities for patients living with dementia such as twiddlemuffs, photo boxes and memory pictures. We also observed on the ward information regarding dementia and contact numbers for support.
- Dementia training and education was not part of the trusts statutory or mandatory training programme. However, there was a dementia and delirium policy available to support staff to care for patients with dementia and a dementia screening tool was in use.

Medical care (including older people's care)

Learning from complaints and concerns

- Information submitted by the trust showed the trust received 855 formal complaints between April 2015 and April 2016. The average number of days taken to close a complaint was 36. Forty six (5.4%) of complaints were re-opened.
- Information provided by the trust identified in November 2015 at the Medical Health Group governance group, there were a number of complaints that had been open for 40 days; an update was requested and the trust identified this was due to waiting for responses from professionals. The trust's gold standard for completing complaints was 25 working days; however complex complaints were assigned a timescale of 40 or 60 days to complete.
- The most common issues complained about were all aspects of clinical treatment which included, care provided, attitude of staff and management of a patient's condition. The staff group most often complained about was medical staff which accounted for 83% of complaints involving staff.
- There were 31 complaints submitted to the trust specifically relating to oncology (3.6%) and 29 relating to cardiology (3.4%). These specialties were in the top 10 most complained about.
- We asked staff on the wards about complaints and they could remember specific complaints which were dealt with appropriately, for example communication issues and issues with medication. Staff knew the procedure for complaints and how to manage and deal with them.
- During the inspection we reviewed a response letter to the complainant which included a copy of the 'being open' report which was used to document issues raised at a meeting with the trust and complainant. The response letter highlighted the issues raised and an apology for the distress and upset caused.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. However, we saw limited information displayed in clinical areas (such as posters or leaflets) setting out the complaint process and explaining to patients how they could raise concerns.

Are medical care services well-led?

Good

In 2014 we rated well-led as 'Requires improvement'. In 2016 the service had improved and was rated 'Good' for well-led because:

- There was a clear vision and strategy for the medicine health group with an operational plan on how this would be delivered.
- Governance and risk management systems were in place to monitor and act on risks.
- The majority of staff enjoyed work and felt proud of their ward.
- There was an open and honest culture at the hospital.

However we also found:

- Due to staffing levels, ward managers were needed to provide clinical care on the ward and did not always have the capacity to allow time to be taken to focus on the leadership of their ward.
- Each ward was audited to ensure the correct level of patient care was provided, although timescales were not always adhered to.

Vision and strategy for this service

- The trust had developed a five year strategy 2016 – 2021; the strategy referenced recommendations and defined long tem goals and plans. Some of the aims of the strategy were the provision of care, workforce and financial sustainability.
- The trust had a set of values and staff we spoke with were familiar with these values. The values were identified as care, honesty and accountability. Each section identified expectations that patients and relatives should and should not see. Staff found the trust values to help focus staff on the behaviours expected.
- The trust focused building on their vision and adopted seven long terms goals which they felt when achieved will make three elements – great staff, great care and great future. This logo was used as part of their branding.
- The trust had a medicine Health Group operational plan for over a five year period.

- Within the oncology department there was a ten year plan with the expansion of beds to be available at the hospital.
- We met with the senior medical care team who articulated the vision for the Health Group. They were aware of the issues and plans were in place to meet the demands and needs of the service.
- The trust worked in partnership with local NHS trusts and commissioning groups to develop a nursing and midwifery strategy.

Governance, risk management and quality measurement

- Within the Medicine Health Group an Integrated Governance Committee was held monthly. This meeting had a set agenda and looked at incident management, serious incidents, risk register, current audit plan and complaints.
- As part of the inspection we reviewed minutes of meetings. In the medicine group integrated governance committee January 2016 minutes it identified there were a number of overdue serious incident actions. It was reported at the November meeting that it was agreed with commissioners that all overdue actions would be completed and closed by the end of January 2016. There were 51 actions, 22 of which became overdue at the end of December. Members of the executive management team reviewed serious incidents at weekly meetings. It was confirmed at the inspection that the overdue actions had now been completed.
- There was a risk register in place that reflected the current risks to the operational effectiveness of the medicine group. These risks were identified at the time of the inspection as current risks. The risk of nurse staffing establishments was highlighted on the medicine Health Group risk register and controls were put in place to minimise the risk. These included twice daily safety briefs, regular discussion with bank / agency staff to improve the fill rates including block bookings and an action plan monitored by the Health Group.
- The trust were aware that they had not met their target in relation to nutrition and hydration outlined in their Quality Account document. The 3Gs nutrition and hydration audits on some wards had been assessed as inadequate. This was not included within the medicine groups risk register to identify any controls in place to reduce the risk.
- Audits were not always completed in the timescales agreed although the trust had an audit programme in place.

Leadership of service

- Each Health Group had a structure of medical, operational and nurse directors. These then linked into the chief operating officer and executive team.
- The Health Group leadership team had recognised the need to develop effective leadership at all levels and this was identified on the risk register. Leadership development for service leaders and the introduction of the 'Great Leaders' programme for middle managers were control measures in place. Ensuring charge nurse competency and appropriate training for staff were also identified as control measures.
- Nurse directors met with the chief nurse every Tuesday and would alert the chief nurse to any major issues as they arose.
- Wards and departments carried out individual fundamental standards audits (3Gs – great staff, great care, great ward). During 2015/2016 medical wards had been rated as outstanding, good, requires improvement and inadequate. The trust was open and displayed the findings, positive and negative, detailing what they needed to improve with in each of the areas and also what worked well. These were displayed on the wards we visited.
- The majority of staff were aware of the executive trust team and identified the chief nurse had been on wards, engaged with staff and was approachable.
- Due to not attaining planned levels of nursing staff, some ward managers spent their management time on the ward providing nursing care.
- Staff felt their immediate line managers were approachable and ward managers were open and transparent.
- Some teams had team meetings were staff felt they could raise issues, however these were not regular due to staffing constraints.

Culture within the service

- All new starters received professional and cultural transformation (PaCT) training. Also current members of staff also completed the training. This training was for staff to understand the expectations of them working within the trust.

Medical care (including older people's care)

- We asked staff about bullying and all staff reported they had not seen or experienced any bullying. Some staff that had worked for the trust a period of years felt there had been positive shift in trust culture where improvements had been made.
- Staff felt they could raise concerns about patient safety to their immediate managers and they would listen. Staff gave positive feedback regarding the culture in the organisation.
- Staff often completed extra shifts on the wards they worked as they liked where they worked.

Public engagement

- A draft patient experience strategy which included medical care services was in the process of being reviewed by stakeholders and the public and patients council. The final version of the strategy was due to be presented to the trust board for approval in September 2016.
- The NHS Friends and Family Test (FFT) for Castle Hill Hospital showed a response of 29%; this was higher than the England average response rate.
- The trust worked with charities and joint initiatives were completed to raise awareness of rehabilitation issues.
- Staff on ward 30 had been nominated by patients and friends for a people award dignity in care 2015.

Staff engagement

- The trust had developed a 'People Strategy' in 2016. Some of the aims of the strategy were recruitment and retention and innovation, learning and development. Senior managers told us that staff had been involved in the all the strategies developed. We asked some staff about the strategies and they were aware of them.
- The trust looked at the four Health Groups they currently had and wondered if the groups were too large and potentially looked at creating a new structure of seven groups. A consultation period was created and staff were asked their opinion, the consensus from the majority of staff was that they preferred the four Health Groups. The trust remained with the four original Health Groups.
- The trust adopted a golden hearts award where staff were nominated for various awards for recognition. We were told some staff had received individual awards.
- Staff worked well on the wards and worked as part of a team and shared an understanding for each other's roles. Many staff enjoyed their job and found it rewarding even though at times they felt overstretched in their role.
- The friends and family test showed that 72% of staff would recommend Castle Hill Hospital for care and 56% recommended the hospital as a place to work.

Innovation, improvement and sustainability

- A number of wards were trialling the use of new types of roles to help and assist and release registered nursing time. These included ward personal assistants, discharge facilitators, ward hygienists and nutrition care apprentice.
- The therapists on ward 29 were involved in an exercise research study for patients with brain tumours.
- Staff were keen to progress research projects to benefit patient outcomes and raise the profile. We were told that innovation was encouraged by the trust. Ward 29 had the aspiration to achieve a level 2a status on data submission to the UK rehabilitation outcome collaboration.
- The trust will be hosting the British Society of Rehabilitation Medicine conference in November 2016.
- There was international recognition for the Haemophilia Centre based within the Queen's Centre for Oncology and Haematology as it was awarded European Haemophilia Centre status in June 2015.

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Castle Hill Hospital (CHH) was part of the Hull and East Yorkshire Hospitals NHS Trust. The Surgery Health Group provides a range of surgical services for the population of Hull and surrounding areas.

On this site the Surgery Health Group provide elective treatments for different specialities such as cardiothoracic, ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, spinal, orthopaedics, colorectal, upper gastro-intestinal, urology. It also provides acute non-elective urology and cardiothoracic services.

The surgery service has eight wards surgical at CHH with 199 inpatient beds. The hospital has fifteen theatres, four-day surgery theatres and two clean procedure rooms.

Between January 2015 and December 2015 the Surgery Health Group carried out 57,579 surgical spells, which placed it in the top quarter of all NHS trusts nationally. Sixty-one percent of procedures were carried out as a day case with 34% elective admission and 6% emergency admissions.

During our inspection, we spoke with 42 members of staff including nursing, medical and allied health professionals as well as 27 patients and two relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 20 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the Surgery Health Group.

We attended a number of staff focus groups and observed care being delivered on wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI) tool. SOFI is a way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust. We carried out unannounced inspections on 9th June and 11th July 2016.

A comprehensive inspection of CHH was carried out in February 2014; all five domains were inspected for surgical services. Safe and Well led were rated as requires improvement and effective, caring and responsive were all rated as good. The service overall was rated as requires improvement.

A focused inspection was carried out in May 2015. Two domains were inspected, for surgical services Safe was rated as inadequate and well led was rated as requires improvement. The service was rated Inadequate overall. The main issues at this inspection were:

- A number of Infection Prevention and Control (IPC) concerns in relation to the environment and compliance with specialised ventilation guidance within theatres and orthopaedic patients not being “ring fenced”.
- Concerns over the number of suitably skilled and experienced staff working in surgical wards.
- No clinical strategy for the Health Group.
- A backlog of complaints and incidents within the Health Group requiring investigation.

The trust was not meeting the overall referral to treatment (RTT) performance standards.

Surgery

Summary of findings

In 2015 we rated surgical services at CHH as 'Inadequate'. Following the 2016 inspection we rated surgical services at CHH as 'Requires improvement' overall because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated, were not always escalated for medical review.
- From our observations it was apparent the five steps to safer surgery checklist, was not embedded as a routine part of clinical roles.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff. In June 2016 ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. We found that nursing staff did not always complete accurately the falls and dementia risk assessments. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance standards for treatment and cancer standards.
- The senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

However,

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI), we carried out showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.

Surgery

Are surgery services safe?

Requires improvement

In 2015 we rated safe for surgical services at CHH as 'Inadequate'. Following the 2016 inspection we rated surgical services at CHH as 'Requires improvement' for safe because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated, were not always escalated for medical review
- We had concerns regarding the effectiveness of the five steps to safer surgery checklist, from our observations it was apparent this process was not embedded as a routine part of clinical roles.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff. From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff. In June 2016 ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds.
- We found that nursing staff did not always complete accurately the falls and dementia risk assessments.

However,

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- The health group was meeting the trust compliance target (85%) for mandatory training. Training data we reviewed showed an overall training compliance rate for the Surgery Health Group of 85.1%.

Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event. No never events had been declared within the Surgery Health Group at this hospital.
- Serious incidents are incidents that require further investigation and reporting. Twenty three serious incidents (SI) were reported; within the Surgery Health Group during the reporting period May 2015 to April 2016. Themes from serious incidents reported included surgical procedure issues, treatment delays and pressure ulcers. We reviewed four serious incident reports and noted the recording of duty of candour discussions, recommendations and further learning identified as appropriate. One serious incident we reviewed was due to be reviewed six months after completion, to ensure the new practices recommended were embedded.
- We reviewed incident data supplied to us by the trust that showed surgical wards and departments reported 2,518 incidents from May 2015 to April 2016. Reported incidents we reviewed showed two graded as death, nine graded as severe harm, 57 as moderate harm, 496 graded as low harm and 1,954 graded as no harm/ near miss.
- The Surgery Health Group reported the second largest number of incidents in the trust (23.4%). Reported incidents showed the top three categories of incidents reported was patient accident at 28% (713 reports), access, admission, transfer, discharge (including missing patient) were 13% (329 reports) and treatment and procedure 11% (280 reports). Staff we spoke with were aware of the top three incidents.
- In 2015, the trust was asked to take action to ensure, that all incidents were investigated in a timely manner. Data we received from the trust in February and March 2016 shows a backlog of 168 incidents required review. We discussed this backlog with the senior management team and they informed us of the work to reduce the backlog, and at the time of the inspection, the Health Group had reduced the backlog to 28 outstanding incidents to review.

- Nursing and medical staff we spoke with were aware of the reporting system and staff could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. The majority of staff we spoke with said that they received feedback following completion of incident forms.
- Nursing and medical staff we spoke with said that learning from incidents was shared internally through safety briefs during shift handovers, quality and safety bulletins, internal emails and lessons learned newsletters. Themes within the newsletters and bulletins we reviewed included new medications, changes to radiology results notifications, falls, blood transfusions and incident reporting.
- There was evidence of changes in practice from incidents. For example, there had been an incident in another heath group with alcohol hand gel; staff we spoke with were aware of this incident and had taken individual ward based actions to identify solutions.
- The senior management team held bi-weekly meetings with ward managers to discuss incidents and actions taken.
- Mortality and Morbidity meetings were held within individual specialities, no specific overall mortality meeting was held for the Health Group. The senior management team spoke with us about the trust Mortality Committee and the governance group providing information into this group; however, from governance and business minutes we reviewed it was not apparent that mortality discussion was held at the Health Group's governance or speciality business meetings. The lack of a forum to discuss mortality and morbidity within orthopaedics was identified in December 2015 as a risk. In June 2016 the Health Group agreed to remove this from the register; however medical staff had challenged this. Within the Health Group strategy it was recognised that a robust mortality and morbidity team review system was required. The senior management team informed us that a new system of case note review mortality meetings was been introduced. Staff from within the Health Group had received training and the centralised system was due to be implemented from September 2016.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of duty of candour requirements and described it as being open and honest with patients when incidents occurred, they provided examples of when patients were cancelled having open discussions with the patient about the reasons for cancellation and when patients had acquired pressure damage whilst in hospital.
- Data we reviewed showed that within the Surgery Health Group duty of candour requirements had been declared on 16 occasions during 2015/2016. The senior management team provided us with examples about its use, for example an increased incidence of pressure ulcer development within the Health Group. Staff recorded duty of candour discussions on the investigation reports and staff said this was also recorded on the incident form and medical notes.
- Response letters to complaints included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots) and catheter and urinary tract infections (CAUTI's).
- Information from the safety thermometer data was displayed in all areas visited.
- In the Health Group during the reporting period, March 2015 to March 2016 there had been 35 pressure ulcers, six falls with harm and 15 CAUTI's.
- The rate of new pressure ulcers reported was highest in March 2015, following this period rates were variable with no trends identified.
- The Surgery Health Group had reported six falls with harm; these had all been reported from September 2015.
- The rate of urinary tract infections reported in patients with a catheter showed a decreasing trend between October 2015 and February 2016.

- Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed March 2016 showed 77.9% of patients received the appropriate assessment of risk. The trust had implemented a new patient administration system and the trust reported that data capture issues were causing low level compliance issues.

Cleanliness, infection control and hygiene

- In 2015, the trust was asked to take action to ensure the results of IPC audits were reviewed especially on wards and theatres. The trust was also asked to ensure compliance with theatre engineering performance measures and annual servicing of ventilation for all theatres. Since the previous inspection, orthopaedic patients were being segregated appropriately and the ward managers were able to discuss results and actions as a result of infection prevention and control audits.
- Infection prevention and control information was visible on all wards we visited; this information included the number of days since last clostridium difficile (C.Diff) infection and methicillin resistant staphylococcus aureus (MRSA) isolate.
- The trust reported zero cases of hospital acquired MRSA July 2015 to April 2016. The trust reported 46 cases of hospital acquired clostridium difficile (C.Diff) in the reporting period April 2015 to April 2016 this was lower than the agreed maximum threshold of 53 cases.
- The trust had a policy for screening surgical patients for MRSA. Emergency and elective patients undergoing surgical procedures and fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening and noted 75% compliance against a target rate of 100% during the reporting period April 2016 to June 2016
- At the time of the inspection, the trust did not undertake audits of the MRSA and C.Diff policies.
- Wards and departments were visually clean and we saw ward cleanliness scores displayed in public corridors.
- We saw staff washing their hands, using hand gel between patients and staff complying with 'bare below the elbows' policies.
- Hand hygiene audit data we reviewed showed 97.2% compliance in the reporting period April to June 2016. However, only two wards and three theatres submitted data, out of these only one area submitted data every month. The trust had recognised a reduced compliance with the audit, and from July 2016 had introduced a new five moments audit tool and IPC ownership tool.
- During the inspection, we saw hand hygiene compliance data displayed on the wards and departments we visited. Following a serious incident the trust had taken a decision for wards to risk assess the provision of alcohol gel at patients' bedsides; some wards had made the decision following the risk assessment to provide personal issue alcohol gel to staff. Soap dispensers we reviewed were in good working order.
- All patients were provided with hand hygiene wipes to clean their hands prior to meal service.
- During the inspection, we observed good compliance with IPC policies for example rooms were available for the isolation of patients, and patients requiring isolation were isolated.
- Staff working on the elective orthopaedic wards spoke with us about being ring fenced for elective orthopaedic patients only to prevent infection as per best practice guidance.
- The hospital participated in national surveillance projects for Knee replacement October to December 2015 and cardiac surgery January to March 2016. Data we reviewed from the reporting periods showed a similar level of surgical site infection when compared with national hospital data for knee replacement. The hospital performed better that all hospitals data in cardiac surgery (non CABG) hospital 0% infection rate and 1.5% national all hospitals rate.
- Environmental cleaning schedules were available and displayed in public areas. We reviewed patient led assessment of the care environment (PLACE) results for the trust and noted 96% slightly below the 98% England average for 2015.
- The infection prevention and control (IPC) team delivered training both face to face and via e-learning. IPC training compliance rates for the Surgery Health Group were 75.7% with a trust target of 85%.
- The trust had completed a review of clinical areas undertaking operating procedures and classified them as ward, operating or clean room standards.
- Specialised ventilation isolation rooms were available on ward 27 for patients with communicable diseases.

Environment and equipment

- The wards and the majority of departments we visited appeared well maintained. One of the areas used for day surgery required refurbishment and did not appear well maintained; floors and walls were damaged and shelving units were not sealed to prevent contamination with body fluid spillages.
- Equipment we reviewed was stored appropriately and had been electrical safety tested.
- In the majority of occasions, for the resuscitation equipment we checked staff had recorded that checks were complete. All resuscitation equipment we reviewed was stored appropriately and within expiry date. We checked three emergency trollies in main theatres they did not have the same equipment stored in each trolley, the resuscitation council recommends that resuscitation equipment and layouts be standardised throughout organisations.
- Staff we spoke with said that there were adequate stocks of equipment and we saw evidence of good stock rotation.
- During the inspection, we observed a laser in use, in theatre 10; staff we spoke with had little knowledge of the policy, responsible person or environmental protection requirements.
- We reviewed the trolley used for difficult airway access within the day surgical unit and noted that it was difficult from visual observation to identify what equipment was single use or how it was decontaminated. This did not reflect recent improvements suggested by the Difficult Airway Society. It is recommended by the difficult airway society to have clearly and concisely labelled drawers they suggest downloading images to label difficult airway trolley drawers, to enable easy access to equipment in emergency situations.

Medicines

- On surgical wards we visited medicines were appropriately stored, with access restricted to authorised staff. On the majority of occasions, staff prescribed and administered medicines appropriately.
- Controlled drugs were appropriately stored; administration records were maintained; however, on most areas visited daily balance checks were not performed in line with the trust policy.
- From prescription charts we reviewed, medical staff did not always follow the trust procedure and safe practice when cancelling a prescribed medicine. Pharmacists had checked the majority of charts we reviewed checks included ensuring patients were prescribed the same medications they had been taking at home, unless this was no longer appropriate.
- Emergency medicines were readily available and they were found to be securely stored and in date.
- The majority of medicines fridges were secure; staff monitored and maintained temperature records in most areas.

Records

- Paper records were available for each patient that attended the wards or department; the trust used a computerised patient administration system, however most records and patient assessments were still paper based.
- Electronic boards were available on all wards visited, which provided access to staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans.
- Ward 15 was participating in a trail of electronic observations recording, via a tablet computer, staff we spoke with said that the trial was improving access to information and documentation.
- We reviewed 20 sets of medical and nursing care records whilst on site and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of the review or administration of medication as per compliance with trust policy and professional standards.
- Patient records were stored in notes trollies that were able to be locked, or where stored in secure areas.
- The wards and departments used risk assessments for falls and pressure damage prevention. Records we reviewed showed that on the majority of occasions theses were completed accurately.
- Completion of venous thromboembolism (VTE) assessment was noted to be 77.9% for March 2016 lower than the trust compliance rate of 100%.
- Individualised patient care plans were used for patients these were used as part of the assessment process to detail the care needs of the patient.
- Ward quality assurance audits were carried out on a monthly basis, five sets of notes were audited each week and areas audited, these included reviews of tissue viability, IPC and patient experience records.

Safeguarding

- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff we spoke with were able to describe their roles in relation to the need to report and take action as required when safeguarding issues were identified.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by refresher training. We reviewed safeguarding training compliance rates for July 2015 to April 2016 and they showed 84.6% compliance with a trust target of 85%.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e-learning programme.
- The trust target for mandatory training completion was 85% compliance; training data we reviewed showed an overall training compliance rate for the Surgery Health Group of 85.1%.
- Individual levels of compliance for training ranged from 82.5% to 92.1%.
- The Surgery Health Group human resources team provided a rag rated spreadsheet to ward managers on a quarterly basis showing levels of compliance.
- New staff received a corporate and a Surgery Health Group induction, which included some aspects of their mandatory training.
- New or junior medical staff received a corporate induction and departmental induction-training programme.

Assessing and responding to patient risk

- In 2015, the trust was asked to take action to ensure use of the best practice guidance, such as the safer steps to surgery checklist.
- The hospital did undertake the 'Five steps to safer surgery' procedures including the World Health Organisation (WHO) safety checklist. The hospital demonstrated compliance with the safety checklist via audit, with five sets of notes reviewed every month, for every theatre. Results we reviewed showed 100% compliance, however an internal audit report provided to us by the trust reported 54% compliance in the reporting period November 2015 to January 2016. The report was completed for 50 patients in most specialities, a recommendation from this report (published in March 2016) was to re-audit one month later and set up a working group to review the form. Post the inspection, the trust confirmed that a working group had not been developed and no further audit had been completed. A new theatre assurance tool had been developed since the internal audit results and the results from June 2016, showed 100% compliance for the WHO audit compliance.
- During the inspection, we reviewed five sets of surgical notes containing WHO checklists and we observed two occasions when WHO checklists were completed. On the two occasions the checklist were completed; however from our observations it was apparent the completion was undertaken without effective involvement of the whole clinical team, for example sign in and final briefing had no input/involvement from the operating surgeon. No verbal communication was apparent for sign in on both occasions no verbal communication occurred on the appropriate use of antibiotic prophylaxis, pre-operative warming, blood glucose control or VTE risk assessment, this should occur in the time out step .
- We had concerns over 15 incident reports we reviewed May 2015 to March 2016 where missing needles and sutures were reported post operatively and incorrect swab counts. We highlighted our concerns at the time of the inspection and the senior management team spoke with us about a new theatre assurance tool. Results from June 2016, showed 100% compliance for the WHO audit compliance.
- The trust used the national early warning score (NEWS) tool; surgical areas used a paper based version to record the early warning score. Nursing staff identified deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with were able to articulate the clinical condition of a deteriorating patient, however did not appear to have consistent knowledge of the actions required to escalate a deteriorating patient for medical staff review. The trust carried out internal audits of the NEWS scores and we noted on average a 96.8% compliance that appropriate action was taken for NEWS scores 7 or above in the reporting period January 2015 to February 2016.Audit data from April 2016 to June 2016 showed 100% compliance for most areas. Within the Health Group strategy, it had been recognised that the development and delivery of improved identification and management of deteriorating patients was required.

- From notes we reviewed we did not see effective escalation of all deteriorating patients. From seven sets of notes reviewed, from patients that had deteriorating early warning scores documentation of escalation and review was only in available for two patients. In five patients that had deteriorated, action or escalation was not apparent. The implementation of the early warning scoring system did not support the process for early recognition and early intervention of patients who were becoming unwell. From medical notes we reviewed one orthopaedic patient had deteriorated this had been escalated and the patient had been seen by the critical care outreach team, however no documentation occurred in regards to a medical review until seven days post the deterioration.
- We reported our concerns about the escalation of deteriorating patients to the trust at the time of the inspection. Post the inspection the trust said they were planning to implement e-observation packages as finances became available.
- We had concerns over consultant review of elective orthopaedic patients during June 2016. Evidence we saw showed that ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds. The senior nursing team had highlighted this to the clinical director and had commenced completion of a safety cross to highlight the issue. We discussed this with the senior management team who informed us that consultant job planning reviews had been undertaken and that improvements would be made post September 2016, No formal protocols were in place to allow nursing staff to discharge patients without medical staff review.
- Staff were aware of escalation procedures for issues of concerns on their wards or departments.

Nursing staffing

- In 2015, the trust was asked to take action to ensure that there are at all times sufficient numbers of suitably skilled and experienced staff.
- At the time of the inspection, surgical wards and departments had 814.6 WTE registered nursing posts and 752 WTE unqualified nursing posts. We reviewed vacancy rates and this showed a 7.6% vacancy rate. All surgical wards we visited had vacancies.
- The trust used the safer nursing care tool to asses nursing staff requirements per ward and department, per shift.
- The surgical wards displayed planned and actual nurse staffing levels for each shift. The trust-planned nurse to patient ratios was 1:8 day shift and 1:10 night shift for all surgical wards.
- Prior to the inspection, we reviewed the safer staffing report May 2016 for surgical wards, and on average there was an 80.5% fill rate for registered nursing RN staff per day shift and 88% fill rate for night shift. For care staff the average fill rates were 80.8% day shift and 103% for a night duty. Data we reviewed ranged between 91% to 48% average fill rate for RN day shifts and 75% to 103% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 189 registered nurse shifts reviewed, we saw that 70 shifts were staffed at below the established levels. Staffing levels we reviewed on wards 8, 10 and 11 all showed periods of registered nurse staffing levels falling below the established levels.
- The Surgery Health Group used bank and agency staff to improve staffing levels; we reviewed use of bank and agency staff and noted 1.3% agency usage.
- Most of the wards we visited had below planned staffing levels overnight. The majority of the staff we spoke with said that when the rotas did meet their planned numbers, staff on duty were moved overnight to improve staffing levels on other areas. We had concerns over the staffing levels on ward eight overnight as they had only one nurse for that area on three out 21 occasions. They were supported by nurses from the adjacent ward at these times.
- We had concerns about the staffing levels within the high observation bay HOB. During the inspection, we reviewed staffing rotas for HOB units on ward 10 and ward 11, we spoke with staff working in the areas, and we found that although staff were clear about the staffing levels required 1:4 registered nurse to patient ratio, they were not always able to maintain these levels. During the inspection, we saw one registered nurse to four patients; however, when reviewing 126 registered nurse shifts the ward staffing level was below establishment on 62 occasions. On these occasions, staff were not able to demonstrate how they maintained a 1:4 ratio in the HOB and a 1:8 ratio for the rest of the

ward. When we asked staff for the protocol or policy for the HOB units, they were not aware of one, however post the inspection the trust provided one which stated the staffing level is agreed as a 1:4 ratio.

- The Surgery Health Group was actively recruiting to vacant posts, both local and international recruitment events had been undertaken, an intake of new registered nurses from the local university were due to commence employment in September 2016.
- Twice daily safety brief reviews took place each day across the hospital, the purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Ward co-ordinators attended safety briefings. Prior to making decisions discussions were held around the skill mix, harm rates of pressure sores, falls and infection status, availability of other staff. Staff were often moved from their substantive area because of these discussions.
- The trust had recently developed new roles to support the nursing ward teams. These included ward personal administrators, to help ward sisters with ward administration duties, discharge facilitators and ward hygienists. All surgical wards had access to these members of staff. Staff we spoke explained the difference these roles had made, especially discharge facilitators and ward administrators.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that patients' clinical conditions were discussed and levels of support or risks were identified.
- We reviewed planned vs actual hours for allied health professionals within the Health Group; these were similar for qualified and unqualified staff.
- Within theatres at this hospital, 16 WTE Operating department practitioner post and 24.6 WTE junior qualified nurse posts were vacant.

Surgical staffing

- For all surgical specialities a consultant is present on site 8am until 6pm Monday to Friday. Acute general surgery had consultant presence 8am until 1pm weekends and bank holidays and trauma had consultant presence 8am until 6pm weekends and bank holidays.
- On-call cover was provided for a 24-hour period, one resident foundation level two doctor was available overnight; two registrars were present on site until 8pm, overnight two non-resident registrars were available on an on-call basis.
- We found that the medical skill mix was similar to the England average for consultants at 43% (England average 41%), registrar group 37% (England average 37%), and junior doctor level 14% (England average 12%). Middle career level was lower than the England average at 6% (England average 11 %).
- At the time of the inspection, surgical wards and department had 372 WTE surgical medical staff, 152.5 WTE consultants and 190.1 WTE junior doctor and middle grade posts. We reviewed vacancy rates and this showed 12 WTE surgical consultants, 14.73 WTE junior doctor vacancies, and three WTE middle grade posts. The senior management team spoke to us about the gaps in the junior doctor's rota, especially overnight; this was also highlighted on the risk register. During and post the inspection the trust confirmed that 89% of all junior doctor posts had been filled for the new August intake.
- Some junior medical staff we spoke with highlighted concerns over the workload within some surgical specialities. On two different occasions staff spoke with us about gaps in overnight surgical cover, they provided us with dates of when there had been no foundation level two cover on site however the trust confirmed there were locum staff on duty.
- The Surgery Health Group used locum staff to improve staffing levels; we reviewed use of locum staff during the reporting period of April 2015 to March 2016 and noted 7.8% agency usage.
- Some junior medical staff we spoke with said that formal handover in the morning did not take place. The hospital at night team did handover to medical staff any patients of concern overnight.
- Formal medical handovers took place twice a day with informal handovers occurring as shifts changed or as patients conditions deteriorated, we were unable to observe these during inspection.

Major incident awareness and training

- The trust had a major incident and business continuity plan. This was available to staff on the trust intranet.

- A recent live incident had led to the business continuity plan being activated. The trust had evacuated a group of patients due to a fire in a nearby theatre. The senior management team spoke with us about being proud of how the staff worked in that situation.
- Staff we spoke to had an awareness and understanding of their roles in major incidents.

Are surgery services effective?

Requires improvement

The effective domain was not inspected during the 2015 inspection, in 2014; we rated surgical services at CHH as 'Good' for effectiveness. Following the 2016 inspection, we rated surgical services at Castle Hill Hospital as 'Requires improvement' for effectiveness because:

- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored worse than the national average (0-49%) for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- The majority of fluid balance charts we reviewed on ward 8 were not maintained accurately

However,

- Policies for the Health Group we reviewed were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dietitians, and ward staff.

Evidence-based care and treatment

- We saw patient's treatment was based on national guidance, such as from the National Institute for health and care Excellence (NICE), the Association of anaesthetics, and from the Royal College of Surgeons.
- The department measured compliance with national guidelines. Data we reviewed from March 2016 showed that one clinical policy and one clinical guideline were overdue for review, and all procedure documents were compliant.
- We saw evidence of discussions in accordance with the National Confidential Enquiry into Patient Outcome and death (NCEPOD) guidelines.
- Policies were stored on the trust intranet and staff we spoke with, said they were able to access them.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery, examples of these included gastro surgery and elective orthopaedic joint replacements.
- The hospital participated in both the bowel cancer audit and lung cancer audit 2015. CHH did not undertake emergency surgery to patients with fractured neck of femur (hip joint) so did not provide data to the national hip fracture audit 2015.
- The Health Group had a local audit programme and these were discussed during audit sessions for the Health Group.
- Wards and departments we visited took part in local compliance audits of infection prevention and control practices, medication and documentation. These audits were called (3G inspections) and had been conducted during 2015/ 2016. The outcome was that the surgical wards had been rated as outstanding (none), good (four), requires improvement (12) and inadequate (one).

Pain relief

- We saw that patients were offered pain relief. Patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Staff used a pain-scoring tool to assess patients' pain levels; staff recorded the assessment on paper records.
- Some surgical patients received intravenous patient controlled pain relief trust post-operatively.

Nutrition and hydration

- We saw patients were offered drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes by using validated nutritional risk assessment documentation. Documentation we reviewed showed good levels of completion.
- We observed two meal services on ward 8 and 15 and noted all patients requiring support with feeding received this within five minutes of being provided with warm food,
- Patients had access to fresh water where appropriate. Fluid balance charts we reviewed were not always accurately completed, four out of six charts we reviewed on ward 8 had gaps in recording and daily totals were not added up, meaning staff were not aware of patient's daily intake of fluid.

- The trust staggered theatre fasting times, however, because of list overruns some patients we spoke with did fast for longer times than planned. The trust did not undertake internal fasting audits.
- A snack menu was available on all surgical wards. This provided patients with additional food between meals such as cakes, yogurts and ice creams.
- Staff we spoke with said they could access hot meals out of hours, for patients who had been to theatre or required a hot meal if they were unable to go to theatre.

Patient outcomes

- At the time of the inspection, the trust was classified as a mortality outlier with the Care Quality Commission for cardiac artery bypass graft. This means that performance within these two areas was outside of the expected range of performance; the trust had investigated the reasons for this and provided the commission with an action plan.
- At Castle Hill Hospital, the risk of readmission following elective surgery was worse than the England average in cardiothoracic surgery and was better than the England average in urology and colorectal surgery. Non-elective surgery readmission rates were worse than the England average in colorectal surgery and about the same in urology and lower in ear, nose and throat.
- The national bowel cancer audit (2015) showed worse than England average performance for the three indicators, including data completeness and review by a clinical nurse specialist. Laparoscopic surgery rates showed that this was only attempted on 24% of occasions, which was worse than the England average of 57%. No action plan was available detailing improvements required.
- We found that the emergency laparotomy organisational audit 2015 showed that the trust scored worse than the national average for four out of the 11 outcome measures including consultant surgeon review within 12 hours of emergency admission, preoperative review by consultant surgeon and anaesthetist and a consultant anaesthetist presence in theatre. The trust scored green in three-outcome measure and that was for direct postoperative admission to critical care. The remaining four outcome measures all scored amber. We reviewed the trust action plan for the audit and noted actions for further implementation of the laparotomy pathway and a resources review. It did not include any actions to improve patient access to consultants.
- The lung cancer audit (2015) showed better performance than the England average results for both discussion at a multidisciplinary team meeting (97% for the trust, compared with 93.6% England average) and the percentage of patients seen by a clinical nurse specialist which was 83.9% compared with 78% England average. However, the percentage of patients receiving surgery was lower 13.5% than the England average 15.4 %. We requested to review the trust action plan for the audit, an action plan was available, and these detailed two actions including a further audit, and it did not include actions for the recommendations in the report.
- The trust participated in the national hip fracture audit; however, CHH did not undertake emergency surgery to patients with fractured neck of femur (hip joint) so did not provide data to the national hip fracture audit 2015.
- Patient reported outcome measures (PROMs) showed that the trust performed better than to the England average for both groin hernia indicators, three varicose vein indicators and one hip replacement indicator. It performed worse than the England average for two of the three knee replacement indicators.
- The Surgery Health Group monitored there performance against a range of clinical indicators via a performance dashboard. This data included compliance with NICE guidance and national audits.
- The orthopaedic department had recently commenced one-day hip and knee replacements, patients were admitted to hospital early in the morning, operated on, post-operatively recovered, mobilised and discharged within approximately 14 hours. An admission and patient selection protocol was available. Early patient outcomes were positive, however at the time of the inspection this procedure had only been undertaken on a small number of patients.

Competent staff

- The Health Group had an internal appraisal target to achieve 85%. Appraisal records we reviewed showed that within the Health Group in May 2016, 87.7% of staff had an up to date appraisal. Data for medical staff appraisals was not available.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.
- Staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.

- Staff we spoke with on cardiothoracic surgery said that during induction they received training on using the specialised ventilation isolation room located on their wards.
- Nurse practitioner roles (nurses with extra training and skills) had been developed on cardiothoracic surgical wards, these nurses carried out pre-assessments on patients and were able to triage and take referrals from other hospitals.
- We saw evidence of on the ward educational sessions being provided on ward 27 for epidural training.
- We observed new starters on ward 16 being buddied with an experienced member of staff to provide support.

Multidisciplinary working

- There were established multidisciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed. Whilst on the wards we saw staff working with the tissue viability team and the diabetes specialist team.
- Referrals were sent to the dieticians from the Surgery Health Group, however due to vacancies within the team referrals received were being prioritised for clinical need some patients that required seeing a dietician prior to discharge did not always manage to be seen, however a letter was sent to the GP explaining this.
- Occupational therapist and physiotherapists held daily meetings with the orthopaedic wards. They also attended ward rounds, to review progress or discharge arrangements for the patients
- Staff within the Surgery Health Group said that they had positive working relationships within the multidisciplinary team. Physiotherapy staff said that they felt part of the ward team.

Seven-day services

- On-site medical cover was available seven days a week.
- Registrars or foundation level two junior doctors reviewed patients on admission.
- Surgical wards and departments had access to diagnostic and radiology services 24 hours, seven days a week to support clinical decision making.
- Access to occupational therapy was available Monday to Friday and physiotherapy services were available six days a week, with emergency cover on a Sunday.
- Pharmacy staff were available six days a week and an on- call service was available out of hours.

Access to information

- Staff recorded information about patients in paper format and on a computer based patient administration system.
- Handover reports were electronic and contained relevant information.
- Discharge summaries were prepared for the GP, records we reviewed showed these contained relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed clinical records and observed that patients consented to surgery in line with trust policy and department of health guidance.
- Nursing and medical staff obtained consent via both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining consent before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff said they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff told us that where this was not possible and due to the nature of the surgery required staff had to make best interest decisions to enable lifesaving treatment to proceed; staff said that these decisions were documented within care records.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the Surgery Health Group showed 86.6% of staff had undertaken mental capacity training against a trust target of 85%. Deprivation of liberty safeguards training was completed by 84.6% of staff.
- Consent audits were carried out, results were disseminated, and recommendations with deadlines were made.

Surgery

- The trust held all paperwork relating to MCA on the intranet, staff we spoke with were aware of how to locate assessment information and record best interest decisions.

Are surgery services caring?

Good

In 2014, we rated surgical services at CHH as 'Good' for caring; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgical services as 'Good' because:

- Patients we spoke with provided consistently positive feedback about their inpatient stay.
- Short Observational Framework for Inspection (SOFI) we carried out through our observations showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- Staff we observed and spoke with were highly motivated and inspired to offer care that was kind and prompted patients' dignity.
- Relationships we observed between patients and staff were strong, caring and supportive.

Compassionate care

- We spoke with 27 patients and two relatives, during the inspection. We observed positive interactions between patients and staff. All patients we spoke with were happy with the care they received; they said that they felt happy, confident and safe during this admission. Patients we spoke with also said that staff were very responsive to their needs.
- Patient- led assessments of the care environment (PLACE) for the trust showed privacy, dignity, and well-being scored 81%, which was below the 86% England average level and dementia care.
- The NHS Friends and Family test (FFT) is a national survey that measures' satisfaction with the healthcare the patient has received. The response rate was 25%, which is lower than the England average of 31%. However, a higher proportion of patients who would recommend the service. Wards and departments we visited displayed their friends and family results. Wards and departments we visited displayed their friends and family results.
- During the unannounced inspection, we carried out two SOFI assessments. Through our observations, we saw that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- Patients on the wards we visited appeared happy and relaxed, all had drinks and call buzzers located within easy reach. Patients we spoke with said that staff did not take long to answer call bells. During the inspection, we did not hear call bells ringing for long periods.
- We observed staff closing curtains/doors whilst delivering personal care. Patients we spoke with said that the environment in the hospital improved their experience as they had more privacy.
- We reviewed comments received by the trust from patients all comments we received were positive about surgical wards and departments.
- During the inspection, we overheard a positive, patient centred episode of care being delivered a nurse on ward 10 was helping a patient with hygiene needs; they explained all their requests to the patient in a clear, positive and kind manner. Assistance provided was at a pace appropriate to the patient, with consent for the next steps being gained.
- Staff we spoke with were highly motivated to deliver good quality patient care. We observed a positive, caring and supportive relationship between patients and staff.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they knew who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients with stoma were encouraged to complete their own fluid balance records.
- Patients we spoke with were all aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

Emotional support

- A multi-faith chaplaincy service was available within the trust and during the inspection.

Surgery

- Clinical nurse specialists were available within surgery and attended the wards to provide support and advice to patients and staff.

Are surgery services responsive?

Requires improvement

In 2014, we rated surgical services at CHH as 'Good' for responsive; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgical services at CHH as 'Requires improvement' for responsiveness because:

- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance indicators for treatment and cancer indicators. A local trajectory for the trust to achieve 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted RTT data and cancer standards was above the agreed local trajectory for both April and May 2016.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter 2, 2015.The trust cancelled 177 patients' operations March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.

However,

- There was evidence of good practice in order to meet the individual needs of patients.
- The trust's policy was to close all complaints within 40 days, each Health Group had a target of 95% to achieve this deadline, within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data which was 30% closure.

Service planning and delivery to meet the needs of local people

- The Surgery Health Group provided elective treatments for different specialities such as cardiothoracic, ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, spinal, orthopaedics, colorectal, upper gastro-intestinal, urology. It also provided acute non-elective urology and cardiothoracic.
- The Health Group had taken into account local transformation plans and commissioning decisions when creating their strategy.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients, incomplete pathways were set at 92%.
- The trust performance of meeting referral to treatment times (RTT) for patients admitted for treatment within 18 weeks of referral was below the national standard of 92%. Trust data from April 2016 showed that 86% of patients were being admitted within the 18 weeks from referral. Speciality specific data showed that no surgical specialities were meeting the incomplete standard, data we reviewed ranged between 53.3% to 90.1% performance to March 2016.
- A local trajectory for the trust to achieve the 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted RTT data was above the agreed local trajectory for both April and May 2016.
- We reviewed performance against the cancer indicators and noted that three cancer standards were not achieved by the trust in February 2016, these were the 31 day drug standards, the 62 day standard and the 62 day screening standard
- A local trajectory for the trust to achieve cancer indicators had been agreed with commissioners and NHS improvement and recent data supplied by the trust showed that performance was above the agreed local trajectory for both April and May 2016.
- The trust reported to us the data management issues since the implementation of the new patient administration system from June 2015 had affected data collection. The trust was carrying out internal verification of patients on the list and clinical reviews of waiting patients to ensure patients did not come to harm during the waiting list process.
- Theatre usage was 77.1% for day surgery and above 81.5% for main theatres December 2015 to February 2016. The data ranged from 61.4% to 94.5% usage in the same period.

Surgery

- Elective theatre lists were available six days a week and emergency theatre lists were available seven days a week. Services shared access to theatres for emergencies overnight and at weekends.
- The percentage of patients whose operations were cancelled and who were not treated within 28 days was consistently better than the England average from April 2013 to December 2015. However, the percentage of patients whose operations were cancelled and who were not treated within 28 days between March 2015 and December 2015 was higher 3.8% than the equivalent period a year early 2.4%. Two surgical patients that had their operation cancelled by the trust for non-clinical reasons in March 2016 and were not re-appointed within 28 days.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter two, 2015.The trust cancelled 177 patients' operations from March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.
- Average length of stay data was similar (3.4 days) to the England average (3.3 days) for all types of elective admissions.
- Non-elective average length of stay performance was about the same 5.1 days as the England average. However, per speciality data showed a lower than the England average length of stay for plastic surgery and upper gastrointestinal surgery and a longer length of stay for trauma and orthopaedics.
- Pre- assessment services including blood tests and screening was scheduled to take place as near as possible to the time of listing to prepare the patient adequately for operation.
- The majority of patients requiring elective surgery were admitted into the hospital via a surgical admissions lounge prior to being transferred to theatre. Patients would be prepared for theatre and consent would be gained.
- During the inspection, no wards had medical patients located on them (medical outliers).

Meeting people's individual needs

- The wards and departments were accessible for people with limited mobility and people who used a wheelchair.
- The department reviewed each patient's needs on admission, or during pre-assessment in regards to earing difficulties.
- Translation services were available for people whose first language was not English. Staff we spoke with said that this service was very responsive and if consent was being gained, there was access to staff that would visit the hospital and interpret face-to face.
- Patients with particular needs were identified to staff at the ward safety briefings, for example, learning disabilities, mental health and dementia.
- A lead nurse for learning disabilities was available in the trust, staff working within the wards were aware of how to contact the lead nurse. Families of patients with learning disabilities were supported to stay with patients. Staff working within the Surgery Health Group provided examples of when they had used learning disability passports, supporting patients with a learning disability through the admission, by referral to learning disability specialist nurse and by accommodating relatives to stay with patients.
- Healthcare assistants on the majority of occasions provided one to one observation of vulnerable patients.
- A vulnerable adult link nurse was available within theatre recovery, carers and parents were allowed into the recovery area.
- The department used a butterfly symbol to support people living with dementia, we saw some areas that were decorated in a dementia friendly way for example coloured signs on toilet door or clocks in rooms. However, no specific areas were identified on the wards to be dementia friendly. Staff we spoke with on ward 15 were knowledgeable about the needs of patients living with dementia. Staff we spoke with on ward 15 showed us "reach out to me" forms to complete for patients living with dementia.
- Basic information for staff about patients was identified on boards behind the bed's, for example the butterfly symbol and acronyms for mobility and dietary requirements and support.
- There were links between specialist nurses and ward staff to ensure continuity of care and support for patients.
- Specialised equipment required for bariatric patients was available. Commodes, chairs and beds were all

available as this site provided planned bariatric surgery. A specialist bariatric nurse had been recently appointed to improve knowledge and pre and post-operative education of staff and patients.
- Discharged patients were given the ward contact number following discharge to contact staff if they have any concerns post-operatively.
- Relevant information to patients on that ward area was displayed on the walls of corridors of wards we visited, such as discharge information, learning disability and butterfly dementia scheme.
- A range of leaflets were available for patients within surgical wards and departments e.g. prevention of pressure ulcers, venous thromboembolism prevention and information for a patients discharge.

Learning from complaints and concerns

- The trust had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS).
- There were 217 complaints received within the Health Group April 2015 to February 2016. The top three complaints were associated with treatment received (145), delays, waiting times and cancellations (27) and attitude of staff (19).
- The trust's policy was to close all complaints within 40 days; each Health Group had a target of 95% to achieve this. Within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data, which was 30% closure.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.
- Staff talked to us about changes in practice that had occurred post a complaint, for example improved patient information leaflets.
- Complaints were shared with staff via team meetings and individual conversations.

Are surgery services well-led?

Requires improvement

In 2015, we rated surgical services at CHH as 'Requires improvement'. Following the 2016 inspection, we rated surgical services at CHH as 'Requires improvement' overall because:

- The senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.
- We had concerns over the response and support offered from the site co-ordination team to staff shortages in the Health Group and periods of understaffing.
- We had concerns over the assurance required for the closure of items from the surgical risk register. We saw evidence of items being closed and clinical staff raising concerns over the closure as in their opinion the risks had not been mitigated.

However,

- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust values and strategy.
- We found an improved staff culture within the hospital, staff we spoke with said this had improved.
- The trust had recently commenced on the day hip and knee replacement operations to improve patient experience and flow.

Vision and strategy for this service

- In 2015, the trust was asked to take action to ensure there is the development of a long-term clinical strategy for the Surgery Health Group. Since the last inspection, the Health Group had developed a five-year strategy 2016- 202. The strategy referenced national reports and recommendations and was aligned to the trust values and strategy. Aims within the strategy included the provision of safe and effective care, delivering key standards and improved productivity and efficiency.

- Staff we spoke with working in the clinical areas were not aware of the Health Group vision and strategy; however this document was a recent development, they were aware of the elective/ emergency split between sites and they could articulate the values of the trust.
- We reviewed the surgery operational plan; which identified vision and goals. These included the separating of elective and non-elective activities, ensuring that patients were treated" in the right place, at the right time, by the right people, first time and within budget".

Governance, risk management and quality measurement

- The Surgery Health Group had a clear management structure; a new operations director had commenced employment in the days prior to the inspection. All management posts were now filled with substantive staff. This new structure required further time to be established and embedded.
- The Health Group held governance meetings; we reviewed four sets of board meeting minutes and noted discussion of risks and incidents. There was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed.
- There was a risk register in place. Risks for the Surgery Health Group were discussed at the integrated governance meeting; medical and nursing staff attendance at these meetings was good. Items requiring escalation to the Operational Quality Committee were clearly identified. The risk register reflected current risks relevant to the operational effectiveness of the department. Data we reviewed from February 2016 showed four high risks, 39 medium risks and 21 low risks identified.
- However, we were unable to identify effective documentation of discussions around gaining assurance and removing risks from the register. Five risks had recently been identified by the Health Group to be removed from the register following a meeting. However, from written communications from the clinical teams, it was apparent that assurance was not available for four of these risks and discussions were ongoing between clinical teams and management.Audits had been completed within the Health Group to provide assurance on key performance measures e.g. the WHO checklist, NEWS completion, infection prevention and control, medicines management, documentation and theatre productivity issues. We saw that on the majority of occasions for NEWS and WHO checklists, 100% scores for the audits had been recorded, however during the inspection we did not see evidence that the clinical practice required to produce 100% audit scores was embedded. Within theatres a new theatre quality assurance audit tool had been developed; this audit had only just commenced and required a further period to assess the impact of the audit results on compliance.
- The senior management team said their main risks for the Health Group were staffing, junior doctor cover overnight, RTT and cancer standards performance. These were all issues identified on the current risk register.

Leadership of service

- The Surgery Health Group had a new senior management structure. Staff commented that they were pleased that there was now a stable, permanent workforce after having interim roles for some months. The senior management team recognised that they needed more time to develop and become fully effective in their roles.
- From our discussions with staff, the majority of staff said that senior leadership was good and staff felt listened too. All staff we spoke with were positive about the support offered from the ward managers.
- From our discussions with staff, the majority of nursing staff said that senior leadership was good and staff felt listened too. Most of the nursing staff we spoke with expressed concern about the response from some of the senior nursing staff working in the site co-ordination team. They provided examples of staff being moved from their substantive ward areas to ease periods of understaffing in other areas. Staff we spoke with said that when they expressed concern about leaving the substantive area with low staffing levels they did not always feel supported and listened too.
- Most of the wards we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies. Minutes of the meetings we reviewed on ward 27 showed good attendance and action plans from incidents were shared at these meetings. Surgical admissions lounge included guest speakers, incidents and local issues. The ward manager on ward 16 had recently arranged health care assistant meetings. To encourage suggestions, access and improve feedback to staff of all grades.

- The majority of staff we spoke with said that the executive team were visible on the wards and departments.
- Staff sickness in the Health Group was 3.3% in May 2015, which was lower than the target of 3.9%.

Culture within the service

- At ward level, staff we spoke with described the culture as improving; they highlighted the past issues with regards to bullying; however, they said that things had improved since the new executive team had been in post.
- The majority of staff we spoke with described the culture at ward level, as good. However, junior medical staff working within a surgical speciality highlighted to us concerns over bullying within their department, the human resources team was aware of and was dealing with the issues.
- The majority of staff we spoke with spoke about their colleagues in a positive manner.
- In the majority of occasions, we found staff morale within surgical wards and departments as good.
- Staff spoke with us about feeling able to raise concerns and feeling listened too by their immediate senior team.
- In the previous year the trust had a Yorkshire and Humber trainee survey 2015 undertaken which highlighted concerns of doctors in training; these concerns included low morale, bullying and a lack of support to trainees. The senior management team had responded to this report by reviewing rotas of on-call foundation level staff and improving support mechanisms.

Public engagement

- The NHS Friends and family test (FFT) had a response rate at ward level of 25%, which is lower than the England average of 31%. Feedback from the FFT for ward 27 included patients not being seen by the same registrar in clinic on each occasions, the department had worked to improve continuity and to ensure where possible the same member of the medical team were seen during appointments.
- Wards we visited had "you said we did boards" which highlighted actions taken because of patient feedback.

Staff engagement

- Department managers spoke with us about an "open door policy" for staff to discuss issues with them.
- The Surgery Health Group had scored the second highest score for staff engagement on the 2015 staff survey.
- The trust held a yearly 'Golden Hearts' award ceremony to recognise great work from staff. Staff working within the Health Group had recently been awarded the Golden heart.
- Staff had been involved in choosing the new values for the organisation of care, honesty and accountability.

Innovation, improvement and sustainability

- Staff we spoke with were proud of the modernisation of the workforce, in relation to the new ward support roles developed over the last year.
- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The orthopaedic department at CHH had recently commenced day case joint replacement operations, two total knee replacements and one total hip replacement had been carried out in May 2016.
- The Gastroenterology department received a national award for introducing a service to support liver research in the community.
- The colorectal team had introduced a nurse led two-week wait clinic to increase available capacity.
- Both staff and patients highlighted to us the ward manager of ward 10 and ward 16, staff and patients we spoke with spoke fondly about the support and leadership of these managers.

Critical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull and East Yorkshire Hospitals NHS Trust provides critical care services at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). The Surgery Health Group manage the service.

There are two intensive care units (ICU) at CHH. ICU1 has 12 beds and is a cardiothoracic critical care unit and ICU2 has 10 beds and is a general critical care unit. The units area adjacent to each other on the same floor and are staffed to care for six level three patients (who require advanced respiratory support or a minimum of two organ support) and 13 level two patients (who require pre-operative optimisation, extended post-operative care or single organ support) across the floor.

Intensive Care National Audit and Research Centre (ICNARC) data for ICU1 showed that between 1 April 2015 and 31 December 2015 there were 641 admissions with an average age of 67 years. Nineteen percent of patients were non-surgical, 79% planned surgical and 2% emergency or urgent surgical. The average length of stay on ICU1 was three days.

Intensive Care National Audit and Research Centre (ICNARC) data for ICU2 showed that between 1 April 2015 and 31 December 2015 there were 481 admissions with an average age of 64 years. Twenty four percent of patients were non-surgical, 70% planned surgical and 6% emergency or urgent surgical. The average length of stay on ICU2 was three days.

A critical care outreach team provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The team is available 24 hours a day, seven days a week.

The critical care service is part of the North Yorkshire and Humberside Critical Care Network.

A comprehensive inspection was undertaken in February 2014. We rated safe, effective, caring, responsive and well led as good. The service was rated as good overall.

During this inspection we visited both units. We spoke with six patients, two relatives and 23 members of staff. We observed staff delivering care, looked at four patient records and three medication charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

In 2014 we rated critical care as 'good' across all domains. Following the 2016 inspection the service was rated as 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified risks to the service that were not on the risk register. We were concerned about the out of hours medical cover at CHH and the impact of the trust's reconfiguration of services. There was a lack of recognition of this or forward planning from the Health Group management team or executive team to mitigate the risks.
- Controls for some of the risks that had been identified were limited and unsustainable and there was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action on some of the risks on the risk register.
- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts to cover CHH. Some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place which was not in line with guidelines for the provision of intensive care services (2015).
- Junior medical staff that worked on ICU2 out of hours did not have skills in tracheostomy and epidural management. Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units. The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015). Patients did not have access to formal psychology input following critical care.
- The service had limited formal mechanisms for collecting patient or relative feedback.

However;

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation.
- The service showed a good track record in safety. There had been no never events, or serious incidents.
- There was clear nursing and medical leadership on the units and in the critical care outreach team and it was clear that staff had confidence in the units' leadership.
- We observed patient centred multidisciplinary team working.

Critical care

Are critical care services safe?

Requires improvement

In 2014 we rated safe as 'good' and in 2016 it was rated 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, the frequency of the consultant on call rota and staffing in the critical care outreach team. Medical staffing was not in line with guidelines for the provision of intensive care services (2015) as some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place. Junior medical staff that worked on ICU2 out of hours did not have skills to manage potential risks associated with tracheostomy and epidural management.
- The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 79-91% in the day and 84-92% at night. This meant that planned staffing levels were not consistently achieved. The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. However,
- The service showed a good track record in safety. There had been no never events, or serious incidents. Staff understood their responsibilities to raise concerns and report incidents.
- The number of staff in the service that had completed mandatory training was above the trust's target.

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between May 2015 and April 2016.
- There service reported no serious incidents between May 2015 and April 2016.
- The units reported 46 incidents between 1 January and 31 March 2016, 70% of these were graded as no harm and 30% as minor harm. Themes of the minor and no harm incidents were skin damage, restraint of patients, for example, using mittens for patients' own safety and medication administration.
- Staff reported incidents using an electronic system. They were aware of what to report as an incident and how to report it.
- Staff could identify on the form when an incident involved a patient that had been referred to the critical care outreach team so a copy was sent to the critical care outreach lead.
- Senior staff had completed training to investigate incidents and shared information from incidents by email and at team meetings.
- Cross site critical care mortality and morbidity meetings were held monthly. The trust provided an example of the record from the meeting. Minutes included any clinical action needed and lessons learnt from the review by the responsible staff member. Junior medical staff were encouraged to attend these meetings. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust included the process for duty of candour in the 'Being Open when Patients are Harmed' policy.
- A member of staff gave us an example of when they had applied the duty of candour after a patient developed pressure damage on the unit.
- The trust had a duty of candour intranet site to provide information for staff.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism.
- The units displayed some of the safety thermometer information so it was visible to staff and visitors. The incidence of pressure ulcers and falls was on display; however, the other components of the safety thermometer were not displayed.

- Data for ICU1 from July 2015 to May 2016 showed 100% harm free care on the day the data was recorded.
- Data for ICU2 from July 2015 to May 2016 showed between 88% to 100% harm free care on the day the data was recorded.

Cleanliness, infection control and hygiene

- Infection control information was displayed to visitors prior to entering the unit.
- All areas on the unit were clean and tidy.
- All equipment was visibly clean and was labelled with the date it had been cleaned.
- ICNARC data showed ICU1 had 4.5 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was higher than similar units.
- ICNARC data showed ICU2 had 3 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was about the same as similar units.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Infection control training information provided by the trust was not site specific. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 86.8% of registered nurses, 83.3% of estates and ancillary staff, 81.3% of additional clinical services staff and 54.6% of administrative and estate staff had completed infection control training.
- Staff completed infection prevention and control audits. Information provided by the trust for November 2015 showed 94% compliance in ICU1 and 94% compliance in ICU2. The results showed concerns about sharps, cleaning checklist and staff's awareness of the five moments of hand hygiene, however, no comparative results or action plan were provided.
- At the time of our inspection the units displayed ward cleaning audit information from July 2016. This showed 98.5% compliance on the cleaning audit and 100% compliance with the hand washing audit.
- Records for flushing taps to prevent legionella were kept and complete.
- The units had facilities for respiratory isolation.

Environment and equipment

- The unit was secure; access was by an intercom.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.
- Staff checked the defibrillator and other emergency equipment daily. Records for this were complete.
- Disposable items of equipment were stored appropriately. We checked over 55 pieces of equipment; only one piece of equipment was out of date. The nurse in charge removed it and informed us this piece of equipment was no longer used
- The service kept up to date environment and equipment maintenance records.
- We checked over 20 pieces of electrical equipment; all of them had up to date safety test stickers on.
- Staff received training on the use of equipment and gave an example of a new piece of equipment being brought onto the unit and the manufacturers providing training on its use. We saw evidence of equipment training in team meeting files.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- There were some medications stored in the top drawer of the resuscitation trolley which was not locked. Staff on both units told us there were plans to have an easy release lock fitted to the drawer.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- We reviewed three medication records. Two had been completed and in line with national and trust guidance; on one record the staff signature was illegible.
- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely and all components of the record were in one place.
- Medical staff completed a daily critical care assessment form that met the National Institute of Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals). However, the document did not have date, version or review date on.
- Nursing documentation included care bundles and quality and safety checklists. Staff explained how these were used, however, we found numerous occasions where the quality and safety checklists were not completed at night time. We raised concerns about this with senior staff during our inspection.
- During our unannounced inspection we checked four quality and safety checklists. Two of these were complete; three night time checks had not been documented in 14 days on the other checklists. This showed practice had improved following our initial inspection.
- Medical documentation did not record that care was delivered in line with guidelines for the provision of intensive care services (2015). For example, records showed evidence of a consultant ward round once a day rather than the recommended twice a day and there was not always a record of a consultant review within 12 hours of admission to critical care.
- Information governance training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 81.8% of registered nurses, 90.9% of support staff and 70% of administrative and estate staff had completed information governance training.

Safeguarding

- Staff were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Safeguarding training information provided by the trust was not site specific and did not provide detail on the level of safeguarding training. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 89.2% of registered nurses, 81.8% of support staff and 80% of administrative and estate staff had completed vulnerable adults training.
- In the service 0% of scientific, therapeutic and technical staff, 87% of registered nurses, 90.9% of support staff and 80% of administrative and estate staff had completed safeguarding children training. The trust target was 85%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and fire training. Annual updates of mandatory training topics were planned into team meetings.
- Mandatory training information provided by the trust was not site specific. Overall compliance with mandatory training in the service was 86.8%. This was better than the trust target of 85%.
- Resuscitation training information provided by the trust was not site specific. The trust target was 85%. However, in the service 71.3% of registered nurses and 50% of support staff had completed resuscitation training.

Assessing and responding to patient risk

- The critical care outreach team was available 24 hours a day, seven days a week. The team consisted of senior nurses who were supported by a consultant intensivist for one session a week. They supported patients stepped down from critical care and reviewed patients alerted to them through the NEWS referral system. The team also supported patients nursed on wards with tracheostomies, delivered non-invasive ventilation outside of critical care units and were a member of the cardiac arrest team.
- Staff on the wards told us they had a high regard for the service provided by the critical care outreach team.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team responded to 4671 referrals across both HRI and CHH. That was on average 13 referrals a day.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team followed up 1407 patients from ICU1 and ICU2. That was on average four patients a day.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- Records reviewed included risk assessments for VTE, pressure areas and nutrition. Staff had completed these in all the records we reviewed.

- Two beds on ICU1 were for post anaesthetic ventilation (PAVU) and four beds were dedicated for cardiothoracic cases.
- The junior doctors, who were the only member of medical staff based on ICU2 overnight, had not had training in the management of a dislodged tracheostomy or in epidural care.
- The junior doctor on ICU1 and the anaesthetic trainee on ICU2 were part of the cardiac arrest team.
- Advanced Critical Care Practitioners (ACCP's) had basic airway skills and assisted in intubation. There was not always an ACCP on duty overnight.

Nursing staffing

- Nurse staffing met the guidelines for the provision of intensive care services (2015) minimum requirements of a one to one nurse to patient ratio for level three patients and a one nurse to two patients ratio for level two patients.
- The units displayed the planned and actual staffing figures. One of the days of our inspection the planned number of registered nurses was 16 for the early, late and night shifts, however, the actual number on duty was 12 on the early shift, 13 on the late and night shifts. The actual number of support workers on duty was the same as the planned number.
- The planned staffing figures included two supernumerary clinical co-ordinators, one based on each unit. This was in line with the guidelines for the provision of intensive care services (2015).
- The service had 50 whole time equivalent (WTE) registered nurse vacancies in April 2016. This was recorded on the risk register, recruitment was underway and the divisional nurse manager was undertaking a workforce review.
- The trust provided information on staffing levels for the six weeks prior to our inspection. The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 79-91% in the day and 84-92% at night. This meant that planned staffing levels were not consistently achieved. Senior staff and the coordinator planned staffing across both sites according to each units capacity.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. The critical care outreach lead had written a standard operating procedure for the suspension of the critical care outreach service; this had not been ratified at the time of our inspection. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- The critical care outreach team generated an electronic handover document.

Medical staffing

- Critical care had a designated clinical lead consultant. Cardiac critical care had a clinical director.
- The consultant establishment in critical care was 16 WTE. At the time of our inspection the service had four vacancies and one consultant on maternity leave. The 11 consultants in post covered the rota which resulted in a more than one in six on call frequency.
- The units met the requirements of the guidelines for the provision of intensive care services (2015) for medical staffing between Monday and Friday 8am to 6pm. Care was led by a consultant in intensive care medicine and the work pattern delivered continuity of care. The consultant to patient ratio did not exceed the recommended 1:8 to 1:15.
- There was no documented evidence that consultants completed twice daily ward rounds which was not in line with the guidelines for the provision of intensive care services (2015).
- One anaesthetic trainee doctor and one junior doctor were based on the units overnight. The anaesthetic trainee was based on ICU1, if they were called away, for example, to theatre one of the consultants on call came in to the hospital.
- The service employed trainee Advanced Critical Care Practitioners (ACCP's). Three were due to qualify three months after our inspection; an additional two trainees were due to qualify in 2017. Three more trainees and one qualified ACCP were due to start in the service three months after our inspection. The ACCP's were not part of the junior doctor rota. The aim was for one ACCP to be based on the units on every shift.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans and completed regular table top exercises.
- Staff knew how to access the major incident and continuity plans on the intranet.

Critical care

Are critical care services effective?

Good

In 2014 we rated effective as 'good' and this rating was maintained at the 2016 inspection because:

- Care and treatment was planned and delivered in line with current evidence based guidance.
- Patient outcomes were in line with or better than similar units.
- We observed patient centred multidisciplinary team working.
- The units had a teacher trainer in post and staff were supported to maintain and develop their professional skills.

However,

- Only twenty five percent of nurses had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%.

Evidence-based care and treatment

- The units policies, protocols and care bundles were based on guidance from NICE, the intensive care society and the faculty of intensive care medicine. Staff demonstrated awareness of the policies and knew where to access them.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The trust's tracheostomy care bundle and resources were in line with National Tracheostomy Safety Project guidance.
- The unit displayed a critical care and anaesthetic research board with poster presentations of research completed and information on current research trials that were underway.
- We observed staff on the ward round assessed patients for delirium.

Pain relief

- A pain management specialist nurse visited the units and reviewed patients and suggested treatment plans.
- ICU2 displayed a pain information board that contained information about the pain link team, pain assessment and scoring system.
- We observed staff on the ward round assessing pain and giving support to patients who required pain relief.
- Three patients told us their pain was well controlled, staff monitored their levels of pain and that additional medications were given promptly.

Nutrition and hydration

- Staff assessed patients' nutritional and hydration needs daily and acted upon the findings.
- We observed a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietician was not available.
- A dietician visited the unit daily. The dietician saw some of the elective patients pre operatively and advised on pre-operative nutrition.
- Halal and kosher meals were available and catering staff had received training regarding special dietary requirements.
- During our inspection we observed water was available and within reach for patients who were able to drink.

Patient outcomes

- We reviewed the Intensive Care National Audit and Research Centre (ICNARC) data for ICU1 from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 0.95. This was in line with similar units.
- ICU1 had a 0.7% unplanned readmission in 48 hours rate. This was lower than the 1.3% rate of similar units.
- We reviewed the ICNARC data for ICU2 from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 1.02. This was in line with similar units.
- ICU2 had a 0.7% unplanned readmission in 48 hours rate. This was lower than the 1.6% rate of similar units.
- The ICNARC data coordinators worked with clinical staff to collect additional information the service used for research and audit.
- The critical care outreach team collected patient outcomes in an electronic database.
- The trust provided a list of titles of projects on the units audit program. Topics included ICU delirium, six hour sepsis care bundle, inadvertent hypothermia in intensive care patients and record keeping.
- Senior nurses completed the trust's nursing quality metrics.

Competent staff

- Senior nursing staff had been allocated responsibilities; these included completing appraisals, managing sickness and clinical expert roles. Nursing staff had link nurse roles, for example, infection prevention and control, pain, pressure care and nutrition.
- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. However, information provided by the trust showed that at May 2016 89.9% of nurses and 100% of additional clinical services staff, estates and ancillary and administrative and clerical staff on the units had received an appraisal. This was better than the trust target of 85%.
- The units had a teacher trainer who was responsible for coordinating the education and training for staff. This met the recommendations of the guidelines for the provision of intensive care services (2015).
- Twenty five percent of nurses in the service had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%. All staff completed the national competency framework for adult critical care nurses as the first step towards meeting the post registration in critical care qualification recommendation.
- Staff within the critical care outreach team were working towards the national outreach competencies. Two staff in the team were completing an MSc and all staff had completed in-house advanced clinical skills.
- New members of nursing staff received an induction onto the unit, were allocated two mentors and had a supernumerary period.
- Simulation courses were available to staff, recent courses had been held on paediatric critical care and evacuation.
- Staff told us there were good opportunities to undertake further relevant training. Nursing staff had the opportunity to complete a management training course where they became the coordinator for six to eight weeks with band six support.
- We observed the ward round being used as a teaching opportunity. Junior doctors told us they received good support and teaching.
- The units displayed information about revalidation for nurses.
- Some clinical support workers had completed additional training and competencies to allow them to carry out interventions and care for patients under the direction of a registered nurse.
- The trust supported trainee ACCP's to complete an advanced practice module at a local university, advanced life support, faculty of intensive care medicine and non-medical prescribers training.
- The trust had recruited nurses with post-operative recovery experience but who did not have critical care training to work in PAVU. These staff had a supernumerary period to achieve set competencies including extubation. One new member of staff was working in this area at the time of our inspection. They told us that they had been well prepared for the role and supported by the teacher trainer and experienced critical care staff.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from occupational health and human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection.
- We observed members of the multidisciplinary team participate in the ward round; however, all members were not present for the whole ward round.
- Physiotherapists, a dietician and a pharmacist visited the unit daily.
- Nurses told us they could access occupational therapy and speech and language therapists when required. We saw in records that when staff made referrals to the multidisciplinary team such they responded promptly within 24 hours.
- Each unit had a full time ICNARC data entry coordinator.
- A member of staff told us of joint work regarding medicines management between nursing and pharmacy staff had a financial benefit.

Seven-day services

- A consultant intensivist was available seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A specialist critical care pharmacist visited the units Monday to Friday to check prescriptions and reconcile patients' medicines. The pharmacy was open seven days a week with a 24 hour on call service.

Critical care

Access to information

- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital. A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.
- Staff had access to guidelines at every bed space and at the nurses' station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- There was a trust information leaflet on Deprivation of Liberty Safeguards (DoLS) in the waiting room on ICU1. This explained the process for applying for a DoLS authorisation and what this meant for the patient.
- Staff we spoke with demonstrated some understanding of consent, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- MCA training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 91.3% of registered nurses and 50% of support staff had completed MCA training.
- DoLS training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 88.3% of registered nurses and 25% of support staff had completed DoLS training.
- Senior staff had written an appendix to the trust restraint policy to make it applicable for critical care.
- Staff showed an understanding of restraint and explained the reasons and the process they would follow if they needed to use mittens or medication for a patient's safety.

Are critical care services caring?

Good

In 2014 we rated caring as 'good' and this rating was maintained at the 2016 inspection because:

- Patients were supported, treated with dignity and respect, and were involved in their care. Feedback from patients and relatives was positive about the way staff treated people.
- We observed all staff responded to patients' requests in a timely and respectful manner.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.
- A member of staff received a trust award in recognition of the care they provided.

However,

- There was no regular psychological support available to patients following critical care.

Compassionate care

- The unit did not carry out patient surveys. Thank you cards from patients and relatives were on display.
- We observed curtains being drawn around patients' beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- All staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- All the patients we spoke with told us they had received good care and did not have to wait for anything from staff. They did not have any suggestions for improvement
- One patient we spoke with had experienced difficulties in sleeping due to the noise level on the unit. Staff offered ear plugs and medication to assist with sleep.
- A member of staff on ICU1 received a trust award in recognition of initiating palliative care for a patient and arranging their discharge home. The nurse had received an award in recognition of this. Staff also arranged the transfer of a patient to a hospice for end of life care.

Understanding and involvement of patients and those close to them

Critical care

- All the patients and relatives we spoke with told us they had been kept informed of the treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence on the ward round where staff spoke to patients in a way they could understand and involved patients in making decisions about their care and treatment including discharge planning.
- We observed staff explaining their care to patients prior to delivering it.
- Patients and relatives told us they thought the visiting arrangements were good.
- We observed staff using the cordless telephone so patients could speak to their relatives when they called the units.

Emotional support

- Staff provided the opportunity for a patient diary to be kept. Patients and relatives were invited back to a clinic to collect and review the diary with staff and visit the unit if they wished.
- The chaplaincy service visited the units daily and they were able to offer pastoral, spiritual and religious support.
- We observed staff on the ward round discuss the symptoms of delirium with a patient and reassure them about the cause and treatment for these. Staff empathised with the patient and gave them all the time they needed to talk.
- The spouse of a former patient on ICU at HRI had set up a critical care patient support group that was available to patients and relatives at both HRI and CHH. The group met regularly and offered telephone support.
- There was no regular psychological support available to patients following critical care. We found evidence that patients may benefit from psychological support as they suffered from intrusive and distressing thoughts and dreams. We informed senior staff about this at the time of our inspection.

Are critical care services responsive?

Good

In 2014 we rated responsive as 'good' and this rating was maintained at the 2016 inspection because:

- Access to care was managed to take account of peoples' need. The delayed discharge and out of hours discharge rates were better than similar units.
- There had been no patients ventilated outside of critical care in the last 12 months.
- The facilities and premises were appropriate for the services being delivered.
- Staff took account of and were able to meet people's individual needs.

However,

- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015).
- There had been eight mixed sex accommodation breaches on ICU2 in the last 12 months.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision could be flexed to meet the differing needs of level two and three patients; however, at the time of our inspection the provision was limited by nurse staffing.
- The service had produced a patient and relative support information leaflet. This included advice about financial support, social care and support including mental health services and carers support. There was also information about the critical care support group.
- The rehabilitation after critical illness service was limited. Critical care outreach staff reviewed all patients who had been ventilated or in critical care for two or more days following discharge, however, the frequency of the visit depended upon the team's capacity. There was no medical or multidisciplinary input to the follow up clinic.
- A visitors' waiting room was available outside the unit; a file was available with general information about the units and nearby accommodation. There was information on the walls about speaking to medical staff and accessing chaplaincy staff. A hot drinks machine was available.
- Staff could meet visitors in private by using the separate quiet room.
- Overnight accommodation for relatives was available.

Meeting people's individual needs

- Translation services were available to patients whose first language was not English. Staff knew how to access the service. During our inspection we observed the coordinator allocated a nurse to care for a patient of the same nationality to aid communication.
- Staff could access leaflets in different languages if required.
- Staff were aware of the butterfly scheme in use for patients living with dementia, however, reported that they cared for very few patients living with dementia. Staff told us they would invite carers or relatives to stay with the patient if required.
- Staff gave us an example of a patient with hearing difficulties was on the unit and their carer stayed to support the patient.

Access and flow

- The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient.
- Information provided by the trust showed that between March and May 2016 the average bed occupancy for ICU1 was 76.3%. This was lower than the England average.
- Between March and May 2016 the average bed occupancy for ICU2 was 101.3%. This was higher than the England average.
- Data provided by the trust showed in the last 12 months:
  - there had been 42 cancelled elective operations across both sites due to a lack of critical care capacity;
  - there had been no adult patients ventilated outside of critical care;
  - there had been eight mixed sex accommodation breaches on CICU2;
  - The ICNARC data for both units from 1 April to 31 December 2015 showed the unit had transferred 0.2% patients due to non-clinical reasons. This was in line with similar units and the network average.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the delayed discharge rate was 0.6%. This was lower than similar units' rate of 1.5%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 0.2%. This was lower than similar units' rate of 0.7%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the delayed discharge rate was 0.3%. This was lower than similar units' rate of 2.9%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 0.7%. This was in line with similar units' rate of 0.8%.

Learning from complaints and concerns

- Staff were aware of the process for managing concerns and complaints and how to access it.
- The unit displayed information and leaflets on how to make a complaint.

The matron visited some patients on the ward following discharge from critical care. One patient raised concerns about the way some members of staff delivered care. The matron shared this feedback with staff who were then able to make changes to their practice.

Are critical care services well-led?

Requires improvement

In 2014 we rated well led as 'good' and in 2016 it was rated 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014. We also found new issues around the identification, management and escalation of risks in the service.
- We identified risks to the service that were not on the risk register. We were concerned about the out of hours medical cover and the impact of the reconfiguration of services. There was no clear evidence of forward planning from the Health Group management team or executive team to mitigate the risks.
- Staff gave us examples of a lack of action on some of the risks on the risk register. Controls for some of the risks were limited and unsustainable and there was not clear evidence or assurance of escalation of the risks beyond the Health Group.
- The service had limited mechanisms of collecting patient or relative feedback.

However,

- There was clear nursing and medical leadership on the units and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the units' leadership.
- Staff were happy in their work and felt that the culture on the units was open and honest.

Vision and strategy for this service

- The Surgery Health Group strategy 2016 – 2021 was in draft at the time of our inspection. It set out objectives that were in line with the trust's vision, values and goals.
- The key priorities for critical care in the strategy were operational and focussed on nurse and medical staffing, the development of new advanced practitioner roles, reduction of cancelled operations and the completion of a demand and capacity analysis to highlight capacity constraints to the trust and the critical care network.
- The management team acknowledged organisational changes at trust level had an impact on critical care provision. These changes were mainly related to the move of almost all elective work to CHH. Elective maxillofacial and ear, nose and throat surgery were planned to be moved to CHH three months after the time of our inspection. The management team did not have a timescale for when elective neurosurgery and vascular surgery would move to CHH.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

- The service held monthly business team meetings that included multidisciplinary attendance. We reviewed minutes from these meetings; governance, ICNARC data, equipment and the risk register were some of the agenda items discussed. Following each meeting an action log was completed with timescales.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. The unit's risk register identified the following key risks: consultant vacancies, delayed discharges, cancellation of elective surgery due to nurse vacancies and risk to services and patient safety due to nurse vacancies. The risk register showed that limited controls were in place to mitigate these risks.
- During our inspection we identified risks to the service that were not on the risk register. At CHH we were concerned about the out of hours medical cover and the impact of the reconfiguration of services. There was no forward planning from the Health Group management team or executive team to mitigate the risk.
- In addition critical care outreach staffing and service suspension, lack of escalation of NEWS scores and the lack of compliance with guidelines for provision of intensive care services (2015), particularly lack of rehabilitation after critical illness was not clearly identified as a risk to patients who used the service.
- Staff gave us other examples of a lack of action on some of the risks on the risk register. Recruitment of consultants had not been actioned promptly, incorrect vacancies had been advertised and a block had been placed on locum consultant appointments. Due to the limited and unsustainable controls in place for some of the risks, for example, consultant staffing, we requested evidence from the management team of escalation of these risks to the executive team. The team provided copies of the Executive Management Committee risk register report and the Surgery Health Group report to the Operational Quality Committee and Health Group board; however, these did not give clear evidence or assurance of escalation of the risks.

Leadership of service

- Senior staff were visible and approachable. There was clear nursing and medical leadership on the unit and in the critical care outreach team.
- It was clear from our conversations, observations and data we reviewed that staff had confidence in the unit's leadership. Most staff reported feeling supported by their teams and managers.
- During our inspection we saw examples of strong leadership at unit level; however, staff told us that senior managers from the executive team lacked understanding of the demand on the units and the capacity of critical care. Staff gave us examples of the reconfiguration of elective surgery work despite the challenge faced in medical staffing.

- Senior staff had completed the internal and external leadership training and received dedicated management time.
- The management team was very proud of all the staff and the patient care they provided.
- Senior staff attended regular cross site meetings as well as site specific meetings and the trust senior nurse forum.

Culture within the service

- Staff we spoke with told us they were happy in their work, felt supported, able to raise concerns and that the culture on the units was open and honest.
- Staff were proud of their teamwork and the care they delivered to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- We observed the nurse in charge offer support to a member of staff away from the patient's bedside after they had dealt with a challenging situation with on the unit.
- Senior staff had worked to reduce sickness in the service, information provided by the trust showed registered nurses sickness was 4% and other staff was 2.6%.
- Staff had access to a counselling service in the trust.
- Staff had completed professional and cultural transformation training and all staff who had worked in the trust for a long period told us the culture had improved and they were optimistic about the future.

Public engagement

- The units displayed thank you cards from patient and relatives.
- Comments slips and a suggestion box were available in the waiting room.
- A patient from HRI ICU and their spouse had set up a patient support group, the spouse had attended staff meetings to feedback their experiences, examples of changes introduced from this was for staff to let the patient know if they were leaving the room and changes to some staff's routines on a night shift.
- Staff had nominated the patient support group for a trust award.
- A member of senior staff visited patients on the ward to receive feedback from their stay. This feedback was collected informally at present and shared with staff at team meetings.

Staff engagement

- Regular staff meetings were held. We saw evidence in the minutes that incidents, training, clinical supervision and equipment were some of the topics discussed.
- ICU1 displayed a large staff notice board with information including mentorship updates, lesson learned, infection control, pressure ulcer prevention and nutrition.
- Staff gave us examples of changes that senior staff had made in response to concerns raised by staff. These included additional options being included in electronic rostering to allow some flexibility for staff and the movement of staff off the unit to cover other areas in the hospital.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- The critical care outreach team was part of a critical care outreach regional network forum to benchmark services and share best practice.
- The service had successfully recruited and retained advanced critical care practitioners (ACCP's). Feedback from the ACCP's on their role and training was very positive.
- The service had submitted a successful business case to use a new electronic clinical management system to collect ICNARC data and critical care outreach data to provide more real time data to understand activity.
- The teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal for their training courses.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

The trust provides services a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

Hull and East Riding Hospitals provided are at the end of life across a wide range of services, including surgical and medical wards (including wards for older people), accident and emergency, critical care and specialist services such as oncology at both Hull Royal Infirmary and Castle Hill Hospital which also incorporated the Queen's Centre for Oncology and Haematology. In addition, the chaplaincy, mortuary and bereavement teams also provided care at the end of life.

The trust employed a Specialist Palliative Care Team; this included nine specialist palliative care nurses and four consultants. The Specialist Palliative Care Team worked Monday to Friday 8am to 6pm. There was provision across both main hospital sites. The team were based at Castle Hill Hospital and provided a daily in reach model at Hull Royal Infirmary.

During 2015, the trust had 2386 in hospital deaths. The Specialist Palliative Care Team received 1386 referrals; this included 1043 cancer referrals and 343 non-cancer referrals.

During our inspection we visited seven wards at Castle Hill Hospital where care at the end of life was being provided, we spoke with eight patients and three relatives. We also spoke with 15 members of nursing and medical staff. We visited the mortuary and bereavement service and spoke with a member of staff from this team. In addition to this, we visited the chaplaincy team and spoke to three of the hospital chaplains.

The last comprehensive inspection of end of life care services at the hospital was in February 2014, we found the service to be good overall.

End of life care

Summary of findings

In 2014, we rated this core service as 'good' overall. Following the 2016 inspection we rated the service as 'Good' because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents. Mandatory training across most services was above the trust targets. Medicines were prescribed and administered safely in line with policy and staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multidisciplinary working across all teams. The trust had recently employed more staff to be able to provide seven-day specialist palliative care nurse availability. Consent to care and treatment was obtained in line with legislation and guidance.
- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and patients' choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the Specialist Palliative Care Team (SPCT) were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

End of life care

Are end of life care services safe?

Good

In 2014, we rated safe as 'Good' and this rating was maintained in 2016 because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents.
- All staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding.
- Mandatory training in most teams providing care at the end of life was above the trust targets however; in some teams, compliance with some subjects was lower than the trusts targets.
- The environments were fit for purpose and equipment was readily available.
- Medicines were prescribed and administered safely in line with policy.
- Staffing levels were appropriate for the services provided.

However we also found:

- Not all staff were up to date with mandatory training.
- Staff were non-compliant with the syringe driver policy in that four hourly checks were not being completed. However, following our unannounced inspection we found that the trust had taken immediate steps to address this including daily audits being undertaken by the Specialist Palliative Care Team (SPCT).

Incidents

- All staff we spoke with told us that they were encouraged to report incidents and that they were confident in the use of the trusts electronic reporting system.
- Staff told us that they received feedback after reporting incidents and we saw lessons learned publications that were produced by the trust each month and disseminated to staff. We saw these displayed in some of the wards we visited.
- There were low numbers of incidents involving patients at the end of life across all core services. Information provided by the trust indicated that 30 incidents involving patients at the end of life had been reported between May 2015 and May 2016. All of these incidents were graded as low or no harm. These included incidents such as deterioration in a patient's skin condition and concerns raised regarding the transfer of patients care.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour. We saw that following incidents, in other services, the trust apologised to the patients involved and their families. There had been no incidents requiring duty of candour for patients receiving care at the end of life however staff told us about being open and honest and apologising if things went wrong.

Cleanliness, infection prevention and control (IPC) and hygiene

- All areas that we visited, that were providing care at the end of life, appeared clean and well maintained. This included ward areas and the bereavement team offices.
- Personal protective equipment (PPE) such as gloves and aprons were available in all areas. Hand wash stations were available in the main foyer area of the hospital and also in each ward. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side wards. We saw staff using appropriate PPE and washing their hands before providing care to patients.
- Staff completed IPC training as part of their mandatory training programme. The trust target for this training was 85%.Overall trust compliance with this was 73%; however, we found that only 43% of staff from the SPCT were compliant with this training.

Environment and equipment

- Staff we spoke with told us equipment, such are syringe pumps and specialist mattresses, were readily available for patients. However, some staff referred to the 'bed policy' and said that they were concerned that when patients were transferred between wards, they had to be transferred on to a bed belonging to the admitting ward

rather than the beds being swapped. This meant that sometimes patients were transferred between beds. Staff told us that they were concerned that this could cause unnecessary pain or distress for patients.

- The trust used two types of syringe pumps. However, wards at this hospital only used one type of device. One palliative link nurse told us that they were the trainer for the type of device used in the area and as such provided training in the use of the pumps for other staff on the ward. We had concern about this because if staff were required to move wards they may not be trained in the correct use of the pump in use in that area.
- We visited the bereavement office at the hospital. The bereavement offices were clean, and tastefully decorated.
- The Human Tissue Authority (HTA) is a regulator set up in 2005 created by parliament; they are an executive agency of the Department of Health. The HTA regulate organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public.
- The HTA inspected the mortuary services for the hospital in September 2015 and deemed that the services provided by the hospital met the required standards for premises facilities and equipment. Maintenance and service records were kept for equipment, including fridges/freezers, trolleys, post mortem tables and the post mortem suite ventilation.
- The fridges in the mortuary had an electronic automated alarm system to alert staff if the temperature of any individual fridge rose above 12 degrees centigrade. Staff were available 24 hours per day in case of emergencies.

Medicines

- The trust had policies and procedures in place for the safe handling and administration of medicines. These included documents that related specifically to care at the end of life including the prescribing of 'just in case' medication boxes for palliative care and guidelines for the use of opioids in palliative care.
- The trust had a policy for the administration of medications via a syringe driver. During our inspection, we found that staff were not completing four hourly checks of the syringe driver and the infusion site in line with trust policy. We discussed this with the SPCT who told us that this issue had been raised in the past. We highlighted this to ward staff at the time of our inspection and found that some staff were unable to tell us how frequently the checks should be. We raised our concerns with the senior trust team.
- During our unannounced inspection, we looked at the charts on four wards and found that compliance with the four hourly checks had improved however; staff were still not fully complying with policy. The trust had taken steps to address our concerns including communication being sent to all wards and a member of the SPCT told us that they were completing a trust wide audit of this issue.
- A member of the SPCT explained that syringe drivers were always prepared to contain 24 millilitres of fluid and run at one millilitre per hour over 24 hours to ensure a standard approach trust wide and therefore maintain patient safety.
- Staff we spoke with explained that if a patient was going home they had to take them off the syringe pump and would arrange for a district nurse to visit the patients home to set up a new pump. We had concerns about this however; staff explained that they gave the patient a subcutaneous dose of their medications to ensure that they remained symptom free until the community nurses could re-establish the syringe pump.
- The SPCT nurses were not non-medical prescribers however, they liaised with medical staff from the wards caring for patients at the end of life to ensure that medications were adjusted when needed. We witnessed this taking place during our inspection.
- We checked the medication administration charts for seven patients receiving end of life care and found that all non-essential medications were discontinued as appropriate. We found anticipatory medications were prescribed in line with evidence based best practice. This included medications for pain, shortness of breath, restlessness, nausea and respiratory tract secretions.
- In addition we saw that medicines reconciliation had been completed on the medication administration charts.

Records

- We looked at the care records for seven patients. We found that documentation completed by members of the SPCT was completed fully and consistently across in all records. This included the patients' prognosis, symptom management and patients physiological, social, spiritual and psychological needs.

End of life care

- We saw comprehensive assessments of patients' needs and care plans in place to manage the risks. This meant that records were in line with national guidance and processes were followed which helped keep people safe however, we looked at ten food and fluid charts and found that these were not fully completed for any of the patients.
- Family involvement was clearly documented in the records reviewed.
- The trust used an intentional rounding tool; we saw that these were in place in all records we reviewed.

Safeguarding

- Staff told us that they completed safeguarding training as part of statutory mandatory training. The team members of the SPCT (medical, nursing and the MDT coordinator) were 86% compliant with vulnerable adult's level 1 and safeguarding children level 2 training. This was above the trust target of 85%.
- Mortuary and bereavement office staff were 100% compliant with vulnerable adults and safeguarding children training. This was above the trust target.
- The chaplaincy staff were 57% compliant with vulnerable adults and safeguarding children training which was below the trust target.
- Nursing staff, we spoke with about training told us that they had completed safeguarding training and were able to describe the process they would follow if they had a concern or needed to raise an alert.
- Staff also said that they knew how to access safeguarding policies and procedures via the trust intranet.

Mandatory training

- The trust target for completion of statutory and mandatory training compliance was 85%. Data showed overall compliance of 76% for the 14 members of staff in the SPCT; however, the team had newly appointed members of staff and staff who had returned after a period of absence.
- The team was above the trust target for major incident (100%), Fire training (86%) and Information Governance (86%) however, they were below target for Moving and Handling (71%), Safety (64%) and Resuscitation training (57%).
- Staff in the mortuary and bereavement service were 100% compliant with all training except for moving and handling which was 71%.
- Overall, the chaplaincy staff were 78.5% compliant with all training, which was below the trust target. Compliance for infection prevention and control training was 43%. Safeguarding children and vulnerable adults training compliance was 57%.

Assessing and responding to patient risk

- The trust used a recognised national early warning score tool (NEWS). These tools are designed to assist staff in the early recognition and response to a deteriorating patient.
- We saw these in use in all of the care records we reviewed, however the forms did not always have a guide for staff to refer to in the event of a patient needing escalation response, except on one ward where we saw a laminated guide in the care record which was stored in the same section of the notes as the chart.
- In most of the records for patients receiving end of life care, we saw that ceilings of care were identified and documented.
- We saw that risk assessment tools had been completed in the records we reviewed. This included venous thromboembolism (VTE), falls, pressure area, malnutrition, moving and handling and IPC. When a patient was identified as at risk, we saw that a care plan was created.
- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw that the trust had a safety alert management flowchart. We also saw details of safety alerts displayed on some of the wards we visited.

Nursing staffing

- There were nine (6.5 whole time equivalents - wte) clinical nurse specialists and a multi-disciplinary team coordinator (0.7wte) in the SPCT.
- There were no vacancies at the time of our inspection and there had been no bank or agency use between June 2015 and May 2016. Sickness levels within the team were predominantly low, the average being 3% between June 2015 and May 2016. There was no sickness for seven of the previous 12 months. This meant there was continuity in the service, which helped to keep patients safe.

End of life care

- The SPCT nurses were available Monday to Friday 08:00 -18:00. Out of hours, staff could contact the local hospice for advice.
- The hospice was also able to contact the regional on call consultant in palliative medicine for further specialist advice if required.

Medical staffing

- The trust employed four end of life care consultants (3.6 wte). The hospital had 1202 general, acute and critical care beds therefore this number was less than the national commissioning guidance for specialist palliative care which was one doctor per 250 hospital beds.
- The consultants worked across the trust and a local hospice.
- There had been no locum medical cover between June 2015 and May 2016. Sickness levels within the team were low. There was no sickness in the medical team in the previous 12 months except for November 2015 when sickness was 1.5%.

Major incident awareness and training

- NHS providers have a statutory obligation to ensure they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. We saw the trusts emergency preparedness, resilience and response (EPRR) business continuity plan 2015/16. This showed evidence of testing for staff available to respond with 30 minutes in the event of a major incident.
- Staff completed major incident training as part of the induction at the trust. 100% of the SPCT, bereavement, mortuary and chaplaincy staff had completed this training.

Are end of life care services effective?

Good

In 2014, we rated the services as 'Good' for effective. In 2016 the services were rated as 'Good' because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patients were prescribed and administered pain relief in a timely manner.
- Information about people's care and treatment, and their outcomes, were routinely collected and monitored. This information was used to improve care.
- Staff providing care at the end of life were highly skilled and competent.
- There was evidence of multidisciplinary working across all teams and also evidence of collaborative working with other providers and the local authority. Referral processes were straightforward and staff did not raise any concerns about these.
- The trust had recently employed more resources to provide seven-day specialist palliative care nursing availability. This was planned to be implemented from September 2016.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However we also found:

- Although patients were assessed for risk of malnutrition, food and fluid charts were not always completed in line with policy. This meant that patients might not always receive appropriate support with food and fluids.
- The trust did not provide face-to-face access to specialist palliative care for at least the hours 9 am to 5 pm, Monday to Sunday and did not have any end of life care facilitators

Evidence-based care and treatment

- We saw that trust polices relating to care at the end of life had been developed based on national guidance such as that recommended by the National Institute for Health & Clinical Excellence (NICE).
- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the trust had developed guidelines for end of life care. Staff did not use a pathway but used the guidelines to develop an individualised plan of care for patients receiving end of life care. This was called the guidance for the management of the dying patient.
- The specialist palliative care nurses we spoke with told us that the guidance was based on the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. The new approach focussed on giving compassionate care and to move

away from processes and protocols. It recognised that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life and should be an integral part of personalised and proactive care.

- Information provided by the trust indicated that the SPCT managed patients on their caseload according to national and local guidelines as appropriate. Examples of these were the rapid discharge policy, the syringe driver policy, the Yorkshire and Humber palliative and end of life care groups: a brief guide to symptom management in palliative care, the DNACPR policy, NICE guidelines on opioids in palliative care, NICE guidelines on neuropathic pain and NICE guidelines on care of dying adults in the last days of life.

Pain relief

- We saw the results of an audit of 44 care records of patients receiving end of life care, which was undertaken by the SPCT in 2015.This showed that 26 (59%) of the patients reviewed had all key drugs prescribed whilst 18 (41%) had some or none of the key drugs prescribed. There were 12 (27%) patients who had a syringe driver in place; however, 20 (45%) patients had two or more injections in the previous 24 hours. This would suggest that a syringe driver should have been started or increased.
- We did not see reference to the guidance outlined in the 2015 core standards for pain management services within any of the trust documents that related to pain relief, however in the records we reviewed, where appropriate, we saw without exception, that patients at the end of life were prescribed anticipatory/ just in case medication in line with NICE guidelines.
- We saw from patients' records that pain levels were assessed regularly and patients we were able to speak with told us that their pain relief was managed effectively and that staff responded quickly when they requested painkillers.
- We observed an end of life care consultant discussing pain control with a patient and suggesting alternative pain relief methods including the use of heat packs, topical applications, unlicensed products that might have been appropriate and also acupuncture.
- In a trust survey of bereaved relatives, we saw that 100% of those surveyed said that they were satisfied or extremely satisfied with the comfort of their relative.

Nutrition and hydration

- An audit completed by the SPCT in 2015 highlighted a lack of documentation of discussions around nutrition and hydration at the end of life. It also highlighted the lack of documentation around regular mouth care, making it difficult to ascertain the level of care given at the end of life to individual patients. This also indicated that the end of life guidance was not always adhered.
- We saw nutrition and hydration assessments in all of the care records we looked at. If patients were assessed as high risk of malnutrition or dehydration food and fluid charts were implemented. ;
- We saw that some patients were prescribed nutritional supplements and that these had been administered as prescribed.
- During our inspection, we saw staff performing mouth care for patients who were nearing the end of their life.
- Patients we spoke with told us that the quality of the food was good and that water jugs were replenished regularly as well as hot drinks and snacks being provided throughout the day.

Patient outcomes

- We saw an audit that had been undertaken in 2015 by one of the SPCT nurses. This audit highlighted areas of good and poor practice. It showed that the end of life guidance developed and implemented by the trust was not always adhered to. The outcome of this audit was that the end of life care guidance would be reviewed following the publication of the National Care of the Dying Audit in 2014. The team felt that the national audit would provide further evidence of the care patients at the end of life and their relatives had received in the trust and would provide a benchmark of other trusts nationally.
- The End of Life Care Audit – Dying in Hospital 2015, showed the trust scored below the England average for three out of the five clinical key performance indicators however, they achieved five out of the eight organisational quality indicators.
- The audit identified that there was no lay member of the trust's board with responsibility for end of life care, the trust did not provide face-to-face access to specialist palliative care for at least the hours 9 am to 5 pm, Monday to Sunday and the trust did not have any end of life care facilitators.

End of life care

- Wards where care at the end of life was provided contributed to the National council for Palliative Care Minimum Data Set (MDS). The aims of the MDS are to provide good quality, comprehensive data about hospice and specialist palliative care services on a continuing basis. The data is used to inform service development, management, monitoring and audit. The information is also used for commissioning of services and development of national policy.
- The trust was not a CQC outlier in terms of any cancer related outcome measures.
- The mortuary team completed a full capacity audit each day.
- The trust did not participate in the gold standards framework.

Competent staff

- At the time of our inspection appraisal rates for the SPCT were 62.5%. In six of the previous 12 months, compliance with appraisals had been 100%. This had dropped due to sickness and newly recruited members of staff joining the team.
- Appraisal rates for the medical team were predominantly 100% between June 2015 and May 2016 however, this had dropped to 75% in September 2015 and May 2016.
- At the time of our inspection, the appraisal rates for the mortuary team were 87.5% and 100% for the bereavement team.
- Appraisals for the chaplaincy team were 83.3%.
- Information provided by the trust showed that the SPCT nurses had all achieved postgraduate qualifications in palliative care at English National Board, diploma, degree or masters levels.
- All of the medical team had trained as a Specialist Registrars in Palliative Medicine before joining the trust as consultants.
- A member of staff who had recently joined the SPCT told us that they thought that all of the specialist palliative care nurses had excellent communication skills and we witnessed this whilst observing the team providing care and support to patients and their families.
- We were told that most wards had a palliative care link nurse. Twice yearly seminars were held for these staff and the SPCT nurses told us that these sessions were well attended.
- All staff in the mortuary were competent at corneal retrieval for organ donation purposes. A report by the HTA in September 2015 deemed that the mortuary staff had worked at the establishment for a number of years and were motivated and experienced in their roles. They were well trained and had worked towards developing robust mortuary procedures.

Multidisciplinary (MDT) working

- The SPCT held an MDT each week on a Wednesday morning. This was held in the Queen's Centre at Castle Hill Hospital. SPCT medical and nursing staff attended in person and attendance was recorded by signing a register. A member of the chaplaincy team and a social worker also attended the meeting. The MDT co-ordinator collated attendance data.
- All new referrals to the service (both in-patient and outpatient) and ongoing complex patients were discussed at the MDT. The list was compiled by the MDT co-ordinator in conjunction with the team from the current caseload as documented on the electronic care record system. In April 2016, the team updated the MDT proforma to ensure that the recommendations of the NICE Guidelines on Care of dying adults in the last days of life, was included.
- In addition to the weekly MDT, the nursing staff from the SPCT also held a daily board round.
- The SPCT also had close working relationships across all wards and departments where care at the end of life was provided and also the local hospice.
- In addition to this, we also saw that staff attended the end of life discharge facilitation and patient pathway meeting. This was a multi-disciplinary meeting involving members of the trust team along with other local NHS trusts, the local hospice, local commissioners and the local authority.
- In their report in September 2015, the Human Tissue Authority reported that the mortuary staff had developed good working relationships with staff in other establishments including the coroner's office, visiting pathologists and local funeral directors.
- The chaplaincy service told us that they have multiple contacts within various faith communities including most religions and also secular, humanist and pagan associations

Seven-day services

- The National Institute for Health & Clinical Excellence (NICE) guidelines state that palliative care services should ensure provision to visit and assess people

approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.

- At the time of our inspection, the SPCT operated a five-day service from 08:00 – 18:00, Monday to Friday. New nursing staff had recently been recruited and a seven-day service was due to become operational in September 2016.
- Out of hours, staff could access specialist support from the local hospice, although staff on some wards were not aware this service was available.
- Hospice staff were also able to contact the regional on call consultant in palliative medicine, on behalf of trust staff, for further specialist advice if required.
- The trust chaplaincy team operated a seven-day service with an out of hours call out system in place.
- The mortuary operated a seven-day service including a 24 hour on call system. This included staff being available for relatives who wanted to see their relatives after they had died.
- The trust had seven day services for imaging, pharmacy and therapy services such as occupational and physiotherapists.

Access to information

- Staff on the wards we visited told us that they were able to access palliative and end of life care policies and guidelines on the trust intranet.
- The palliative care team had an intranet site, accessible to all staff electronically where current policies and information re palliative and end of life care could be accessed.
- We also saw palliative care resource folders on some of the wards however; on two wards we visited, some policies within these folders were out of date. This included the just in case prescribing (valid until 2014) and the syringe driver guidance (valid until December 2014). We raised this with either the link nurse or a senior nurse on the wards.
- The SPCT had access to an electronic patient records system that is also widely used by general practitioners and community nursing teams in the region. Staff were able to view and share end of life care patient details on the system. However, the SPCT also completed written documentation in the patients paper based care record that was resulting in duplication of work.
- Staff in the mortuary were able to book appointments electronically with the registrar's office for bereaved relatives. However, most systems within the mortuary were paper based. Staff believed that more electronic systems would be beneficial.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- Patient or next of kin consent to share information was documented in patients care records. We saw this in 100% of the records we reviewed. In addition to this, we witnessed staff seeking consent before providing any care or treatment.
- During our inspection we looked at 16 do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found all of these forms were kept in the front of the patients medical records, which was in line with trust policy.
- Six of the16 forms indicated that the patient lacked capacity. We could not find evidence of a mental capacity assessment in two of the patients' notes; however, in all of the records we saw that a best interest decision discussion or meeting had taken place involving the patients' family.
- In all records, we saw documented evidence that a discussion had taken place with the patient or their relatives.
- 100% of the forms were signed and dated, however a senior clinician had not signed one form.
- This meant that predominantly the completion of DNACPR forms was of a high standard and in line with local policy and national recommendations.
- Staff completed training in consent, MCA and DoLS. Information provided by the trust showed that 79% of staff from the SPCT had completed this training. 100% of mortuary, bereavement and chaplaincy staff were compliant with this training.

End of life care

- The trust had a mental capacity act, deprivation of liberty safeguards, consent and physical restraint policy and also a resuscitation policy (which incorporated DNACPR guidelines) to support staff.

Are end of life care services caring?

Good

In 2014 we rated caring as 'Good' and this rating was maintained in 2016 because:

- Feedback we received from patients was consistently positive about the way staff treated them.
- We observed a number of staff and patient or carer interactions during our inspection. We observed consistently caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involves them in planning their care.
- Patients said that the staff were 'marvellous' and that the SPCT 'had got it right'.
- Patients were supported emotionally. All staff were very responsive to the psychological needs, not only of patients but also those close to them.
- We saw an initiative that had been implemented by the bereavement team which we thought was outstanding.

Compassionate care

- We saw ward staff and the SPCT being compassionate and caring to patients and their families.
- We observed consultations between the SPCT and their patients, we saw that the team were sensitive, and used appropriate communication. Patients were given the opportunity to ask questions.
- We found that staff were sensitive to the needs of the patients and their families.
- We spoke to one patient who told us that the staff were 'really caring -marvellous' and that the ward had a lovely atmosphere.
- Another patient could not praise the SPCT highly enough. This patient told us 'they have got it right' and that other areas of the trust could learn from the team. We witnessed a consultation with a patient and a consultant. We noted that the consultant was caring and compassionate with the patient and her family member. Following the consultation the patient told us that this was usual for the team and 'no different because we were there'.
- In a 2015, externally collated, survey of bereaved relatives, we saw that 100% of people surveyed were satisfied with the way in which the palliative care team respected the patient's dignity. One patient told us that staff always maintain their dignity.
- The trusts own, 2015, bereavement survey showed that most (87%) bereaved relatives felt that their relative received a high standard of care. 9% of relatives disagreed with this. 4% did not respond to the question on the survey.
- The bereavement team had implemented an initiative to support bereaved relatives. They had displayed a notice, which said that they were aware that not everyone had the chance to say what they wanted to someone before they died. They provided a supply of cards and envelopes and invited people to write a message to their loved one, which the team then placed with the deceased patient. We felt that this was an area of outstanding practice.
- In addition to this a member of the bereavement team told us that 'often relatives do not realise this is the mortuary.' But that they always say to the loved ones 'this is where mum or dad is now and I will look after them whilst they are here.'

Understanding and involvement of patients and those close to them

- We saw staff involving patients and families in decisions about care and that conversations with relatives were documented in patients care records.
- One relative told us that they had been given open visiting and described the hospital as being like a hotel.
- A patient told us that a doctor had discussed the treatment options available and had given them 'time to think' about what they wanted in terms of treatment.
- One patient told us that the SPCT involved their family at all stages of their illness.
- The trust provided the results of a service evaluation of bereaved relatives by the association for palliative medicine of Great Britain and Ireland (APM), which had been undertaken in August and September 2015.

End of life care

- The results of this were predominantly positive including 80% of relatives being satisfied or extremely satisfied with the availability of the palliative care team and 87% being happy with the way the family was included in treatment and care decisions.
- The trusts own bereavement survey in 2015 showed that 94% of relatives felt that their relative had been treated with dignity and respect at all times and 96% of relatives said that they found the information provided in the trusts bereavement pack useful.
- One of the chaplains told us that 'listening is very important.'
- The bereavement office included a waiting area, with complimentary tea and coffee facilities. There was also a private room available for the bereavement staff to speak to relatives and carers in private.

Emotional support

- We saw staff providing emotional support to patients and their relatives during our inspection.
- In an externally collated bereaved relative's survey, conducted in 2015, we saw that 87% of relatives were satisfied or extremely satisfied with the emotional support provided by staff.
- A bereavement support group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- Following a death on a ward, staff completed a deceased transfer form, which was transferred with the patient to the mortuary. Ward staff advised relatives that they should contact the bereavement office. The bereavement office team then dealt with all aspects of care for the bereaved family. This included collecting the patients belonging from the ward, ensuring death certificates and cremation forms were completed appropriately and in a timely manner and that families received help and support to contact the registrar's office.

Are end of life care services responsive?

Good

In 2014 we rated responsive as 'Good'. In 2016 we rated the services as 'Good' because:

- Services were planned and delivered in a way that meets the needs of the local population.
- All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. This included the mortuary service who were available operated a 24 hour service.
- Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and each patient's choice in relation to their preferred place of care was achieved for high numbers of patients.
- The facilities and premises were appropriate for the services being delivered.
- We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- There were no complaints about the teams providing specialist end of life care, however when complaints were received about end of life care on generalist wards, senior staff from the Health Group were made aware and contributed to providing a response.

Service planning and delivery to meet the needs of local people

- Care at the end of life care was provided on generalist wards at the hospital, staff were able to refer patients to the SPCT if they needed advice and support to care for any patients with complex needs including symptom management.
- The team also provided training and education to the staff on the generalist wards and the majority of wards had palliative link nurses.
- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed the patients at end of life patients and had discussions with them and their families.
- Care at the end of life was also provided in other departments at the hospital including the critical care units.
- The trust had a 'Preferred Priorities of Care' document that was completed for patients. We saw these in the majority of care records we reviewed. An audit provided by the trust showed that, between January and December 2015, 82% of 205 patients had their preferred place of care recorded in their care records.

Meeting people's individual needs

End of life care

- The results of a recent trust survey showed that 100% of relatives were satisfied with the information they had been given about how to manage the patient's symptoms. In addition, 100% of relatives indicated that they were satisfied or extremely satisfied with the palliative care team's response to changes in a patient's care needs and 87% indicated that they were happy with the speed at which symptoms were treated.
- However, within the same survey, only 50% of relatives who responded felt that their relative had enough choice about where they wanted to die however, 27% of relatives did not answer this question. 23% felt that their relatives did not have enough choice about preferred place of death.
- On all wards we visited staff told us that whenever possible end of life care patients would be cared for in a single room.
- The trust provided details of the interpretation/ translation services used. Staff we spoke with knew how to access the services as and when they were needed.
- The trust employed a learning disabilities (LD) liaison nurse who would be made aware of any patients with learning disabilities who were being cared for in the hospital. At the time of our inspection we spoke with the LD liaison nurse; however there were no patients with LD receiving end of life care.
- The trust used a dementia screening assessment and the butterfly scheme. Trust policies such as the dementia and delirium policies were available to support staff to care for these patients.
- Dementia training and education was not part of the trusts statutory or mandatory training. Three members of the SPCT had undertaken training in dementia.
- In all areas we visited, we were told that relatives and carers of patients at the end of life would be offered open visiting.
- Chaplains were also able to conduct funerals on behalf of the trust if requested.

Access and flow

- Staff working on the wards and departments, providing care at the end of life, were able to access specialist support from the SPCT via a referral form. Staff we spoke with told us that the team were very responsive and usually saw the patients within 24 hours or sooner if required.
- The SPCT had seen a year on year increase in referrals from 689 in 2010 to 1,386 in 2015.
- The team had also seen a yearly rise in the number of referrals for non-cancer patients from 215 (18.1%) in 2013 to 343 (24.7%).
- In November 2015 and April 2016, snapshot audits of referrals to the SPCT showed that 98% of patients were seen within one working day of referral and 2% within 2 working days.
- The SPCT also held consultant led clinics. Patients were able to ring and refer themselves for appointments or they could pre-arrange appointments. One consultant told us that in addition to this they would see patients outside of the clinic times dependant on need.
- The trust employed 5.35 wte chaplains (six people in total) which met the NHS Chaplaincy Guidelines 2015. Promoting Excellence in Pastoral, Spiritual & Religious Care. In addition to this, there were 26 chaplaincy volunteers. The role of this team was to provide religious, pastoral and spiritual care appropriate to the needs of individual patients. Referrals for spiritual care came from:
- Patients themselves using the chaplaincy team phone number and email.
- Staff recognising spiritual need in a patient and offering immediate support themselves or referring on to the chaplaincy team.
- Carers of patients may refer to the chaplaincy service for support.
- Community groups outside of the trust are able to refer their members for care to the chaplaincy team
- The chaplaincy team used an electronic patient flow management software system that enabled them to alert colleagues to spiritual care needs for patients by a flag on the system.
- The trust had developed a 'rapid discharge' pathway to support ward staff to be able to organise a rapid discharge home for patients at the end of life. This was a checklist and aide memoire for staff, giving prompts to ensure they are able to organise care and services in a timely manner. Collaboration was sought with social services and the discharge team to support this and the SPCT also supported and facilitated if required.
- Data provided by the trust showed that 47% of patients were discharged to their preferred place of care on the same day, 35% were discharged the following day and 18% of patients were discharged 48 hours or more later.
- We saw that mortuary capacity was listed as a risk for the mortuary service. Staff we spoke with in the service explained that when some of the elderly care wards had

been transferred from Castle Hill Hospital this had increased demand for the service at Hull Royal Infirmary. In order to minimise the risk, staff had developed close working relationships with undertakers and were able, if necessary, to liaise with funeral directors to collect deceased patients. Staff explained that it was possible to transfer deceased patients to the mortuary at Castle Hill but that this option would only be taken with the coroners and families consent.

Learning from complaints and concerns

- There had been no complaints relating to the SPCT, mortuary, bereavement service or chaplaincy teams in the 12 months prior to our inspection.
- Information provided by the trust indicated that there had been two complaints involving patients who had died in the previous 12 months however further data received indicated that, between April 2015 and March 2016, 45 complaints involved a patient death.
- The most common clinical area for complaints involving a death was in oncology with nine complaints (20%). The majority of these complaints related to dissatisfaction over the way the patient was treated prior to their death.
- During our inspection, we discussed complaints with the Clinical Support Health Group senior management team and were told that they would be involved in any complaint that involved a patient at the end of life. We were also told that complaints were analysed for themes within the Health Group and where necessary the senior management team would be involved in the response to the complaint.
- We saw Patient Advice and Liaison service information displayed on the wards we visited.
- Following the death of a patient, the bereavement team offered support to relatives. This included asking relatives if they had any concerns with the care provided on the ward where their relative had died. Patient Advice and Liaison service leaflets were available in the bereavement office reception area and bereavement staff signposted relatives to this service if necessary.
- Staff we spoke to told us that complaints were shared with the team including the learning and actions. We saw this in minutes of team meetings we looked at.

Are end of life care services well-led?

Good

In 2014 we rated well led as 'Good' and this was rating was also 'Good' in 2016 because:

- All teams were aware of the trust vision and values. We saw these displayed during our inspection. In addition to this, we saw team visions and mission statements for individual teams for example, the mortuary and bereavement team and the chaplains.
- Whilst there was no trust end of life strategy at the time of our inspection, the SPCT were working collaboratively with other providers and using the national End of Life Care strategy: New Ambitions document to benchmark and influence the care and treatment they provided to patients.
- Robust governance, risk management and quality measurement processes were embedded in the teams and the Health Group. The Health Group had a Quality Governance & Assurance Committee.
- The Health Group management structure was clear. Staff we spoke with told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board.
- We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- We saw examples of Innovation, improvement and sustainability.

However we also found that:

- At the time of our inspection, the trust did not have a Non-Executive Director (NED) for end of life care representation at board level.

Vision and strategy for this service

- All staff we spoke with were aware of the trusts vision and values. We saw these displayed in clinical areas. We also saw individual visions and mission statements displayed.
- We saw the vision for the mortuary and bereavement service displayed in the reception area of the

bereavement office. This was to deliver 'Specialist, high quality mortuary facilities and bereavement care'. Staff we spoke with were aware of and based their care around the service vision.
- The chaplaincy's mission was to be available for those requiring spiritual care in the broadest sense of the word, to listen and be alongside those who may be experiencing loss, fear, distress or anxiety.
- We requested a copy of the trust strategy for end of life care but were told that the trust did not have a strategy. We were told that this was being developed and this was currently in draft stage. However, the SPCT were working collaboratively with other care providers and completing a gap analysis in relation to the national End of Life Care Strategy: New Ambitions document.
- In addition to this, the team had a specialist palliative care multidisciplinary team operational policy (2016). This document outlined the aims, objectives and responsibilities of the team.

Governance, risk management and quality measurement

- The SPCT were part of the clinical support Health Group. The Health Group had a quality Governance & Assurance Committee.
- The SPCT produced an annual report, which highlighted any service developments, achievements and risks in terms of quality assurance.
- Operational policy meetings to discuss operational issues and service development within team were also held quarterly. We saw an action plan that had been developed to monitor compliance with the operational policy and service development.
- We saw the risk register for end of life care. There was only one risk highlighted which was in relation to mortuary capacity. Staff we spoke to about this were aware of the risk and could explain why the risk had arisen and the actions taken to mitigate the risk.
- Following an inspection of the mortuary services at the hospital, in September 2015, the Human Tissue Authority (HTA) found that all applicable HTA standards were assessed as fully met.
- The HTA also reported that all aspects of the mortuaries work was supported by ratified documented policies and procedures as part of the overall governance process.

Leadership of service

- The Health Group management structure included a medical director, an operational director, a director of nursing and a clinical director.
- Clinically there was a lead consultant and a lead cancer nurse; however, there was not a lead nurse within the SPCT.
- The trust met the recommendation to have a designated board member with specific responsibility for care of the dying. This was the chief medical officer. There was also Medical Director for Clinical Support; however, there was not a Non-Executive Director (NED) lead for end of life care on the trust board, we discussed this with the senior management team and were told that the director of nursing was progressing this.
- There was a mortuary and bereavement services manager who was deemed by the Human Tissue Authority (HTA) to have a good understanding of the HTA Act and who worked to ensure improvements are implemented as required.
- There was a lead within chaplaincy service.
- All staff we spoke to told us that senior managers were approachable, supportive and visible.

Culture within the service

- We found that staff were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- The end of life care teams, including the SPCT, the mortuary and bereavement teams and the chaplains were described by the senior management team as having a unity of purpose, being passionate, pulling in the same direction, being proactive and providing fantastic care.
- We spoke with a newly appointed member of the SPCT who told us that they had been made to feel really welcome in the team.
- The medical and nursing staff from the SPCT told us that they had very good, close working relationships.
- The HTA reported that the mortuary staff have worked at the establishment for a number of years and were motivated and experienced in their roles. They are well trained and have worked towards developing robust mortuary procedures. The team was dedicated to ensuring that the dignity of the deceased was maintained and that relatives visiting the mortuary were treated sensitively.

End of life care

- We spoke with three members of the chaplaincy team and found them to be warm, friendly and welcoming. Other staff commented that the chaplaincy service were excellent.

Public engagement

- The trust collated bereaved relatives feedback, on an ongoing basis, through the bereavement team and they used this information to improve the service for bereaved relatives by providing feedback to any areas where care fell below expectations.
- A bereavement group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- One family we spoke with said that they would like to be issued with a pass so that they could access or leave the ward without disturbing the staff. The SPCT nurse we were observing told the family that she would let the ward staff know about this suggestion.

Staff engagement

- Staff we spoke with told us that they were supported to professionally develop.
- Staff told us that they felt that communication between the team members and the information received from the trust was good.
- Compliments from patients and other services were discussed at the SPCT meetings.
- New staff told us that they felt supported by the team and a member of staff who had been on long term sick told us that the trust had been supportive.
- The chaplains provided an introduction to their service at the trusts induction for new members of staff. In addition to this, they also held a biennial spirituality day for staff, the aim of this was to raise awareness about staff wellbeing and coping strategies. There also ran spirituality in healthcare, spirituality in loss and spirituality in privacy and dignity sessions twice a year.
- The chaplains had 2700 contacts per year, of these 20% (540) were contact with staff members.

Innovation, improvement and sustainability

- The SPCT operational policy outlined the responsible key clinicians for service improvement including research, audit, education, information and patient and carer issues.

The SPCT were working collaboratively with other teams and care providers on initiatives such as:

- Improving access to hospice care from the acute hospital through cultural transformation and
- Improving specialist palliative care services to patients with non-malignant diseases through cultural transformation.
- Three of the SPCT nurses had been nominated for the trusts golden heart awards.
- Macmillan Cancer Support recognised one of the SPCT nurses with a 2014 'Henry Garnett Award'.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the other hospital within the trust, Hull Royal Infirmary (HRI). The trust also has several off-site locations delivering outpatient and diagnostic imaging services.

Between January 2015 and December 2015 there were 641,018 outpatient attendances for first and follow up appointments at the trust overall, including the off-site locations. In addition to appointments at the HRI and CHH sites, the trust ran outpatient clinics at The East Riding Community Hospital (ERCH), Westbourne NHS Centre and Bransholme Health Centre. These locations had 5.3% of the trust's total appointments in 2015, with 4% (27,984) at ERCH, 0.6% at Westbourne NHS Centre (4592) and 0.3% at Bransholme Health Centre (2547). We visited Westbourne NHS centre as part of this visit, but not the other two off-site locations.

Between May 2015 and April 2016, there were 704,483 attendances at the HRI and CHH sites; 299,903 (43%) of these were at the CHH site. The highest numbers of attendances were seen in clinical oncology (previously radiotherapy) at CHH, with 69,000 attendances during this12 month period, followed by cardiology (30,000), ear, nose and throat (24,000) and plastic surgery (22,000).

Services at the trust were split into four Health Groups, medicine, surgery, family and women's health and clinical support. Outpatient services were provided in each of the four Health Groups.

During the inspection, we visited the following outpatient departments, clinics, and areas:

- Cardiology
- Respiratory medicine
- Ear, nose and throat Audiology
- Eye clinic
- General outpatients
- Bookings team
- Orthopaedic
- Cardiothoracic
- Plastics outpatients
- Westwood Suite (plastics day surgery unit)
- Breast care unit
- Radiology
- Pathology (haematology, biochemistry and blood transfusion)

From April 2015 to March 2016, the total number of investigations in all radiology modalities was 410,341. This was an increase of 13,172 compared to 2014/2015 and represented a 3.3% increase in demand.

Radiology at the CHH site had two CT scanners and two MRI scanners, in addition to four general x-ray rooms, two fluoroscopy rooms and four ultrasound rooms. Radiology provided staff to work in the four rooms in the cardiac catheter labs, but did not manage this service. Scanners in oncology were not managed by the radiology service. The nuclear medicine PET (positron emission tomography) CT scanner was in a separate building. An external company was contracted to manage this building and scanner.

We spoke with 47 members of staff in outpatients, radiology and pathology, including managers, nurses,

Outpatients and diagnostic imaging

radiographers, medical staff and administration staff. We also spoke with eight patients and two relatives. We reviewed paper and electronic patient records in outpatients and radiology and looked at other records such as audits, meeting minutes, policies and procedures. We also reviewed the systems for managing the departments and quality and performance information.

We carried out an announced comprehensive inspection between 28 June and 1 July 2016. When we inspected this service in May 2015, the service was rated as good overall.

Summary of findings

At the inspection in 2015 we rated outpatients and diagnostic imaging services as 'Good' overall. The effective domain was inspected but not rated. This was because we are currently not confident we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the service as 'Requires improvement' overall because:

- The trust was not achieving the national standards for referral to treatment and urgent cancer treatment. However, a plan was in place with trajectories, that had been agreed with commissioners and NHSI and at the time of the inspection this was being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual health groups were taking action.
- A cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should: all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery since the 2015 inspection and a previous never event in March 2015.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies for nursing and support staff in

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some outpatient specialties, and in radiology there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.

- We found there were a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.

However,

- Outpatients and radiology had increased their appointment capacity by running clinics out of hours and at the weekends, to cope with the increased demand and ensure patients had their appointments. However, there were on going concerns about the trust not meeting national standards for referral to treatment and urgent cancer treatment. However, a plan was in place and locally agreed trajectories, agreed with commissioners and NHSI were being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action to review any issues.
- Staff providing care and treatment to people in outpatients and radiology were caring. Patients gave positive feedback about the care they received and we saw staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing difficulties or those who needed an interpreter.
- The facilities and premises used to deliver services were good. The environment in all of the areas visited was in good state of repair, clean and comfortable and sufficient well-maintained equipment was available.
- Outpatient services were split between the four Health Groups, meaning there were different levels of management and clinical support for each service. There was no outpatient risk register, however risks were identified on risk registers of Health Groups but this did not allow a cohesive oversight. There was also limited evidence of outpatient audits and quality monitoring.
- There was inconsistency in the governance and management oversight in outpatients due to it being split across the four Health Groups. The trust had recognised this and it was being addressed with a weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality and an 'outpatient transformation project' , but this was running behind schedule. This project's aims included improving clinic utilisation, bookings processes and performance against national standards. We were also told that an overarching management post was to be developed.
- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme in which all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- The trust had effectively managed a serious incident that had been reported by Radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further seven six serious incidents regarding specific patients had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

In 2015,we rated outpatients and diagnostic imaging services at CHH as 'Good' for safe. In 2016 we rated the safety of this service as 'Requires improvement' because:

- A cluster of eight serious incidents had been declared in outpatients across the trust, relating to patients that had not had their appointments when they should: all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- There had been two never events declared in radiology at the CHH site since the last inspection, both involving wrong site/side surgery. There had also been a never event, in March 2015.
- The use of safety checklists was still not being audited. Safety checklists and witnessed swab counts were not being completed in line with trust policy. There was variation in practice in the use of surgical safety checklists and counts, of items such as swabs and sharps, between outpatient specialties carrying out day surgery. The medical director for the Family and Women Heath Group acknowledged this was an issue.
- There had been some improvements in the number of histopathologist and echo cardiographer vacancies since the last inspection, but there were still a number of vacant positions to fill.
- Staff vacancies in and across outpatients specialties were variable; there were regular unfilled duties for nursing and unregistered staff in ophthalmology, maxillofacial, medical outpatients and general surgery.
- In radiology, there were five vacant consultant radiologist posts out of an establishment of 33 and the department had been unable to recruit neuro-radiologists due to national shortages. In general x-ray there was a high proportion of radiographer vacancies; 9.5 whole time equivalent (WTE) posts were vacant out of an establishment of 56 WTE (17%).
- The on call rotas for radiologists in radiology had a high level of commitment and low numbers of staff on each of the four rotas.
- A new radiology checklist had been introduced following the never events, however no audits had been carried out to confirm staff compliance with its completion. Senior staff said audits were due to start in August 2016. This meant there was limited assurance both about the effectiveness of the new checklist for patients undergoing similar procedures in the future and whether lessons had been learned and shared.

However;

- Medicines were managed safely and kept securely, most departments had enough equipment to provide the safe care and treatment patients required and infection control practices were good.
- The trust had responded effectively to a serious incident reported within Radiology in December 2015 related to a failure to print up to 50,000 radiology reports. A further seven patient related serious incidents had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- Staff were well supported for training, and services were meeting the trust target of 85%. Mandatory training included safeguarding, infection control, information governance and major incidents.

Incidents

Outpatients

- The majority of staff we spoke with knew how to report incidents and about learning lessons from incidents. Incidents were reported and tracked on the trust's Datix incident management system.
- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been seven incidents reported in surgical outpatients and 11 in medical outpatients. No data was submitted for the other outpatient specialties.
- In April 2016, a cluster of eight serious incidents had been declared in outpatients, relating to patients that

had been lost to follow up and/or delays in diagnosis. This had led to delays in diagnosis and incidents of varying harm to patients including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

- No 'never events' had been recorded in outpatient services. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Following never events in other areas of the trust, the trust had produced a training video and was in the process of delivering it to staff. Senior staff had undertaken 'human factors' training.
- However, we found a lack of awareness when discussing with outpatients staff the lessons learnt from the never events. Some staff could not tell us about the never events that had occurred at the trust.
- We found the majority of patients and their relatives had been contacted following the serious incidents and the requirements for the duty of candour had been followed. However, some patients and families had not been contacted about their serious incident investigations. These included patients with Alzheimer's disease and a patient who was admitted urgently to the intensive care unit.
- Representatives of the outpatients management team told us outpatients had a duty of candour register. The medical director for the Family and Women Heath Group told us patients who had suffered harm were always made aware of the event and asked whether they wanted to see investigation reports.
- When we reviewed the serious incident reports, we saw the panels discussed the duty of candour requirements and nominated a person who would be responsible for patient liaison.

Diagnostic Imaging

- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 166 incidents reported in radiology at the CHH site.
- A serious incident (SI) relating to the failure to print radiology reports had been reported in December 2015. The incident was detected when a consultant neurologist questioned why some radiology reports were taking so long to be sent to them.
- A root cause analysis investigation identified that the problem had been an issue for some time, with up to 50,000 radiology reports not being printed in the 12 months prior to the issue being identified. In addition to delayed printing, there was a high proportion of reports that had not been printed at all. For example, in the three months from June 2015, 20% of reports did not print. A sample from 2012 showed 4% of reports did not print at that time.
- Overall, seven SIs had been reported, four of which related to the radiology printing issue and this had been tracked with the commissioners at the monthly SI panel meeting to identify any more as they arose.
- Further investigation of the radiology SIs showed three were categorised as major, three as moderate and one as high. Three of the seven incidents were not related to the printing problem; one was caused by a misinterpretation and the other was due to the reporting backlog. All seven patients involved in the serious incidents experienced significant delays in diagnosis and/or treatment, which caused them distress. As a result of the incident the system had been changed so that all radiology reports were sent electronically both within the trust and to primary care and there was a mechanism in place which automatically monitored the opening of the reports and if action had been taken. Any exceptions were routinely reported and escalated to the medical director if required.
- Two never events had been declared in radiology since the last inspection, both involved wrong site / side surgery and both occurred at the CHH site. The first occurred in October 2015 and the second in March 2016.
- The two radiology clinical directors had made presentations to the trusts' Quality Committee about the SIs and never events on 23 June 2016, entitled ,"Learning from recent radiology SIs" and "Never Events in Radiology 2014/15 and 2015/16".
- A new radiology checklist had been developed by the radiologists after the second never event occurred. This was because the form developed after the first never event was found to be too complicated; with 33 boxes

and 55 questions for staff to complete. However, from reviewing this new radiology checklist we were not assured that it addressed the issue of a wrong site procedure being carried out.

- Staff we spoke with in radiology were all aware of how to report incidents and about the radiology serious incidents and never events. They also knew about the requirements the duty of candour. Staff told us there had been "a big push" in the past year to ensure staff knew about the duty of candour.
- Radiology managers told us the radiology safety checklist was currently kept in the patient notes and not scanned into the radiology information system (RIS). They said when the RIS was replaced, which was due in November 2016, the forms would be scanned in. They explained this was the reason it was currently difficult to audit the completion of these checklists.
- Radiology managers told us they monitored trends of incidents. They said the main incident type reported was extravasation incidents; however, these were lower than national averages. Extravasation is when fluid leaks into the tissue, usually surrounding an injection, site and the degree of injury experienced is variable.
- The number of radiation incidents requiring notification to external regulators was low. We reviewed the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) notifications from January 2015 to June 2016 and saw there had been seven incidents notified in this period.

Pathology

- The pathology laboratory manager told us incidents in pathology were recorded on 'Q-pulse' the department's electronic quality management system (QMS). They said a CAPA (corrective action preventive action) process was followed and if an incident had affected a patient, then it would also be reported on Datix. They said trends of incidents involving pathology were analysed in order to identify any recurrent issues.

Cleanliness, infection control and hygiene

Outpatients

- The environment in all of the outpatients' areas we visited was visibly clean, tidy and uncluttered. Surfaces and flooring were intact which aided effective cleaning.
- Cleaning staff followed cleaning schedules. We saw comprehensive cleaning checklists in all the clinical treatment rooms. These were all completed as required and up to date.
- We saw waste was correctly segregated and sharps bins appropriately labelled.
- Alcohol hand rub was easily accessible within the departments and we observed staff and patients use it appropriately. We saw staff and patients had good access to hand washing facilities.
- We saw infection-control awareness notices on display in patient waiting areas and toilets.
- Personal protective equipment was available in all clinical rooms visited. We saw equipment with 'I am clean' stickers attached. The nurse in charge in general outpatients explained equipment in the department was cleaned every evening after the clinics had finished. They also told us staff deep cleaned each trolley in the department weekly. Records we reviewed confirmed this.
- Mandatory training records submitted by the trust showed the majority of staff groups were up-to-date with infection-control training and were achieving the trust target of 85%.
- Staff in plastics outpatients told us the room in the Westwood Suite used for minor procedures was a cleanroom, but did not have air changes. We observed a minor procedure during the inspection. We saw staff in this area gowned up in surgical scrubs prior to carrying out the procedure.
- We also observed a patient undergoing a coronary angiograph in the cardiac catheter laboratory. A coronary angiograph is an invasive procedure involving insertion of instruments in to the patient's blood stream and the procedure is carried out under sterile conditions.
- The 'scrub' team consisted of the medical consultant and healthcare practitioner; both of whom wore a sterile single patient use surgical scrub gown and sterile gloves.
- However, the 'scrub' technique of the assisting healthcare practitioner was not in-line with expected standards. Prior to the small incision being made to the patient's neck, the assisting practitioner was sitting on a stool, arms crossed with hands under each armpit; on several occasions, the practitioner's hands went below waist height. At one point, the assistant's hands reached below their waist and under the gown to use it to cover

their gloves whilst they touched their face; at this point the senior practitioner in the room asked them to de-scrub and put on a fresh sterile gown and gloves. This showed infection control measures were not always being carried out effectively.

Diagnostic Imaging

- All of the areas visited with visibly clean and there were effective systems and processes in place to reduce the risk of spread of infection. People were cared for in a clean hygienic environment.
- We saw there were hand gel dispensers available and staff had access to appropriate personal protective equipment, such as gloves and aprons. Staff told us the escort nurses cleaned wheelchairs between uses.
- We saw appropriate hand washing notices in place, waste was segregated appropriately and flooring complied with current guidance for flooring in healthcare facilities.
- We saw cleaning records in the rooms, which staff completed each day. Records we reviewed showed these were all completed as required.
- Mandatory training records showed the majority of radiology staff were up-to-date with infection-control training, apart from admin and clerical staff whose percentage compliance was 45%. Medical staff compliance was 94%, against the trust target of 85%.

Environment and equipment

Outpatients

- The environment in all of the outpatient areas visited was in good state of repair, clean and comfortable. We saw water fountains in all of the clinic waiting areas visited. However, the junior sister in plastics outpatients told us their water fountain had only been recently installed, after two years of requesting one.
- In ophthalmology, we visited the eye clinic; we found equipment within the treatment rooms was appropriate. We found staff did not use any equipment that required sterilisation as everything was single use and disposable.
- We reviewed comprehensive equipment management and medical estates records for CHH equipment. We saw these documented the equipment number, location, manufacturer, model number, service and repair dates, and calibration dates.
- Staff in ear, nose and throat services told us medical physics at HRI kept equipment records for the department.
- The cardiology outpatients unit was around seven years old; the environment was in a good state of repair and of a suitable layout.
- The unit had recently purchased two new echocardiograph machines and the third existing machine was functioning well; service contracts were in place with the manufacturer.
- The unit had two cardiac analyser machines. Staff told us these did not have much service life left; a business case had been submitted for two new cardiac analyser machines.
- Staff told us there were four cardiac laboratories at Castle Hill Hospital, and two vascular laboratories at Hull Royal infirmary. A consultant interventional cardiologist told us the trust had purchased a digital reporting system six years ago; however, they said it did not work and had never been switched on.
- There was a capital replacement programme in cardiology, and staff told us they were currently buying a new treadmill. They said new 'echo beds' had been ordered in February, but these had not arrived yet. Senior staff had been getting quotes for changing room layouts.
- Staff in the cardiothoracic office told us the Lorenzo computer system for booking and changing appointments was very slow and sometimes, "went down." They said there was no option to toggle between different screens if someone phoned to change an appointment and that changing an appointment, "took forever."
- Staff in cardiothoracic and cardiology services had been piloting a new voice recognition (VR) system for about a month. Office staff in cardiothoracic and cardiology services told us colorectal and upper GI were going live the same system. We reviewed a letter produced by a consultant using VR. Staff explained when the consultant had signed the amended letter they copied it into Lorenzo. They felt the new VR system would be more accurate and would save on staff time and resources.

Diagnostic Imaging

Outpatients and diagnostic imaging

- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment.
- Appropriate personal protective equipment was available for staff to use in radiology. We observed radiology staff wearing specialised personal protective aprons; these were available for use within all radiation areas. Staff were also seen wearing personal radiation dose monitors, these were monitored in accordance with the relevant legislation.
- Staff told us consumables were barcoded; this avoided any overstocking. The radiology department shared its stockroom with endoscopy.

Pathology

- The pathology laboratory manager told us pathology staff were delivering training across the whole trust for staff to use the new 'Bloodhound' system. They explained this tracked the removal of blood for transfusion from the blood storage units. They explained this would ensure there was a robust audit trail.
- Alarms on all of the blood storage units / blood fridges went through to the hospital switchboard.
- Haematology had plans to introduce digital morphology for reading blood films.

Medicines

- People were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines.
- Medicines storage and management was checked in all the outpatients and radiology departments visited. We found all medicines checked were in date and stored securely. Staff recorded fridge temperatures regularly as required. Review of historic checks showed these were all complete and within recommended ranges. Staff were aware of what actions to take if there was an issue.
- Room temperatures where medicines were stored were not monitored but we found air conditioning units were in use and the rooms felt cool.
- None of the areas where we looked at medicines storage at the CHH site used controlled drugs.
- Prescription pads and record books were stored securely. We reviewed prescription records in outpatient clinics and found they were all correct.

Records

Outpatients

- People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate patient records were available
- Patient records were stored securely: in general outpatients we observed that notes trolleys were kept locked and secured by a digital lock. In the ear, nose and throat (ENT) service, the paper notes were kept on notes trolleys in the consulting rooms. We did not see any notes left unattended during our visit.

Diagnostic Imaging

- The radiology manager told us the information system (RIS) was due to be replaced in November 2016. This would enable staff to scan checklists and forms into patients' records.
- Radiology stored and viewed images on the departmental PACS (picture archiving and communication system).
- The radiology department had recently implemented an electronic reporting system, eResults. The radiology manager told us the majority of users, including GPs, now received their results electronically. They said this would reduce the risk of the printing errors recurring in the future.

Safeguarding

Outpatients

- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology and medical outpatients were all up to date with training for vulnerable adults and safeguarding children. The trust data submitted showed that level 1 and level 2 children's safeguarding training was above the trust target of 85% in all four Health Groups apart from medicine (82% in level 1 and 84.6% in level 2) and surgery (84.6% in level 2).
- Most staff groups within these specialties had achieved 100% compliance against the trust target of 85% and dermatology was 100% compliant in all staff groups. Compliance rates medical and dental staff were lower in some areas but were still meeting the trust targets. For example, in ophthalmology, medical staff achieved 90.3% compliance in vulnerable adults training.
- The trust did not submit disaggregated mandatory training data for other outpatient areas.

- No safeguarding issues were identified during the inspection. Staff were aware of their responsibilities and were able to describe what actions they would take they had concerns.

Diagnostic Imaging

- The radiology manager told us staff received mandatory training in safeguarding adults and safeguarding children and this training was all up to date. We did not see evidence of this during the inspection, but radiology mandatory training records submitted after the inspection confirmed what the manager had told us.

Mandatory training

- Staff received training and development appropriate to their roles and responsibilities.
- Ten mandatory training courses were available for all staff these included infection control, information governance, major incidents and safeguarding.

Outpatients

- Staff we spoke with all told us their mandatory training was up to date.
- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology, ENT, surgical outpatients and medical outpatients were all up to date and meeting the trust target of 85%. The trust did not submit disaggregated mandatory training data for other outpatient areas.

Diagnostic Imaging

- The radiology manager told us they monitored mandatory training of staff on a monthly basis and that mandatory training for non-medical staff was up to date. Records submitted by the trust confirmed this.
- Mandatory training records were kept electronically and the radiology manager told us these records were reliable and kept up to date and meeting the trust target of 85%. The clinical leads in each modality area were responsible for managing training.
- We observed information about mandatory training was on display in the department.

Assessing and responding to patient risk

- We checked resuscitation trolleys in all areas visited, including the Westbourne NHS centre. We found appropriate equipment was available and in date. The trolleys were all clean and tidy. We reviewed; daily and monthly checks in all departments visited, and these were all completed.

Outpatients

- There were systems and processes in place for assessing and responding to patient risk to keep patients safe. For example, in general outpatients the nurse in charge showed us their emergency treatment room and explained this was for any patients who deteriorated or felt unwell while they were in the department. We observed there was a resuscitation trolley outside the door and the room contained a soft stretcher, IV equipment, blood tray, and vomit bowls. In ear, nose and throat outpatients, we saw cardiac emergency buttons in all ENT consulting rooms.
- Staff in ENT outpatients told us they kept records of which scope had been used for which ENT patient to provide traceability; staff told us these records were kept for 12 months.
- In general outpatients and ENT, we observed reclining chairs were available in clinic rooms where blood tests were carried out. This meant patients that felt unwell or fainted following the procedure could be laid back until they recovered.
- In the eye clinic, we followed a patient's eye injection treatment. We observed the completion of a paper pre-injection safety checklist. We saw the nurse completing the form and the doctor carrying out the injection both signed the form.
- However, we found a variation in practice between outpatients' specialties carrying out day surgery. For example, in the plastics outpatients Westwood suite, where day surgery was performed, we observed a patient undergoing a minor procedure. We observed one of the nurses completed the final surgical check on the checklist without speaking to the rest of the people in the room.
- We reviewed the minor procedures register and the theatre and day surgery specimen register in the Westwood Suite and saw these had been completed as required. Two nurses double-checked the labelling on the sample pot during the procedure we observed.
- We observed the same nurse (scrub nurse) complete steps four and five on the form. However, the verification step, step six, was left blank. When we asked the

registrar performing the procedure about the signing step six, they said the scrub nurse would complete that section. However, this meant the checklist was not being completed contemporaneously as required.

- We reviewed nine sets of notes from patients that had undergone day surgery in plastics outpatients. We found the safety checklists had three sections, which should be signed by different staff; i.e. ODP/anaesthetist, circulating nurse and scrub nurse. In all nine sets of notes checked, the same staff member had signed all three sections for signatures. This meant the checklist was not being completed as instructed on the form.
- In the cardiac catheter lab, we observed a patient undergoing coronary angiography. The unit used the WHO checklist. We observed the patient being checked by staff before entering in to the procedure room; this included checking the procedure, site, allergies and consent. Other appropriate checks were conducted with the patient and the staff team within the procedure room.
- During our observations of the coronary angiography, we noted that surgical swabs, sutures, hypodermic needles and a surgical blade were used during the procedure. We noted that these items were not 'counted out' between two members of staff before, during and after the procedure. We also noted that a 'sticky' surgical pad was not used during the procedure to prevent sharps from accidently being moved and/or lost during procedures.
- At the end of the procedure, some swabs remained on the surgical trolley which were placed in to a bin and some swabs remained on the sterile sheet on top of the patient; these were collected up along with the sterile sheet and but in the bin together.
- The sharps were individually placed in to sharps boxes, which is not as safe as using designated sharps holders and disposing of all contained sharps in one go.
- The processes we observed provided no guarantee that swabs and sharps were all accounted for at the end of the procedure.
- When we asked the medical director for the Family and Women Heath Group about staff conducting swab counts during surgical procedures, they acknowledged there was variation in practice between outpatients' specialties carrying out day surgery. They confirmed ophthalmology carried out swab counts during procedures but some outpatients specialties did not. A process of counting swabs and sharps between two members of staff provides assurance that they are all accounted for at the end of each surgical procedure.
- Staff in plastics outpatients confirmed there were no counts of blades done in the Westwood suite (day surgery). They said this was because there was only one blade in use at a time.
- We checked resuscitation trolleys in all areas visited, including the Westbourne NHS centre. We found appropriate equipment was available and in date. The trolleys were all clean and tidy, we reviewed; daily and monthly checks, in all departments visited, and these were all completed.

Diagnostic Imaging

- The radiology department had three radiation protection advisers (RPAs) and each modality area had named radiation protection supervisors (RPSs). These gave advice on radiation protection when needed, to ensure patient safety and minimise radiation risk. We reviewed the risk assessments for radiation protection and found these met with current requirements.
- The RPAs and RPSs had received appropriate training in line with IR(ME)R guidance. Staff told us the support given by the RPAs and RPSs was excellent.
- Staff told us the RPSs met every three months these meetings included sharing of learning about incidents.
- All of the staff in radiology had undertaken IR(ME)R training. Training was carried out by radiation physics staff, who also held the training records. Records of IR(ME)R training viewed during the visit and submitted after the visit confirmed these were all complete as required.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited.
- Radiology equipment had routine quality assurance tests to check diagnostic reference levels for radiation exposures. Staff reported any trends or increases in exposure to radiation to the RPS for investigation.
- The consultant breast radiologist in the breast care unit told us the recent introduction of digital tomosynthesis would help reduce the number of exposures patients underwent. It would also reduce the number of patients needing MRI scans.

Staffing

Outpatients

Outpatients and diagnostic imaging

- Staff vacancies in and across outpatients specialties were variable; there were regular unfilled duties for nursing and unregistered staff in ophthalmology, maxillofacial, plastic surgery medical outpatients and general surgery. For example, planned hours compared with actual hours in ophthalmology showed 17.9% of nursing and 26.9% of unregistered staff hours were unfilled. In maxillofacial the figures were 28.6% for nurses and 52.1% for unregistered and in plastics outpatients 16.8% for nurses and 19.3% for unregistered.
- Staff in outpatients told us they had daily safety huddles where staff discussed staffing levels, the work allocation for the day, which clinics were running and any issues.
- In cardiology, staffing had improved since its last inspection; however, senior staff told us they were still short staffed. They told us echo cardiographers were band six and were difficult to recruit. The service lead described how the numbers of newly qualified echo cardiographers coming through from university was limited; which made recruiting new staff challenging.
- The acting head of cardiac physiology told us it was also a struggle to recruit physiologists in cardiology. They said newly qualified physiologists at the trust were employed at band five, when some trusts offered band six posts for these positions.
- They said two band five staff were due to start and two band six positions had been filled and a third was out to advert. They said there was a business case for more band six staff in the department and one band seven post had been frozen. They said several people in the department were retiring and senior staff were looking at workforce planning.
- The department had not used any agency staff in the previous 12 months. Staff told us there was good flexibility among the staff in the department; most of the staff were part-time.
- Senior staff in cardiology told us the reporting sonographers were band six. They explained it was difficult to retain staff because nationally reporting sonographers were usually employed at band seven.
- Nursing staff in general outpatients told us there were currently no vacancies. Bank and agency staff had been used in respiratory clinics and to cover initiative clinics. However, staff from other areas working overtime or part-time staff working extra hours usually covered gaps in the rota.
- In the ear, nose and throat service (ENT), the charge nurse told us there was one band two vacancy and one member of staff on long-term sick leave. They said the department did not use agency or bank staff, in-house staff usually covered gaps in the rota.
- The senior management assistant for patient administration in general outpatients told us 15 WTE agency staff had been employed on 18-month fixed term contracts for clerical positions in the bookings team. They said funding was available for a further five WTE posts within this admin team.
- The staff nurse in charge of general outpatients told us their staff also covered shifts at East Riding Community Hospital as and when required.
- Staff at Westbourne NHS Centre told us staff from the Hull and East Yorkshire hospitals staffed their outpatient clinics.
- In plastics outpatients the junior sister told us there were vacancies for a 30-hour staff nurse and 1.5 WTE healthcare assistants. A business case had been written for another part-time staff nurse. They said the department was currently using bank staff and nurses from plastics trauma to cover gaps in the rota.
- They said the shortage of staff in the department affected communication within the clinic, as the healthcare assistant may be working in the day surgery theatre. They said some consultants clinics ran behind because they were waiting for staff to be available to act as chaperones.
- The reception staff in plastics outpatients were not part of the plastics team. This meant there was sometimes no one on reception after 3pm, depending on the working hours of these staff.
- Staff in cardiothoracic services (CTS) told us there were CTS outpatient clinics in cardiology at York, Scunthorpe, Scarborough, Grimsby, and CHH. They said the other sites had got rid of the secretarial staff associated with these clinics. This meant a large increase in workload for the CTS administrative staff at CHH, which had resulted in a backlog of letters to be sent out. However, they said all the clinic letters were currently up-to-date.

Diagnostic Imaging

- In radiology, general x-ray there was a high proportion of radiographer vacancies; 9.5 whole time equivalent (WTE) posts were vacant out of an establishment of 56 WTE (17%).

Outpatients and diagnostic imaging

- Staff told us there were currently seven radiographer vacancies at CHH; they said they were going into schools to talk to 16-year-olds about careers in radiology.
- Staff in CT told us five new staff were due to start in September and there were four locums currently working in the department. They said the department did not use any agency staff.
- Radiology supervisors and managers stayed in their own areas, band five radiographers rotated between sites. Some staff in CT and MRI rotated between the HRI and CHH sites. There were two advanced practitioners at the CHH site.
- The radiology managers told us there was low staff turnover and good staff retention in the department.
- The cardiac catheter labs were not managed by the radiology service but radiographers who worked in this area were managed by radiology.

Medical staffing

Outpatients

- Cardiology staff told us there was one locum in the medical consultant team. One of the consultant interventional cardiologists told us there was a national shortage of medical staff with experience and skills in cardiology. They told us the department had 14 consultants, seven interventionists and one academic. They said that in 2004 the department had eight consultants overall.
- At the time of the inspection, there were two consultant vacancies in cardiology; the establishment should have been 16 consultants.
- The consultant radiologist in the breast care unit told us there were, "no staffing issues at the moment." They said there were plans to replace a locum breast radiologist with a permanent position and one of the registrars was interested in becoming a breast radiologist.

Diagnostic Imaging

- There were two vacancies for vascular radiologists and two new consultants in the vascular team. The department was advertising for a musculoskeletal radiologist. There were 4.9 WTE radiologist vacancies out of an establishment of 33 consultant positions. The clinical directors told us there was a national shortage of neuro-radiologists. At the time of the inspection, there were two full-time radiology consultants working in neuroradiology.
- The consultant radiologists had four separate specialist on-call rotas; neuroradiology was one in five, interventional radiology (non-vascular) was one in four, CT was one in seven and vascular was one in six. This was a high out of hours' commitment for the radiologists. When we asked the clinical directors whether they felt this was sustainable in the long term, they thought it was.
- Two radiologists worked remotely for the radiology service, mainly reporting results.

Major incident awareness and training

- Major incident training was one of the mandatory training courses for all staff at the trust. Data submitted by the trust showed 94.3% staff in the trust had completed this training.
- The radiology department had a major incident policy which staff were aware of.

Pathology

- The pathology laboratory manager told us there were business continuity standard operating procedures to follow if an alarm on a blood storage unit (blood fridge) went off.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain is inspected but not rated. We last inspected the domain in May 2015. At the 2016 inspection we found:

- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas, nurse led clinics and expanding use of extended roles. There was high use of advanced practitioners, specialist nurses and reporting radiographers.
- Services were moving towards seven-day working, many clinics were working extended days and weekends.

- Patients visiting cardiology now had 40-minute appointment slots, in accordance with national guidelines. This was an issue at the last inspection, when appointment times were 20-minutes long.

However;

- We found issues with document and version control in radiology. We found uncontrolled paper copies in circulation. This meant there was a risk staff were not following the current procedure.
- There were issues with the completion of consent documentation in the cardiac catheter labs.
- The systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the National Institute for Health and Care Excellence (NICE) quality standards relating to frequency and reviews.

Evidence-based care and treatment

Outpatients

- The head of department in cardiology told us patients visiting the department now had 40-minute appointment slots, in accordance with national guidelines. This was identified as an issue at the last inspection, when appointment times were 20-minutes long.
- In cardiology, we asked about national bodies that provided best guidance for cardiology practice and whether benchmarking audits had been conducted against national standards. The service manager mentioned three national bodies but said audit information was limited. The three bodies were the British Heart Rhythm Society, British Cardiovascular Society and The Registration Council for Clinical Physiologists.
- Staff told us the cardiology department was following the RCCP (Registration Council for Clinical Physiologists) guidelines for stress tests.
- The audit lead in cardiology told us all implant (pacemaker) data was submitted to the British Heart Rhythm Society as required by national guidelines.
- A consultant cardiologist told us they were currently applying to the British Society of Echocardiography for accreditation of the four cardiac imaging subspecialties.
- They said the department contributed to national audits for dataset registry, angioplasties, mortality rates, and pacemakers. However, local audits within the department were yet to be established. They explained that a new IT system would be needed before this could happen, as data was currently held within different systems.
- However, the systemic problems with the outpatient appointments and clinics meant not all services were meeting all of the NICE quality standards relating to frequency and reviews.

Diagnostic Imaging

- The external July 2015 MPE inspection report for compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 in interventional radiology theatres showed good compliance with the regulations and no major areas of concern.
- Internal audits of compliance with radiation regulations showed good compliance.
- Radiology had an approved plan for clinical audit; this was discussed at the monthly radiology management team governance and strategy meeting.
- However, we found document and version control in radiology required improvement. For example, we found there were no dates on flowcharts and there were no lists of printed copies of documents in circulation in clinical areas, no electronic document control system and no way of knowing whether the document in use was the most up to date version.
- When we looked at the '2016 Radiology Checklist,' which was available in radiology clinical areas, we found there was no date of issue and no review date. The radiology manager told us all departments were using this document.
- We found there was no audit of the completion of the safety checklists at the end of each session / day. An audit of checklist completion had been approved by the trust; however, this was not due to start until August / September 2016.
- The radiology management team told us the results of audits were presented at radiology team meetings. They said reporting radiographers sent out teaching emails to staff telling them about the results of departmental audits.
- The consultant radiologist in the breast care unit told us they were using tomosynthesis. They explained this method used three-dimensional digital exposures, had higher sensitivity and was more accurate. As a result, the sensitivity of detection of breast cancers was improved by 40%.

Outpatients and diagnostic imaging

Patient outcomes

Outpatients

- Between December 2015 and March 2016 between 82.3% and 91.4% of cancelled outpatients clinics were cancelled within six weeks of the appointment date. The main reasons for cancellation of clinics were not provided by the trust.
- The follow up to new rate was similar to the England average from September 2014 to May 2015, ranging between 2.22 and 2.37 follow-ups per one new appointment.
- The ratio then dropped below the England average, falling to a low of 1.33 in August 2015. This was mainly due to a drop in Castle Hill Hospital's follow up rate.
- The trust had a low (better) follow up to new rate (2.0) between September 2014 and August 2015, compared with other trusts.
- The trust did not provide information relating to the percentage of patients waiting over 30 minutes to see a clinician.
- When we asked the audit lead in cardiology whether they audited patient outcomes, they said patient outcomes were only recorded in the patient case notes.
- A consultant cardiologist told us the department was currently performing an audit of patient outcomes following day case procedures compared with patients staying in overnight. They said this would be significant service change if patients did not have to stay in overnight after their procedures.

Diagnostic Imaging

- The radiation protection adviser's annual report for 2014 showed patient radiation dose audits had good compliance with the local and national diagnostic reference levels, and had continually improved.
- The radiology manager told us the reporting radiographers carried out the radiation dose audits.

Pathology

- The pathology laboratory manager told us all of the blood sciences pathology departments were accredited with clinical pathology accreditation (CPA). Their last inspection had been in February 2015 and the departments were due to be inspected by the United Kingdom Accreditation Service (UKAS) in February 2017.

Competent staff

Outpatients

- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas. There were a number of nurse led clinics and there was expanding use of extended roles.
- The head of department in cardiology told us the department was a training establishment for students, and students often requested to come back to the department when they qualified.
- Staff in cardiology told us there were two band three staff who had been trained to do tape analysis; this freed up time for the more senior grades within the department.
- Cardiology staff told us each technician should attend one British Heart Rhythm Society (BHRS) accredited course each year. The training lead told us two staff had attended the British Heart Rhythm Society conference in Birmingham in September 2015.
- Staff we spoke with all told us their appraisals were up-to-date. One auxiliary nurse who had been in post for eight months told us they had appraisals after three and six months.
- Staff in plastics outpatients told us dressing clinics were nurse led and the department had nurse prescribers. The junior sister told us they planned to do more nurse led clinics in the future.
- Staff in the eye clinic told us there were no nurse practitioners at Castle Hill Hospital and medical staff carried out eye injections.
- We asked a technician who had been working in the eye clinic for four months about their training. They told us they had learnt "on the job" by following another technician. A senior technician signed them off as competent, in their learning workbook after six to eight weeks.
- Appraisal data submitted by the trust showed the majority of staff groups in the four Health Groups were compliant with the 85% target. However, in medicine all staff groups had compliance rates below 85%. The data did not show figures for staff working in outpatients separately. Staff told us appraisals were done via the trust's HEY247 electronic system. Staff we spoke with all told us their appraisals were up-to-date.
- Nursing staff told us the trust was offering training for revalidation; they said there was a NMC (Nursing and Midwifery Council) link person in the trust. They felt comfortable about the process.

Outpatients and diagnostic imaging

Diagnostic Imaging

- Records were kept of consultants' registration / qualifications and robust systems were in place to record ongoing continuing professional development (CPD) with the Royal College of Radiologists (RCR). This was relevant to each consultants practice, as part of the appraisal and revalidation process.
- Consultants were required to participate in appraisal annually and submit evidence of CPD to the Trusts database system, where copies of the evidence were stored. These were confidential to the consultant and the responsible officer (and their deputies). There was an automated system of alerts, including reminder letters from the Chief Medical Officer. There was a separate database of satisfactory completion of the RCR CPD.
- Radiology staff received equipment specific training and managers kept separate records for new equipment used by the radiologists.
- Staff we spoke with told us they were trained and competency assessed on all the equipment they needed to use. Staff told us there were good opportunities for continuing professional development within the department, they told us there had recently been an MRI study day.
- We saw there was a good induction programme for agency staff working in radiology, which covered all departments. Staff told us their induction was supportive and included a six-month probationary period. We saw that staff induction documentation was kept in individuals' folders. Staff told us the forms had been changed recently to include trust induction.
- Radiology ran a preceptorship programme with existing staff mentoring staff on the programme. Staff explained staff on the preceptorship programme had a six-month probationary period. Newly qualified staff were employed at band four until they achieved Health and Care Professions Council (HCPC) registration.
- Radiology had a number of extended roles for radiographers. The radiology management team told us the president of the Royal Society of Radiographers had visited the department recently and was impressed with the number of extended roles for staff.
- Appraisals were up-to-date in all of the radiology departments.
- The radiology manager told us there was a training budget within the department and staff had not been refused any request for training, as long was as it was required for their role. There was a separate training budget for the radiologists and external companies financially supported the department for training.

Multidisciplinary working

Outpatients

- The nurse in charge in general outpatients told us there were bariatric MDT's once a week. Attendees included dieticians, psychiatric nurse practitioners and consultants. They discussed patients' options, lifestyle, nonsurgical weight loss and follow-up.
- In cardiology outpatients, staff told us they worked together well with the cardiology ward staff.
- In the ear, nose and throat service (ENT), the charge nurse told us multidisciplinary team meetings were held on Wednesdays for ENT and maxillofacial patients.
- The junior sister in plastics outpatients told us they ran joint clinics with physiotherapy and occupational therapy. They said they also worked closely with the tissue viability nurses on the wards.

Diagnostic Imaging

- We found good examples of internal and external MDT working in radiology.
- The radiology management team told us their service was critical to many of the other departments in the hospital. They said they maintained good working relationships with staff in other areas.
- The consultant breast radiologist in the breast care unit told us the breast surgeon's office was near to theirs. They said this was convenient for MDT working and there was, "fantastic communication" between the two services which helped keep patients safe.

Seven-day services

Outpatients

- Staff in the majority of outpatients' clinics we visited told us they held evening and weekend clinics to keep up with the backlog. When we met with the outpatients' management team, they confirmed this.
- For example, staff in the ear, nose and throat service (ENT) told us they ran initiative clinics every Thursday evening from 5pm to 8pm. The normal opening hours in ENT were 8am to 5:30pm Monday to Friday; the Department did not open on Saturdays.

- Staff at Westbourne NHS centre told us there were no outpatient clinics on Fridays, as City Health Care used the premises for paediatrics on Fridays. Clinics at the centre were open from 8am to 5.30pm Monday to Thursday.

Diagnostic Imaging

- The radiology manager told us the service was unable to further extend the working day or increase capacity across seven days due to the finite number of radiologists and radiology support staff.
- Staff in radiology told us CT scanners were open from 8pm to 6pm. Contrast appointments were between 9am and 5pm and non-contrast between 8am - 9am and 5pm - 6pm. Staff told us there was always consultant cover. They said the Saturday rota had just been extended to 8am – 6pm.
- Staff in CT told us the opening hours might be extended to 8am – 8pm.This was due to the outpatient backlog.
- Radiology staff in plain imaging at CHH did on call from home. The departments were open until 10pm and on call was from 10pm to 9am. There was an on-call room staff could stay in. CT staff at CHH also did on-call.
- There was on call cover for urgent and emergency work at the CHH site in all modalities. On call started when the day shift finished Monday to Friday and at weekends.
- In fluoroscopy, the weekday finish time was 5.30pm. In MRI, on call cover from Monday to Friday was from 8pm to 8am. In CT, weekday on call cover started at 6pm on weekdays and in ultrasound and the cardiac catheter labs weekday on call started at 5pm.

Pathology

- The on-site pathology laboratory services closed at 5pm; after 5pm, urgent samples were sent to the HRI site. There were haematology, biochemistry, blood transfusion and virology laboratories at the CHH site. We did not visit the virology laboratories.

Access to information

Outpatients

- Trust data submitted prior to the inspection showed that 1% of patients were seen in outpatients without their full medical record being available. Missing clinical information can result in delays or disruptions to patient care and a potential risk of harm.
- Nursing staff in the cardiology clinic told us preparation of patient notes was very well organised. They said notes were tracked and traced in advance and were available the day before they were needed.
- The senior management assistant for patient administration in general outpatients told us the majority of missing notes were located in time for the patients' appointments. They showed us evidence, in the form of a list, of missing notes that could not be found. We saw there was an average of two sets of notes missing per day.
- The manager explained temporary notes would be made until the originals could be located. The list of missing patient records was reviewed every month by the team that prepared notes and searched for missing records. The senior management assistant for patient administration said that 26,000 patient notes were used every month and key performance indicator (KPI) data showed 99.3% of these were available in May 2016 and 99.5% were available in April 2016. This meant the KPI target was being met.
- Staff in the eye clinic told us patient records were 'paper free' and were available on the Med iSOFT and Lorenzo computer system. This meant there were no missing patient notes in the eye clinic.
- Staff at Westbourne NHS centre told us patient notes were requested centrally. They said each clinic had between five and 15 patients and was a mixture of first appointments and follow-ups. They said temporary sets of notes were put together for patients without notes; they estimated temporary notes were used about five times a month.
- The manager in general outpatients told us the medical records team would be "going electronic" within 18 months.

Diagnostic Imaging

- Staff in radiology told us the intranet site was easy to use.
- The radiology management team told us that the radiology information system (RIS) was due to be replaced in November 2016. They said the new system would feed into the electronic patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff with spoke with in outpatients and radiology understood the relevant consent and decision-making

requirements of legislation and guidance. Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information submitted by the trust showed overall compliance rates of 87.6% for MCA training and 86.8% for DoLS training.

- In audiology and ENT, we saw DoLS leaflets were available. The band seven charge nurse told us DoLS was included in mandatory training for staff.
- We reviewed nine sets of notes from patients undergoing day surgery in plastics outpatients. We saw consent forms had been correctly completed in all of the records.
- Staff in the eye clinic showed us a patient's consent form; this was completed as required.
- In the eye clinic, we observed a patient assessment, which included the patient giving verbal and written consent. The nurse asked the patient to check their signature on the consent form. The nurse also checked the patient could see it clearly. The patient agreed it was their signature and that they could see clearly. We also observed the doctor checking the consent form with the patient prior to their procedure.
- Nursing staff in general outpatients told us they did not perform any procedures which required consent. They said if consent was required it would be completed by the consultant during the consultation.
- In the cardiac catheter lab, we reviewed two sets of patients' notes, in one case, the patient copy of the consent form remained in the notes. In both cases, consent for the procedure did not follow the trust policy on two-stage consent. On one patient's consent form, the patient had signed for the procedure on the day; there was no signature prior to the day of surgery. On the second patient's consent form, the patient had signed at the pre-assessment clinic but not on the day of the procedure. Patients should sign the consent form at pre-assessment and on the day of the procedure.

Are outpatient and diagnostic imaging services caring?

Good

At the 2015 inspection, we rated the outpatients & diagnostic imaging services as 'Good' for caring. At the 2016 inspection the rating remained 'Good' for caring because:

- Staff treated people with respect, and respected their privacy and dignity.
- Feedback from patients and relatives about the care received was generally good.
- People understood the care and treatment choices available to them and staff gave them appropriate information and support about their care treatment.
- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.
- Staff told us how they supported patients emotionally. For example, in the breast care unit a new procedure had been introduced which meant the number of procedures breast cancer patients required was reduced. Staff in the unit did all they could to minimise stress and anxiety for patients.

Compassionate care

- We observed positive, friendly interactions between staff and patients in all of the areas visited.
- We heard nursing staff introducing themselves to the patients. We observed staff had a caring approach towards patients, especially those with mobility issues and/or poor vision.
- We spoke with eight patients and two relatives during the inspection. They were all happy with the service. One patient in audiology outpatients commented, "I have been treated with kindness and the staff are courteous and respectful" and a patient in the cardiology outpatients waiting area commented that staff had been "accommodating and friendly."
- Patients and relatives waiting in the eye clinic told us the staff were always helpful, pleasant and respectful. They said they were happy with the care
- Friends and family test results for outpatients at the trust were good, with 94% of those surveyed saying they would recommend the service. However, response rates over the six months from December 2015 to May 2016 were low, ranging from 2.9% in December 2015 to 5.3 % in April 2016.
- We saw friends and family cards and boxes (for completed cards) in outpatient reception areas and friends and family display boards showing results and feedback. In the plastics outpatients waiting area we saw their friends and family test results were displayed on a tree.

- We saw friends and family test results and information were on display in the outpatient waiting areas. Staff told us they gave patients friends and family test cards to complete after they had had blood tests taken
- Staff in cardiology felt their patients got a good service. One auxiliary nurse said, "The patients are happy."
- Nursing staff in general outpatients told us they had their own clinics, which was good for patient continuity.
- All of the outpatient areas visited had water fountains, some also had refreshment machines and televisions for patients to use.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with were all happy about the information provided relating to their care and treatment. We observed and staff told us, that staff introduced themselves.
- In general outpatients waiting area we saw there were clear instructions for patients using the self-check in kiosks.
- We saw the TV screen in the general outpatients waiting area was displaying health information. Information boards on the walls also displayed health information. There were a wide range of information leaflets, covering a large variety of health conditions, available for patients.
- Patients we spoke with, told us staff had explained everything clearly to them. One patient in the eye clinic told us they were always kept informed about their care and treatment.
- When we visited the respiratory medicine outpatients' clinic, we saw information for patients about lung cancer awareness on display.
- We observed a patient assessment in the eye clinic. The nurse carrying out this assessment fully informed the patient about the procedure. The auxiliary nurse carrying out the vision test also explained to the patient clearly about their vision test.
- We observed the eye surgeon giving their patients information about their eye injection procedures; these were regular injections (every 10 weeks).
- In the Jack Brignall PET-CT scanning centre, patients were given written information about the centre and its aim, which was to provide patients facilities and treatment of the highest quality.

Emotional support

- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.
- Patients attending bariatric clinics all sat together during talks from dietitians or other health professionals. These patients could also choose to attend peer support meetings.
- In general outpatients, there was a counselling room. The nurse in charge told us this could also be used for patients with behavioural problems, learning difficulties or dementia. They said this room was also used for prisoners attending the department, to ensure they moved quickly through the department.
- In the plastics outpatients Westwood Suite for day surgery we saw posters and leaflets about 'Changing Faces' which provided a skin camouflage service.
- Staff in plastics outpatients told us two people had been on a camouflage make-up course. This was used to teach patients how to use camouflage make-up following facial reconstruction. The department could also access breast tattooing for patients following mastectomies.
- A photographer came to plastics outpatients' clinics once a week to take before and after photographs of patients undergoing treatment.
- Plastics outpatients told us if patients came from care homes without a carer they would ensure they were given something to eat and drink if they were in the department over lunchtime.
- There was a clinical specialist nurse based in oncology who provided emotional support for patients attending melanoma clinics in plastics outpatients.
- In the ear, nose and throat service (ENT), we saw one of the consulting rooms was used as a quiet room for breaking bad news to patients.
- One patient in audiology told us they had a phone number so they could ring the clinic directly if they had any problems.
- The breast care unit carried out vacuum assisted biopsies. This one stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient.
- The consultant breast radiologist told us, "We do all we can to decrease patients' anxiety and stress." We looked in the comments book in the breast care unit and saw that patient feedback about the service was universally positive.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

In May 2015, we rated the responsive domain as 'Requires improvement'. At the 2016 inspection the rating remained as 'Requires improvement' because:

- Outpatients were not meeting the national referral to treatment (RTT) standards for incomplete pathways. This meant patients were not always able to access outpatient services when they needed to. There were appointment backlogs and waiting lists in the majority of outpatient specialties, which totalled over 30,000 patient episodes at the time of the inspection.
- The percentage of people waiting more than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between Q1 2014/2015 and Q4 2015/2016.
- The appointment booking process was variable across services, specialties and sites. Several patients told us their choices of appointment time and location were not taken into account.
- There were capacity and demand problems in the majority of outpatients clinics visited. Staff in clinical areas were unsure of the details of their waiting lists and backlogs.

However;

- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since Q3 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in Q1 and Q2 of 2015/2016.
- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway. Standard operating procedures and clinical validation had been agreed in early June 2016 and was ongoing at the time of the inspection.
- The bookings centre had dedicated staff dealing with cancer referrals and extra 'initiative clinics' were being used to help reduce the backlog. For example, one of the orthopaedic consultants had recently offered five Sunday dates for clinics.
- We found many examples of nurse led clinics, which meant the capacity for appointments was increased.

Service planning and delivery to meet the needs of local people

Outpatients

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway.
- The clerical officers in the booking centre told us there was a text message service to remind patients about their appointments.
- The facilities and premises used to deliver services were good. Signage was clear in all areas visited.
- Patients told us there was no problem getting through to the appointment centre by telephone. Staff told us the appointment centre was open from 8am to 8pm on Monday to Friday and 8am to 12 noon on Saturdays.
- The bookings process appeared to give patients a choice about their preferred hospital site or location. However, most of the patients we spoke with told us their preferences about location or time of appointment had not been taken into account.
- The clerical officers in the booking centre told us they could enter a patient's appointment preferences into the system. For example, a.m., p.m., evenings, certain days of the week or dates when they were on holiday. However, we observed that these preferences had not been used/entered in the majority of patient records reviewed.
- When we asked the patient administration manager about this, they told us that giving patients a choice of appointments was difficult to manage.
- Some patients told us there were parking problems at the CHH site; they said parking could be difficult and was expensive. Staff at Westbourne Health Centre told us the main complaint from their patients was the lack of a car park.

Diagnostic Imaging

Outpatients and diagnostic imaging

- We saw there were appropriate waiting areas for patients, including areas for hospital beds, which had piped oxygen available. However, there were no facilities for baby changing. When we asked staff about this, they said they would let parents use a private room.
- There was a central helpdesk in the radiology department for requesting porters.
- Patients attending radiology for plain film imaging were mostly walk-ins and unplanned.

Access and flow

Outpatients

- Between April 2015 and March 2016, the trust's referral to treatment (RTT) performance was consistently worse than the England average and the national standard for incomplete pathways. The operational standard is that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. The trust was performing clinical validation for patients that had breached the 18-week RTT standard in order to prioritise appointments for those most at risk.
- The trust had an agreed trajectory with the local Clinical Commissioning Groups (CCGs) and NHS Improvement (NHSI) to meet the standard by March 2017. The trust had met the individualised local trajectory between April and June 2016.
- The trust position relating to the RTT and cancer national standards was improving. The improving cancer position meant the majority of cancer targets were being delivered. The RTT trajectory had improved overall for 2015/16 when compared with 2014/15. There were specific challenges in some areas, and a recovery plan had been agreed for 2016/17.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between Q1 2014/2015 and Q4 2015/2016.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since Q3 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in Q1 and Q2 in 2015/2016.
- The 'did not attend' (DNA) rate was mostly higher than the England average between September 2014 and August 2015. The DNA rate ranged between 7.1% and 10.2% at trust level, compared with the England average of between 6.6% and 7.7%.
- On 22 June 2016, there was an outpatient follow-up backlog of 29,968 patients. This was the number of patients on an access plan who were overdue a follow-up. The largest individual specialties follow-up backlogs on this date were: - ophthalmology 8,117, ear, nose and throat (ENT) 1,032 and plastic surgery 1,369.
- A further backlog report dated 27 June 2016 showed there were 30,431 patients overdue for their appointments on that date, 6,702 of these were over six months overdue and 2.898 were 12 months overdue.
- An 'outpatient waiting list backlog report' was run every day. The patient administration manager said these reports helped bookings centre staff know where to focus their work.
- Members of the outpatients' improvement team told us cardiology had a large backlog. Data provided following the inspection showed cardiology had the largest backlog in the Medicine Health Group; 2,092 on 22 June 2016. They said they were looking at ways to reduce the DNAs, cancellations and new to follow-up ratios by increasing activity and slot utilisation. They were also looking at clinic productivity.
- The medical director for the Family and Women Heath Group told us there were long waits for appointments in some specialties, due to a shortfall in capacity. They told us there were problems with the additional slot issues (ASI) list; they told us patients were not meant to be on the ASI list for more than four days but this was not always achieved.
- There was follow up slippage in outpatients for patients with chronic diseases and long-term conditions. In some specialties, there was evidence this had led to patient harm. For example, ophthalmology patients with wet macular degeneration needed regular injections every four weeks. The capacity and demand problems meant these patients were often not seen until between six and eight weeks. There was evidence that some patients vision had deteriorated because of this.
- We asked the patient administration manager about booking rules, they told us staff in the appointments

and referral centre did not work from booking rules. However, members of the outpatients' improvement team told us different specialties had their own booking rules.

- Staff told us, and we observed long waits in some outpatient clinics. For example, in plastics outpatients we spoke to a patient whose appointment was already running 20 minutes late. They told us they would like to know how long their wait was going to be. About 20 minutes later a nurse came out and told all the waiting patients how long the clinic waits were; these were not on display. The wait time for the patient we spoke with was almost an hour.
- This patient also told us they had waited more than three months for their follow-up appointment, and then had to ring twice to make their own appointment. They had been told to ring if no follow-up appointment was sent. This patient was waiting for results to show whether they had cancer after a biopsy. This meant the service appeared to be putting the responsibility onto the patients to follow up and book their own appointments if the hospital missed sending them an appointment.
- The patient administration manager told us they held regular RTT meetings with the business managers in each specialty. They said some business managers were responsible for more than one specialty. They discussed additional slot issues (ASIs), targets and holding lists. They explained that holding lists were lists of patients that there was no appointment slot for.
- They explained some specialties were worse than others; for example, upper gastrointestinal, neurology and paediatrics were worst. In trauma and orthopaedics, some areas were better than others. We asked about the serious incidents, which had been declared in outpatients, they confirmed these had occurred because patients had not had their planned appointments.
- When we asked the patient administration manager why some individual specialties, such as cardiology, booked their own appointments they told us cardio thoracic services and cardiology had always booked their own appointments. However, cardiology staff told us that when the central bookings team had booked their appointments, clinics slots were left unfilled.
- The patient administration manager told us they were looking at centralising appointment bookings for all specialties. They felt this would improve quality and consistency. They said East Riding Community Hospital appointment bookings were done centrally and that worked well.
- In the central bookings centre, we found there were dedicated staff assigned to booking clinics for patients on the cancer two-week wait pathway. They told us they followed the patient through from initial referral to checking the patient had attended their appointment.
- If patients did not attend for their cancer appointment, staff followed a process to contact them and rebook. If the patient did not want to rebook or was not contactable after two phone calls, then staff contacted the initial referrer and informed them.
- Staff in the booking centre told us there were regularly extra clinics, called initiative clinics. They told us one of the orthopaedic consultants had recently offered five Sunday dates for clinics.
- The senior management assistant for patient administration in general outpatients told us initiative clinics at Castle Hill Hospital were held across all specialties. These included Saturday morning clinics and evening clinics during the week. For example, urology held extra clinics on Wednesday and Thursday evenings from 5pm to 7pm and neurology held Saturday morning initiative clinics at both hospital sites.

Cardiology

- The head of department in cardiology told us appointments started at 8.05am in the morning. They said the waiting time for routine appointment was currently six weeks and urgent patient referrals were given an appointment within a week.
- Staff in cardiology told us that the change in appointment time from 20 minutes to 40 minutes had been,'fantastic' for both patients and staff.
- In cardiology, appointments for patients requiring an ECG and an echocardiogram were arranged the same day. Urgent requests from clinics for echocardiograms were done on the same day and urgent ultrasound scans were fitted in on a regular basis.
- Senior staff told us the department was meeting the six-week target for routine scans, however they said it would be better to see these patients within four weeks.
- Cardiology patients had open access and were not discharged until staff were happy with their progress. Cardiology staff told us a protocol had just been

approved for patients to be discharged after six hours. They explained this would save patients staying in hospital overnight after their procedure, which would also have financial benefits.
- Cardiology ran a regional service and was a referral service for neighbouring trusts in North Yorkshire. Staff told us demand has increased by around 3% per year. They said the department currently received approximately 7,000 referrals annually, this was predicted to increase to 9,000 referrals a year.
- One of the medical staff in cardiology told us the department needed to increase their throughput to cope with the increasing demand.

General outpatients

- The manager in general outpatients told us the appointment and referral centre at HRI made all new appointments and the centralised booking team in the Queen's Centre at CHH booked follow-up appointments.
- We visited the Queen's Centre and found the centralised bookings team was two band 2 clerical officers. The staff told us they were responsible for filling vacant clinic slots and booking follow-up appointments for CHH and the East Riding Community Hospital. They explained that clinic receptionists booked patient appointments at the desk after a patient's first appointment, if the appointment was within six weeks.
- The clerical officers told us patients always had at least three weeks' notice of their appointments. They said if an appointment was less than a week away, they had to phone the patient to inform them. We saw that coloured flags on the system indicated where the patient was in the 18-week referral to treatment pathway.
- They said each consultant had their own waiting list and some consultants had a different waiting list for each site if they worked at multiple sites.
- The clerical officers told us that if a patient cancelled their appointment they came back onto the waiting list.
- In general outpatients we observed patients using the self-check-in kiosks and booking in at reception. There were two staff on the desk. In audiology we saw patients had to use an automatic check-in as there was no receptionist.
- The senior management assistant for patient administration in general outpatients told us the computer system generated daily 'clinic utilisation reports.' These were reviewed on a regular basis. For example, on the day of our visit there was a meeting between the senior management assistant for patient administration and business manager for urology, plastics and ear, nose and throat (ENT).
- The senior management assistant for patient administration showed us the agenda for a scheduling meeting on 8 June 2016. We saw the agenda included; tracking of slots, capacity, initiative clinics, and meeting targets.
- In general outpatients, we observed, and patients told us, that appointments were running on time. However, in ENT, we heard a new patient being told there was a one-hour wait for appointments. We saw the whiteboard in the ENT patient waiting area gave wait times for each of the six doctors on duty. On the day we visited, one clinic was running 45 minutes late and another one hour and 20 minutes late.

Patient feedback

- We spoke with eight patients and two relatives during the inspection.
- One patient and their spouse in the eye clinic told us they were, "not impressed with the booking system." They couldn't understand why they couldn't make an appointment when they were leaving the department or why they got appointments at different hospital locations.
- Another patient and their spouse in the eye clinic told us they preferred appointments at HRI, as transport was easier for them. They were not aware they had an option to choose a preferred site.
- We spoke with two patients in the cardiology outpatients waiting area. Patient one had been discharged from hospital two weeks previously and was happy with the service including outpatients. They had received their outpatient appointment on time. Patient two told us they went in to their booked appointment slightly ahead of time.

Westbourne NHS Centre

- Staff at Westbourne NHS centre told us patients often received duplicate appointments. They said most of their DNA appointments were in neurology. The bookings team at HRI booked these appointments centrally.

Plastics outpatients

Outpatients and diagnostic imaging

- Staff in plastics outpatients told us there were large backlogs in appointments for Botox and in the hand clinic. Data submitted by the trust showed the number of patients on an access plan who were overdue for a follow up in plastic surgery on 29 June 2016 was 1,325.
- The junior sister in plastics outpatients told us they did not keep records of patient waiting times in clinics. They said clinics frequently ran over time by 30 minutes to one hour.
- Plastics outpatients had a system for fast tracking patients, using a smiley face on their notes.

Cardiothoracic

- Office staff in cardiothoracic told us ward clerks emailed them when patients required a follow-up appointment. They said usually these appointments were required after six weeks, however capacity issues meant appointments were not currently available to be booked for 10 weeks.
- They said 'patient admin' i.e. the central bookings team at HRI, were meant to do the cardiac follow-up appointments from the outpatient clinics but they did not have the resources to do this. They said extra outpatient clinics had been put on in the past in order to clear backlogs.

Diagnostic Imaging

- Radiology staff told us there were four escort nurses available to transfer inpatients to the department. These were either called by telephone or a message sent on the computer.
- Staff in CT told us appointment slots were 20 minutes long between 9am and 5pm.
- The Operational Plan for 2016/2017 showed there had been a 5% annual increase in demand across all of radiology.
- The percentage of patients waiting over six weeks for a diagnostic test was consistently below the England average between April 2014 and March 2016. We saw the majority of breaches for six-week imaging appointments occurred in MRI; these were due to issues relating to sedation and general anaesthetic and 'cardiac capacity'.
- Staff in radiology told us their 'did not attend' (DNA) rate in ultrasound was currently 5% and in MRI and CT varied but was around 3%. When we visited the MRI department at 10am, staff told us there had been two DNA patients already that day. When we asked staff whether any actions were being taken to reduce the DNA rates they said no actions were being taken currently, as this was not a priority.
- If plain films were not reported within six days, these were outsourced. This ensured patients got their results in good time.
- Managers told us demand for the services was increasing; for example, plain film x-rays had increased by 1%.
- The department used two radiologists who reported flexibly and remotely one in Scotland and one in Portugal.
- The radiology clinical directors told us consultant radiologists could have PACS (picture archiving and communication system) installed at home. This enabled them to do their reporting remotely and was a way of coping with the shortfall in radiologists.
- The clinical directors told us plain imaging reporting had changed from paper to electronic on 22 May 2016. They explained that all reports were now sent back to the referrer electronically. This reduced the paper used, staff time spent sorting reports and postage costs. Two emails were sent for each report, one to the consultant and one to the group, to ensure they didn't get missed.
- They said all reports were audited daily to check they had gone out on the day of authorisation. There was previously a delay of six to seven days between the authorisation of the report and it being sent out to the referring clinician. They said 11 out of 150 trusts in the country had electronic reporting in place in radiology and Hull was number 12. They told us this improved patient safety.
- Any urgent reports were faxed to GPs; this was also audited.
- We asked the radiology clinical directors about reporting backlogs. They told us there had been a backlog of 64,000 plain films a year ago; this had reduced to 8,000 at the beginning of April 2016 and 2,500 on 30 June 2016. The demand for plain film had increased 1% 200,000 annually.

Pathology

- The pathology laboratory manager told us urgent sample results were available within one hour. Air tubes transported samples from the wards to pathology specimen reception.

Outpatients and diagnostic imaging

- There were three external blood storage units (BSUs) at the Castle Hill site; one of these was in the oncology day unit and one in the cardiac building. This ensured blood for transfusion was readily available for procedures, such as those in cardiac theatres.

Meeting people's individual needs

- Staff in cardiology ECG told us they would fast-track patients with complex needs. They said their patient population was mostly older (over 70) and they saw a significant proportion of patients with dementia. However, staff were not trained in dementia awareness. Staff confirmed the trust did run dementia awareness training.
- In general outpatients, we saw dementia friendly signage on the disabled toilet.
- Interpreters were available; if these were required, they were arranged prior to the clinic appointment. Secretaries informed the department if a new patient had any additional needs.
- We spoke to one patient accompanied by an interpreter. They told us (via the interpreter) that everything was fine and they had no problems with the service.
- In general outpatients we heard that a bell rang when a patient's name came up on the electronic board and staff called the patient into the clinic room. This meant people with hearing difficulties knew when they were called for their appointment.
- In ear, nose and throat and audiology, we saw that mixed patient toilets were clearly signposted. We saw these were large toilets with a handrail; however, there would be no room to turn a wheelchair. Waiting areas we visited were all accessible for patients in wheelchairs.
- In the eye clinic, we observed staff guiding patients with poor vision between different waiting areas, treatment and testing rooms.
- In general outpatients, we saw there were bariatric scales and large blood pressure cuffs for use with bariatric patients. There were also specific bariatric chairs available in the waiting areas. The nurse in charge explained there was a pilot bariatric clinic running which was funded by North Lincolnshire Clinical Commissioning Group. They said bariatric clinics were held at least once a week during the pilot.
- We saw there was a small children's play area in general outpatients. When we asked staff about this, they said there were no children's clinics but this play area was to support parents who came for appointments accompanied by their children.
- The nurse in charge in general outpatients told us about their 'patient clarity system.' This was used to identify any patients with special needs so that staff were aware. For example, patients who were very anxious or who had hearing or vision difficulties.
- The junior sister in plastics outpatients told us they were developing a card, which would be used to bookmark patient notes, to alert staff to patients living with dementia, those with pressure care problems or those needing transport.
- Staff in the bookings centre told us that, in addition to booking clinics, they booked 'advocacy.' This included additional support for patients with learning needs, hearing deficiencies or needing an interpreter. If face-to-face interpreters were not available, they would check with the clinic to see whether they could use the language line at the patient's appointment.
- In radiology, there were disabled toilets available in patient waiting areas and we saw low reception desk areas so that people in wheelchairs could access this reception area.

Learning from complaints and concerns

Outpatients

- Data submitted by the trust showed there were 166 complaints about outpatients in the 12-month period from April 2015 to March 2016; this represented 26% of the 646 complaints received by the trust. Seventy-one (43%) of these related to patient care.
- The highest number of complaints were received by the outpatients fracture clinic (15), followed by elective orthopaedics (10) and ophthalmology (10). Cardiology outpatients had eight complaints and plastics outpatients six complaints.
- The junior sister in plastics outpatients told us complaints were usually about waiting times in clinic. They said they recorded verbal complaints in a book and would advise patients about the Patient Advice and Liaison Service (PALS).

Outpatients and diagnostic imaging

- The patient administration manager told us they did not get as many complaints as they would expect. They told us they did not record verbal complaints from patients or relatives.
- Office staff in cardiothoracic told us patients frequently complained about changes to appointment dates. They said they had no way to record verbal complaints and would redirect patients that complained to PALS.

Diagnostic Imaging

- Radiology had received eight complaints in the same period, two of which related to patient care.
- The consultant breast radiologist in the breast care unit told us complaints were discussed at their governance meetings; however, they did not remember ever having a complaint about the service.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

When we inspected this service in May 2015, we rated the 'well led domain as 'Good'. At this inspection, we rated the well-led domain as 'Requires improvement' because:

- The effectiveness of the leadership, governance, culture and support for outpatient services varied between the four Health Groups .The visibility of the leadership was variable. There had been no overall governance structure or cohesive management oversight of the outpatient departments, but this had recently been addressed and was development.
- The trust, for some time, had not been achieving the national standards for referral to treatment and urgent cancer treatment and current outpatient capacity did not meet the demands on the service. There were significant concerns relating to appointment backlogs and waiting lists in outpatients which had not been addressed since the last inspection. The trust had agreed revised local trajectories with the local commissioners (CCG and NHSI) and was meeting these.
- The ongoing backlog position was being monitored and addressed at senior management level; however, staff we spoke with in outpatients clinics were unaware of what was being done to improve the situation and were unaware of their own waiting list positions and backlogs.
- The systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the NICE quality standards relating to frequency and reviews.
- There were high numbers of complaints about outpatients. The overarching system for capturing and managing issues and risks within outpatients was under development. This meant that at the time of the inspection there was limited management oversight of incidents, risks, audits, quality and patient safety about outpatients.
- Since the last inspection, outpatients had declared eight serious incidents and radiology had declared seven. There had also been two never events in radiology. In both services, there was a lack of assurance that the lessons learnt from the serious incidents in both services and never events in radiology had been embedded to ensure no further incidents occurred.
- In cardiology, there was lack of clarity about clinical audit, audit plans and audits that had been conducted including the results of such audits and their impact on the service. This was an area requiring improvement from the previous inspection.

However;

- The trust had a vision and strategy and staff were aware of this.
- Management, leadership and governance were good overall in radiology and pathology. Radiology and pathology had risk registers in place.
- The Clinical Support Services Health Group had operational plans and an outpatient improvement team was working on a two-year plan for the outpatient specialties. There were plans to appoint an outpatients matron or manager.
- The trust was aware of the problems in outpatient services and had plans in place, agreed with commissioners and NHS Improvement, to make improvements. The lack of an overarching governance structure or management oversight in outpatients had recently started to be addressed by the weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient

transformation project' was also in progress, which was running behind schedule. This project aimed to improve clinic utilisation, bookings processes and performance against standards.
- Staff reported positive culture changes at the trust, especially relating to the historical bullying issues. A more positive ethos had led to change in staff morale; staff told us they were well-supported by their local line managers and there were positive comments about the new trust board
- There were good examples of innovation in radiology.

Vision and strategy for this service

- The trust had developed its five-year strategy following wide consultation; this was approved at the Trust Board in April 2016.

Outpatients

- We saw the 'HEY Improvement Portfolio' included an outpatient transformation project. The project overview document showed this work had started in August 2015. This was to review the overall outpatients management structure, operational policies and processes.
- When we reviewed the directors report from 25th of April 2016, we saw the project was categorised as 'at risk 'and was currently running four weeks behind schedule. Goals included clearing the outpatient follow-up backlog and improving customer service. Work streams in oncology, cardiology, cardio thoracic and orthopaedics had commenced. The project had an agreed project overview document, rollout schedule and key performance indicators. Weekly performance against the KPI's was being monitored.
- Representatives of the outpatients' management team told us they felt there was a positive culture change happening within outpatients. For example, services were moving to seven-day working and extended days. Staff were going through consultation at the time of the inspection. Any new staff employed had seven-day working as part of their contract. Many procedures were being done as day cases and non-theatre nurses were carrying out procedures.

Diagnostic Imaging

- The CT and MRI operational plan for 2016/2017 showed services were working towards seven-day working, expanding radiography reporting and expansion of the CT colonography (CTC) service.
- The radiology manager told us radiology was part way through a three to four-year programme of retrofits of all rooms in the main building. Radiology had a clear strategy for equipment replacement; the plan was to have digital radiology (DR) equipment installed across all areas.
- Radiology staff we spoke with knew about the trust vision and values and the radiology equipment replacement programme.

Governance, risk management and quality measurement

Outpatients

- Each of the four Health groups had a number of outpatient services within it. The Family and Women's Health group included dermatology ophthalmology, plastic surgery and ENT. The Medicine Health Group included general medicine, cardiology and neurology. The Surgery Health Group included neurosurgery, head and neck, urology and general surgery. The Clinical Support Health Group included audiology, oncology and clinics for allied health professionals.
- There had been limited overarching governance and management oversight of the outpatient departments, however recent changes were starting to address this including the Performance and Access (P and A) meetings and the work of a transformation board. There had been variation in the management of and support for outpatient specialities across the Health Groups.
- There were significant concerns relating to appointment backlogs and waiting lists in outpatients, especially in ophthalmology, which had not been addressed since the last visit. Senior managers were regularly monitoring the ongoing position.
- At the time of the inspection there was oversight of governance at trust level and a project overview document and outpatients' action plan was in place. Their aims were:
  - to quantify, as a priority, by specialty, the number of patients that had passed their outpatient follow up date;
  - a standard approach to validating these patients;
  - to develop trajectories for reduction and elimination of follow up backlogs and;
  - a clinical review of these patients to quantify if any had experienced harm.
- Some action plan target dates were overdue.

Outpatients and diagnostic imaging

- There were trust-wide performance and access (P and A) meetings every week to review and monitor waiting lists. These meetings were led by the chief operating officer and had started a few weeks before the inspection. We were told these meetings provided assurance and oversight and that attendance lists and action notes were taken.
- There was an outpatient project steering group, which met every month. We reviewed the notes from February 2016 meeting. We saw agenda items included consultant annual leave, clinic slot utilisation, hospital cancellations and project updates.
- There was no specific outpatients risk register. However, we found some risks were identified within the Health Group risk registers, which reflected the main areas of concern. These specifically included ophthalmology, dermatology and a composite risk relating to specialties within the Medicine Health Group regarding the number of overdue appointments outstanding in respiratory medicine, endocrinology, diabetes, cardiology, neurology and rheumatology.
- There were no overarching outpatient governance or quality meeting minutes submitted and there was no discussion recorded of risks, risk management, governance or quality monitoring at the outpatient project steering group meeting.
- Outpatient managers told us there were regular weekly operational meetings between patient administration, business managers and divisional general managers.
- The trust had introduced a new patient IT system to improve the tracking and monitoring of patients including those who were on waiting lists. Outpatient managers told us there had been many issues with the new IT system and the transition from the previous computer system and this meant there had been some double counting and cleansing of the data had been required. They said this meant that data collated following the changeover to the new computer system had not always been reliable.
- In cardiology, there was a weekly meeting to present interesting cases. Staff told us these were beneficial.
- Cardiac physiology staff had carried out capacity and demand audits, which resulted in a reduction to the numbers of available clinic slots. Repeat audits had been carried out six months later, and the numbers of clinics reduced again. Staff told us this meant a better match between clinics and demand.
- We spoke with the service lead in cardiology about clinical audit, as this was an area requiring improvement from the previous inspection. We found there was lack of clarity about audit plans and audits that had already been conducted, including the results of such audits and impact on the service.

Diagnostic Imaging

- Data provided prior to the inspection showed radiology was aware of the departmental risks and kept up-to-date with compliance against regulations. Their most recent medical physics expert (MPE) and RPA reports were very good, and clearly identified any issues that needed action.
- We saw some evidence of identifying and learning from serious incidents and never events. The two radiology clinical directors had made presentations to the trusts' Quality Committee about the SIs and never events on 23 June 2016, entitled: 'Learning from recent radiology SI's' and 'Never Events in Radiology 2014/15 and 2015/16'. We saw evidence of actions taken and changes made to practice.
- Radiology had undertaken a look-back exercise with the commissioners to check for harm from serious incident relating to the non-printing of reports incident. A new monitoring system alerted staff if radiology reports had not been viewed and/or actioned; this could be escalated to the medical director for action.
- We reviewed the radiology risk register and saw a number of risks related to ageing equipment. The department was well aware of this issue, and had a rolling equipment replacement programme to replace all the computerised radiology equipment and digitise all of the rooms. There were also issues with the RIS and PACS information systems and plans were in place to replace these.
- The radiology management team told us the department was collaborating with neighbouring trusts in the area to undertake regional insourcing. This is where critical work within the region is assigned using local resources within a collaborative network, rather than outsourcing it. This should be more cost effective and helps maintain local control.
- Eight trusts were undertaking a joint procurement of a new PACS system. They said they would be able to manage capacity and demand better when the new radiology information system (RIS) was installed.

Outpatients and diagnostic imaging

- Two of the consultant radiologists shared the clinical director role in radiology; one for governance and one for information technology. This was because the role was felt to be too much for one person. They worked four long days a week each, with one crossover day. The radiology manager and section leads in each modality area supported them.
- The radiology management team told us there was 'excellent in-house governance' in radiology. For example, in 2015, 2,050 ultrasounds were peer-reviewed and this work had been nationally recognised. They said they were proud of their work and maintaining the safety of patients.
- We reviewed minutes of the radiology management team meetings and radiology governance and strategy meetings for February, March, and April 2016. We saw these discussed serious incident investigations, business cases, workforce planning and departmental risks.
- The two reporting radiologists who worked remotely for the department visited the department regularly and understood the local discrepancy and governance policies.
- The radiology management team told us the departmental spend on outsourcing reporting was significant. They said they had to balance the finances against the turnaround times for results. They said the trust executive team were supportive and recognised their challenges.

Leadership of service

Outpatients

- There was limited trust-wide operational management of outpatient services at the trust and each of the Health Groups offered different levels of management and clinical support. Staff talked of plans to get all outpatients services into one structure, and the appointment of an outpatients matron. However, we did not see any documentary evidence to confirm this.
- The leadership in the four Health Groups had changed recently. Each of the Health Groups had a medical director, director of nursing, and operations director. These were supported by matrons, apart from the Surgery Health Group, which had a divisional nurse manager.
- There was an outpatients' transformation project board and representatives of each of the Health Groups attended this. This reported to a trust transformation board; weekly performance against key performance indicators was monitored.
- The junior sister in plastics outpatients told us they had started in the department at the end of March 2016. They said their band seven manager was based at HRI and they saw them about once a week or once a fortnight. They said the previous band six sister had retired two years ago and the post had been vacant since. The junior sister in plastics outpatients was responsible for the plastics outpatients' clinics and the Westwood Day surgery suite.
- Staff in plastics outpatients told us they had had no support for two years, since the previous sister left.

Diagnostic Imaging

- We found competent staff managing the radiology areas we visited and staff we spoke with told us the leadership and support in the departments was good.
- Interventional radiology was part of radiology and radiologists carried out interventional radiology procedures.
- The two radiology clinical directors told us the medical director in the Health Group was supportive and they could take any problems to them.

Culture within the service

- Staff we spoke with were aware of the requirements of the duty of candour. They knew about being open and honest with patients and families when things went wrong and some were able to give us examples of when they had done this.

Outpatients

- Staff had heard of and/or attended the PaCT (bullying awareness) training. Staff acknowledged the history of bullying in the trust and reported that things had improved recently. They said the PaCT training was good.
- Staff in cardiology told us the atmosphere was good in the department and the managers were very approachable. They said it was a good team to work with.
- An auxiliary nurse in general outpatients told us the department was supportive about training and development and the whole team was very supportive.

Outpatients and diagnostic imaging

- Staff in general outpatients told us they were aware of the historic culture of bullying; however, this was not currently a problem. They said emotional support was provided if there were problems with aggressive patients.
- The outpatients' management team told us they felt the bullying culture had changed, there was additional support to staff, and PaCT training was available. They said outpatients had good working relationships between staff and departments.
- Representatives of the outpatient management team told us that serious incident investigations were more supportive to staff than they had been in the past. They said the new chief executive 'set the tone.'

Diagnostic Imaging

- Radiology staff we spoke with were generally positive about culture within the department and told us the team was very supportive. Staff told us they got good backup from the radiologists and good feedback from students. One radiographer told us there was, "A nice atmosphere."
- The radiology management team told us they felt the culture in the department was good. They said they had involved the trust's 'anti-bullying Tsar' when there had been issues with bullying. They said the staff survey results for the department had shown an improvement.

Public engagement

Outpatients

- Outpatients' friends and family test results were consistently good but the response rate was low.
- Cardiology staff told us the department did not carry out a separate friends and family test.
- The nurse in charge in general outpatients told us they were currently carrying out an audit of bariatric patient opinions. They said when this was completed they would collate the information and add it to the patient information board. It would also be shared with North Lincolnshire CCG as they were funding the pilot of bariatric clinics at the CHH site.

Diagnostic Imaging

- The Friends and Family test (FFT) results for the radiology day unit (RDU) were good; recent scores for people who would recommend the service were reported as 4.89 / 4.9 out of 5.
- We were not provided with any national friends and family test data for other radiology services.
- We were shown a flyer given out by staff PET-CT scanning centre which asked patients to give feedback about their experience in the department.

Staff engagement

Outpatients

- On 1 June 2016, plastics moved to the 'Family and Women's Health Group. They told us the senior management team felt this was a better set up in order to manage the service effectively. Surgical outpatients was in the Surgery Health Group.
- The junior sister in plastics outpatients told us the department was now having staff meetings every six weeks and the minutes were circulated to staff. We observed staff meeting minutes were on display on the staff noticeboard.
- Staff felt they were "well-looked after" from a lone working point of view, with security staff being available to escort staff around the grounds of the hospital after dark. They said the lone working policy was helpful to them with the site being very spread out.
- In cardiology, staff told us there was a telephone communication book for messages. They said it was very difficult to hold staff meetings due to the limited staff resources in the department.
- Staff told us managers sent regular updates by email, for example training updates and changes to standard operating procedures. They were required to respond to confirm they had read them. This provided an audit trail.
- Staff in general outpatients told us they had staff meetings every four weeks, when managers shared information and talked about incidents. However, staff in ear, nose and throat service (ENT) told us their team meetings were "occasional." The charge nurse told us an ENT newsletter was being developed.
- Reception staff in the general outpatients' department told us there was a good support network and good teamwork.
- We saw staff noticeboards in staff areas / staff rooms in general outpatients and ENT.

Diagnostic Imaging

- There was a radiology newsletter, this was available to staff on the trust's intranet.

- Radiology staff reported seeing their manager frequently.
- Staff told us there was staff meeting every six weeks.

Pathology

- The pathology laboratory manager told us there was a daily huddle first thing in the morning. They said staff talked about what had happened the day before and whether any improvements could be made.

Innovation, improvement and sustainability

- The chief executive of the Society of Radiographers attended a meeting between nursing staff and a support worker in radiology to discuss creating radiology link nurses on all wards. As a result, they wrote an article for the Society of Radiographers magazine, to be published in the summer of 2016.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit were doing vacuum assisted biopsies. The consultant breast radiologist told us this was a one-stage procedure which avoided patients needing two or three biopsies. This significantly reduced the stress and anxiety for the patient and saved resources in terms of time and finances.

Outstanding practice and areas for improvement

Outstanding practice

We found areas of outstanding practice including;

- The responsiveness of the Specialist Palliative Care Team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that planning and delivering care meets the national standards for the referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to longest waits.
- The trust must ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls.
- The trust must ensure learning from never events is further disseminated and lessons learnt are embedded.
- The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's national early warning score (NEWS) and escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- The trust must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.
- The trust must ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- The trust must ensure the effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts.
- The trust must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The trust must review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- The trust must ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.

Outstanding practice and areas for improvement

- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- The trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitability skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

Action the hospital SHOULD take to improve

- The trust should ensure nursing staff have the correct skills to work specialist areas, specifically within medicine.
- The trust should ensure ward sisters/charge nurses have dedicated time to carry out their management duties.
- The trust should review the provision of rehabilitation after critical illness in line with national recommendations (Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation After Critical Illness).
- The trust should strengthen formal mechanisms to obtain patient and relative feedback within critical care and other services.
- The trust should ensure that all policies, guidelines and pathways on the trust intranet are up to date.
- The trust should ensure that staff become fully compliant in completing syringe driver checking forms.
- The trust should ensure that all members of the Specialist Palliative Care Team are fully compliant with all mandatory training.
- The trust should consider appointing a non-executive board member with responsibility for end of life care and an end of life care facilitator.
- The trust should consider developing a trust end of life care strategy.
- The trust should ensure the facilities and environment used by audiology are appropriate for patients' needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for patients. The trust must: 1. ensure that planning and delivering care meets the national standards for referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to the longest waits. Regulation 12(1) 2. ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls. Regulation 12(2)(a) & (b) 3. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b) 4. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b) 5. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy. Regulation 12(2)(g) 6. ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient. Regulation 12(2)(g)

Requirement notices

7. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: Some patients' food diaries and fluid balance chart were not fully completed therefore it is not possible to monitor whether their needs were being met. The trust must: 1. ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The trust must: 1. ensure that elective orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a) 2. ensure the effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)

This section is primarily information for the provider

Requirement notices

3. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).

4. must ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.

5. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient services. Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. The trust must: 1. ensure that there are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically ensure critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012). Regulation 18(1)

Integrated Performance Report 2016/17

February 2017

January data

The Indicators contained in this report are in line with the Quality of Care and Operational Metrics outlined in the NHS Improvement – Single Oversight Framework
https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

RESPONSIVE

Description	Aggregate Position	Trend	Variation

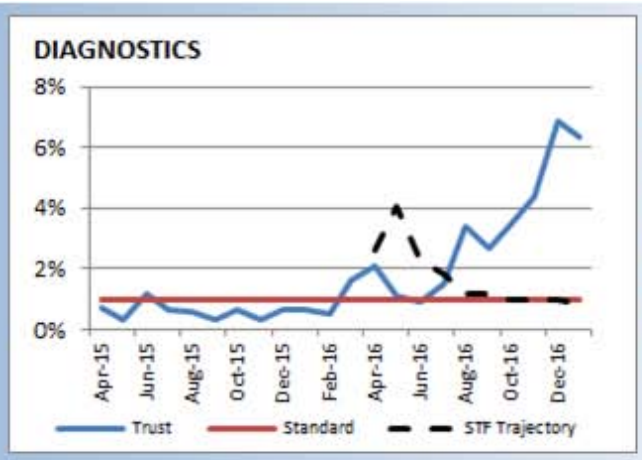
Diagnostic Waiting Times: 6 Weeks

All diagnostic tests need to be carried out within 6 weeks of the request for the test being made

The target is less than 1% over 6 weeks

Diagnostic waiting times has failed to achieve target with performance of 6.37% in January

Sustainability and Transformation trajectory is 0.8% the Trust also failed to meet this trajectory



>6 Week Breaches:

MRI = 185
CT = 176
Non-obs U/sound = 9
Cardiology - echo = 18
Neurophysiology = 11
Urodynamics = 3
Colonoscopy = 74
Flexi sigmoidoscopy = 26
Cystoscopy = 47
Gastroscopy = 9

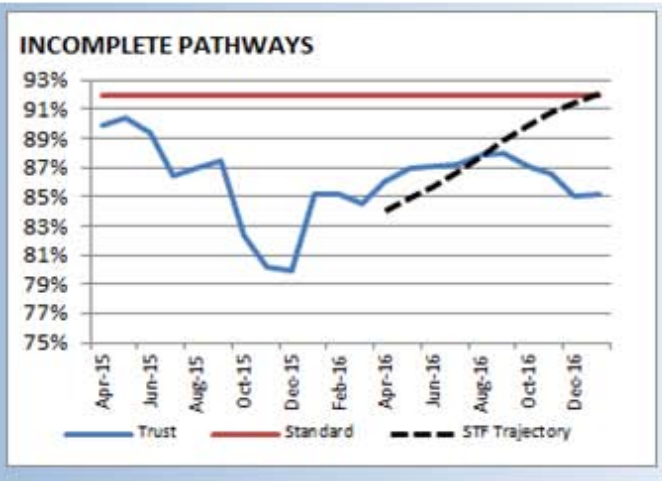
TOTAL 558

Referral to Treatment Incomplete pathway

Percentage of incomplete pathways waiting within 18 weeks. The threshold is 92%

The Trust failed to achieve the January Sustainability and Transformation trajectory of 92.0%

January performance was 85.2%



The RTT return is grouped in to 19 main specialties.

During December there were 17 specialties that failed to meet the STF trajectory

RESPONSIVE

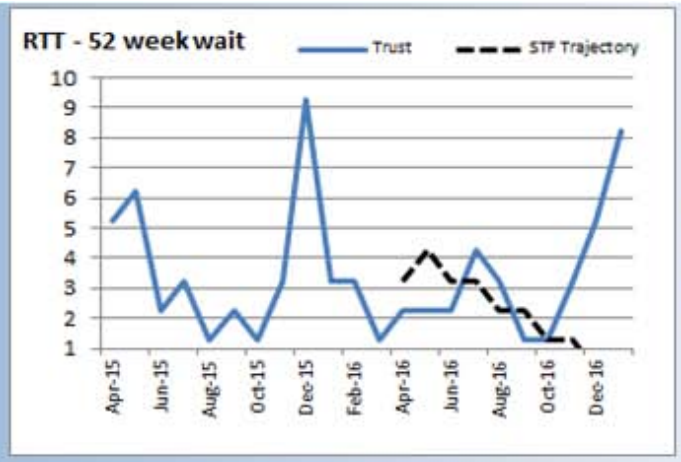
Description	Aggregate Position	Trend	Variation

Referral to Treatment Incomplete 52+ Week Waiters

The Trust aims to deliver zero 52+ week waiters

The Trust failed to deliver the national standard of zero breaches with 8 breaches for January

The Trust also failed to achieve the STF trajectory of zero breach during January



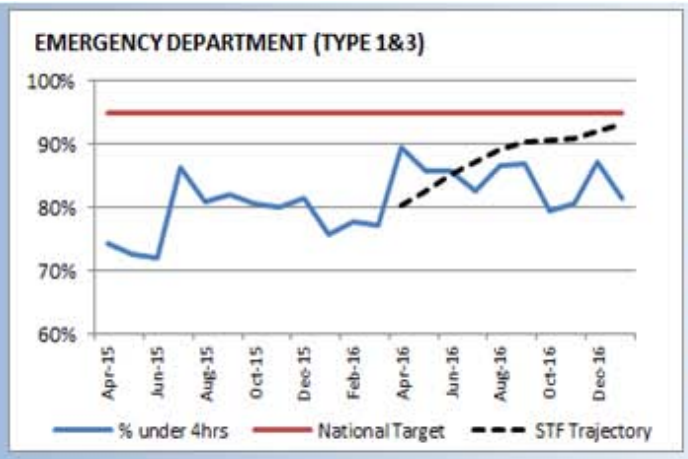
The reported breach specialties were:

Cardiology x1
Cardio- thoracic Surgery x4
Gastroenterology x1
General Surgery x1
Plastic Surgery x1

A&E Waiting Times

Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge. Target of 95%.

A&E performance has remained below the national 95% threshold with performance of 81.4% for January which was also below the agreed Sustainability and Transformation trajectory of 93.2%



Performance has deteriorated by 6.1% during January compared to December performance of 87.3%.

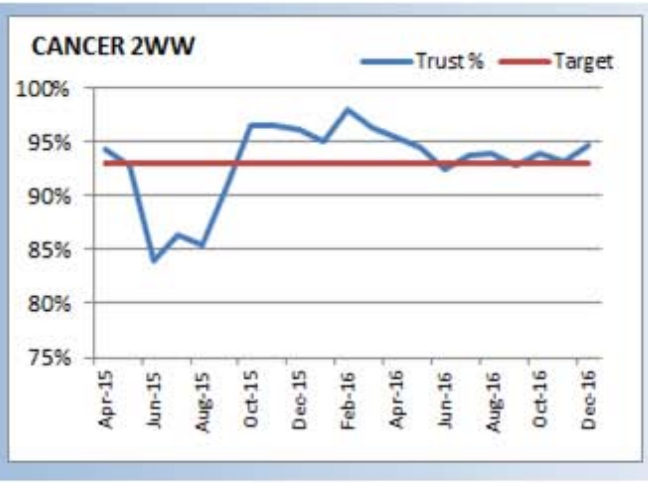
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: Two Week Wait Standard

All patients need to receive first appointment for cancer within 14 days of urgent referral. Threshold of 93%.

December performance achieved the 93% standard at 94.7%



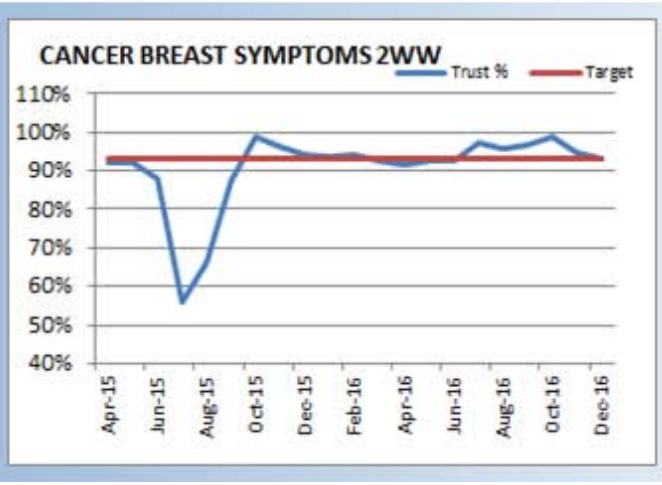
Tumour Sites failing to meet the 93% standard:

Head & Neck 92.2%
Lower GI 91.4%
Lung 91.7%
Urological 88.9%

Cancer: Breast Symptom Two Week Wait Standard

All patients need to receive first appointment for any breast symptom (except suspected cancer) within 14 days of urgent referral.

December performance achieved the 93% standard at 93.1%



Integrated Performance Report - February 2017

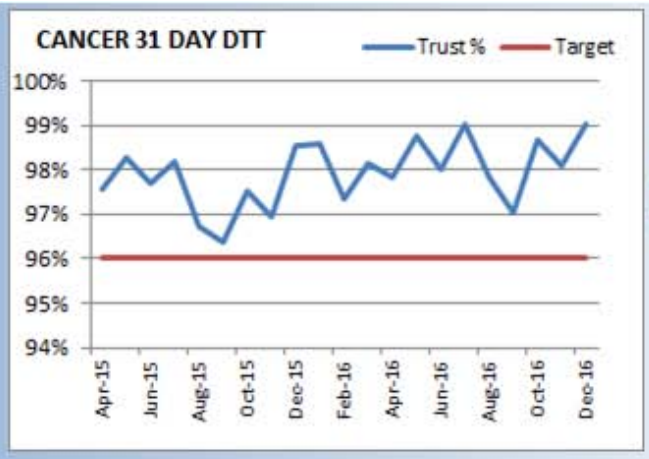
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Standard

All patients to receive first treatment for cancer within 31 days of decision to treat. Threshold of 96%.

December performance achieved the 96% standard at 99.0%

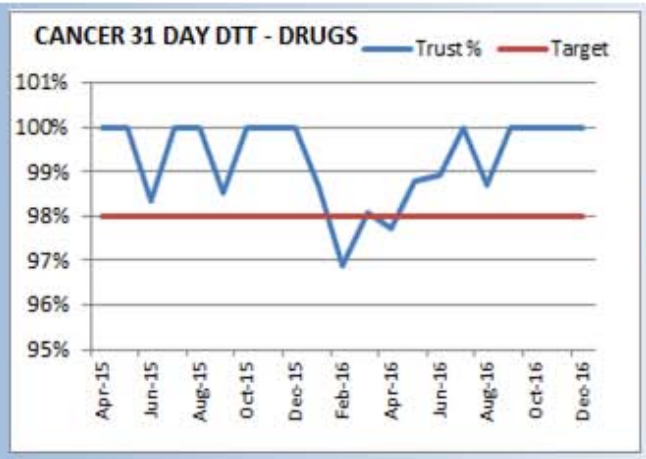


There were no tumour sites failing to meet the 96% standard

Cancer: 31 Day Subsequent Drug Standard

All patients to receive first treatment for cancer subsequent anti cancer drug within 31 days days of decision to treat. Threshold of 94%.

December performance achieved standard at 100%



There were no tumour sites failing to meet the 94% standard

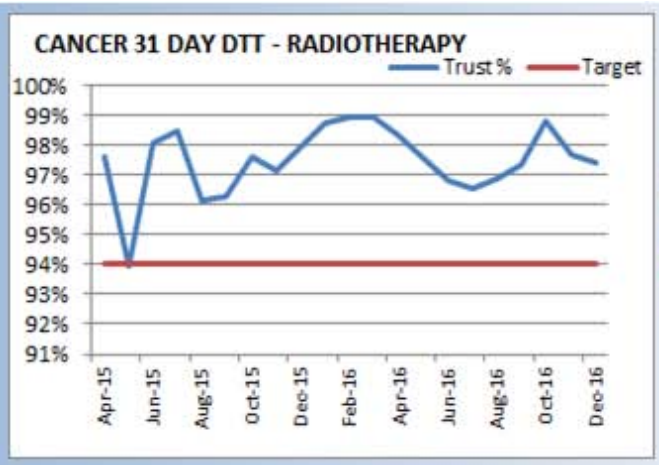
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 31 Day Subsequent Radiotherapy Standard

All patients to receive first treatment for cancer subsequent radiotherapy within 31 days days of decision to treat. Threshold of 94%.

December performance achieved standard at 97.4%



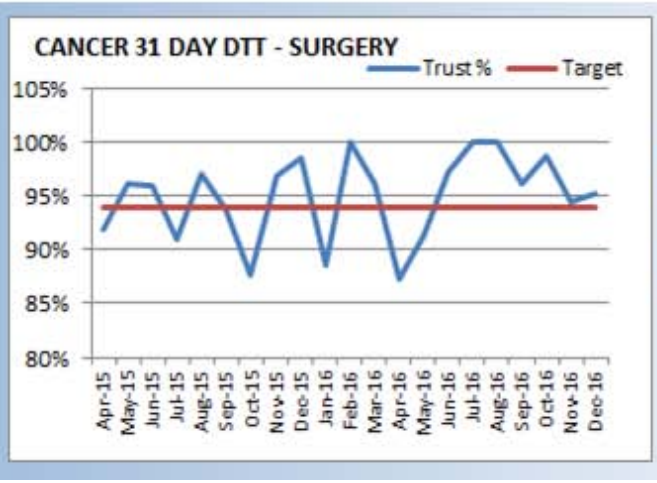
Tumour Sites failing to meet the 94% standard:

Haematological 0% (1 Patient)

Cancer: 31 Day Subsequent Surgery Standard

All patients to receive first treatment for cancer subsequent surgery within 31 days days of decision to treat. Threshold of 94%.

December performance achieved standard at 95.2%



Tumour Sites failing to meet the 94% standard:

Breast 87.5%
Skin 93.8%

Integrated Performance Report - February 2017

RESPONSIVE

Description	Aggregate Position	Trend	Variation

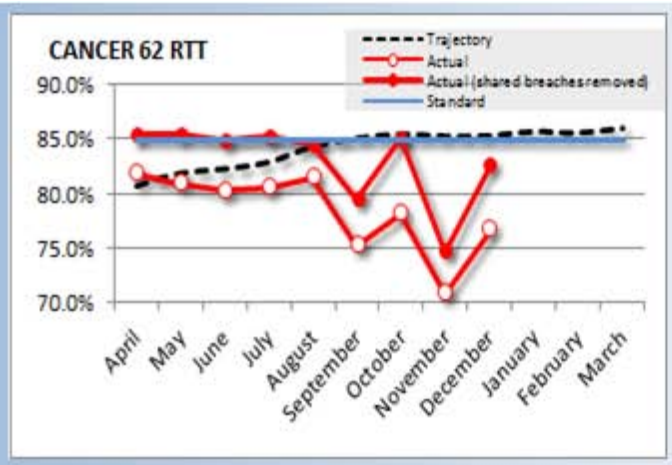
Cancer: ADJUSTED - 62 Day Standard

All patients need to receive first treatment for cancer within 62 days of urgent referral. Threshold of 85%

Sustainability and Transformation trajectory is 85.5%

The adjusted position allows for reallocation of shared breaches

December failed to achieve the STF trajectory of 85.5% with performance of 82.7%



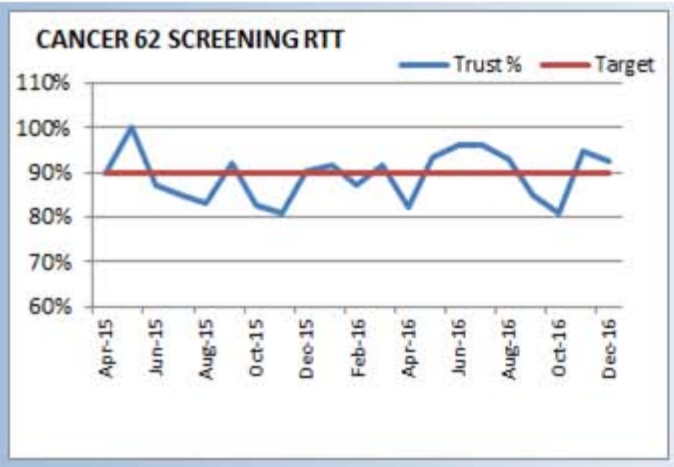
Tumour Sites failing to meet the 85% standard:

Head & Neck 71.4%
Lower GI 50.0%
Lung 42.9%
Upper GI 60.0%
Urological 78.7%

Cancer: 62 Day Screening Standard

62 Day Screening

December performance achieved standard at 92.5%



Tumour sites failing to meet the 90% standard:

Lower GI 66.7%

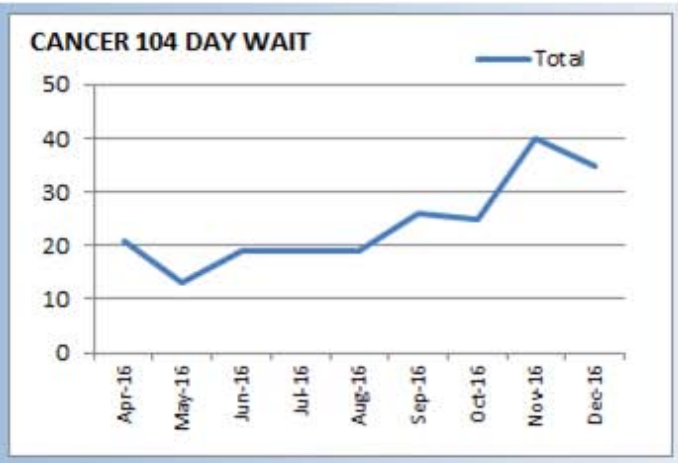
RESPONSIVE

Description	Aggregate Position	Trend	Variation

Cancer: 104 Day Waits

Cancer 104 Day Waits

There were 35 patients waiting 104 days or over during December



December by Tumour Site:

Breast x1
Colorectal x5
Gynaecology x2
Haematology x3
Head and Neck x4
Lung x8
Skin x3
Upper GI x5
Urology x4

SAFE

Description	Aggregate Position	Trend	Variation

Occurence of any Never Event

Occurence of any Never Events

There were zero Never Events reported during January

Further information is included in the Board Quality report

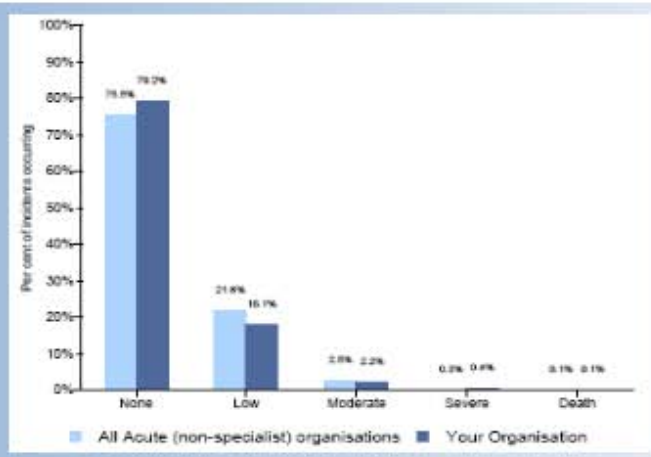
Potential under-reporting of patient safety incidents

Number of incidents reported per 1000 bed days

The latest data available for this indicator is October 2015 to March 2016 as reported by the National Reporting and Learning System (NRLS).

The Trust reported 5,896 incidents (rate of 34.44) during this period.

The Median rate for reporting in this period was 39.91



Degree of Harm:

None 4672
Low 1057
Moderate 129
Death 5

The Trust has now moved in to the middle 50% of reporters, previously the Trust was in the lowest 25% of reporters

Integrated Performance Report -February 2017

SAFE

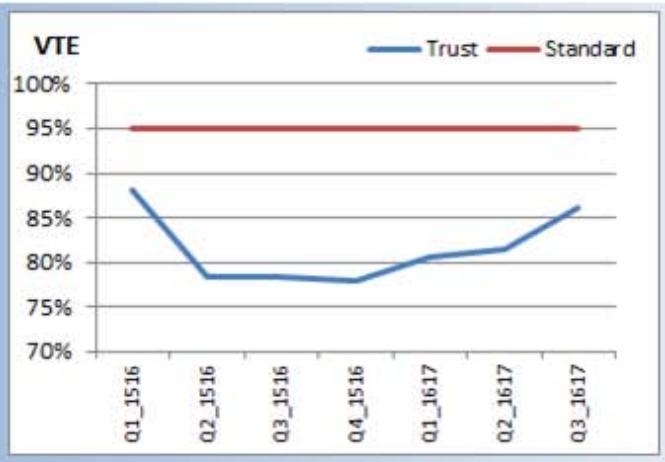
Description	Aggregate Position	Trend	Variation

VTE Risk Assessment

All patients should undergo VTE Risk Assessment

This measure is reported quarterly

The Trust is currently failing to achieve this indicator with performance of 86.15% for Q3 2016/17.



Health Group Performance:

Clinical 96.60%
Family &Women 91.00%
Medicine 71.28%
Surgery 90.48%

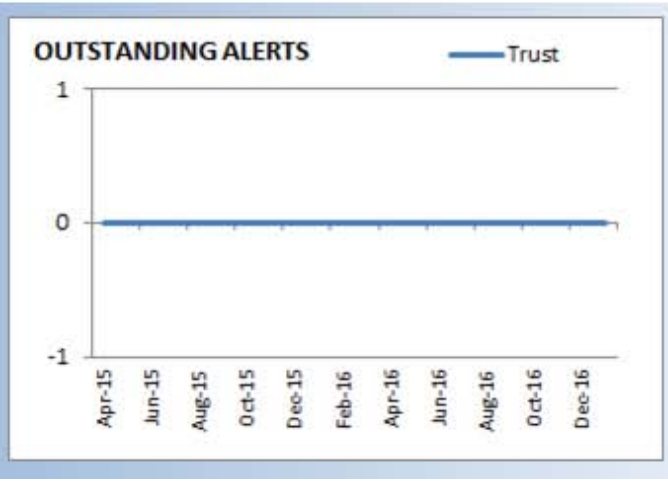
Further information is included in the Board Quality report

Patient Safety Alerts Outstanding

Number of alerts that are outstanding at the end of the month

There have been zero outstanding alerts reported at month end for January 2017.

There have been no outstanding alerts year to date.



Integrated Performance Report -February 2017

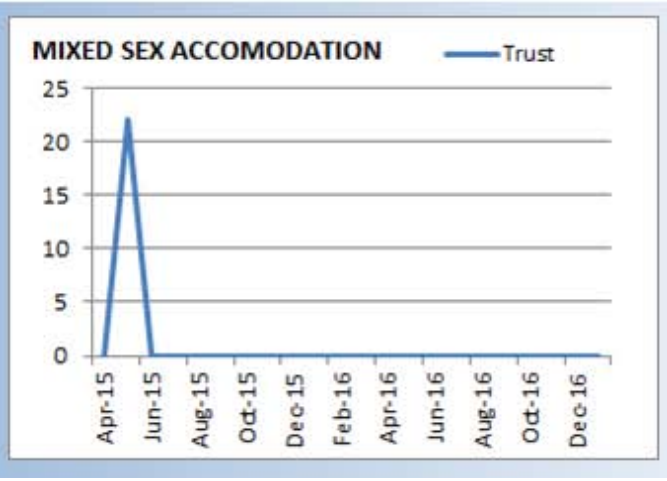
SAFE

Description	Aggregate Position	Trend	Variation

Mixed Sex Accommodation Breaches

Occurrences of patients receiving care that is in breach of the sleeping accommodation guidelines.

There were no occurrences of mixed sex accommodation breaches throughout January 2017.

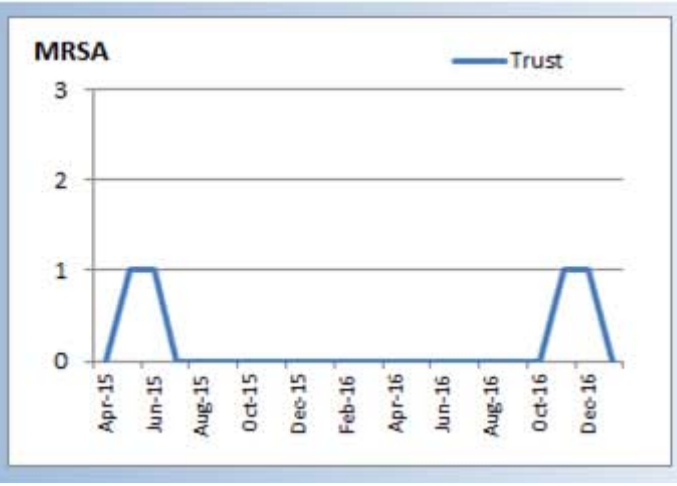


MRSA Bacteraemias

National objective is zero tolerance of avoidable MRSA bacteraemias

The Trust has reported 2 cases of acute aquired MRSA bacteremia year to date

There were no cases reported during January



Further information is included in the Board Quality report

SAFE

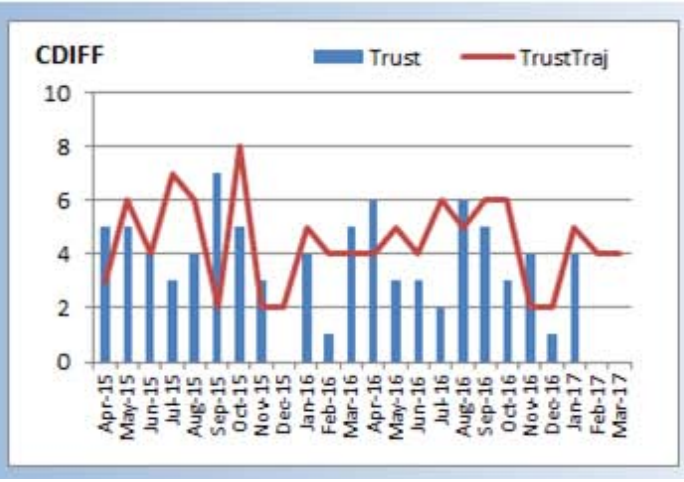
Description	Aggregate Position	Trend	Variation

Clostridium Difficile

The Clostridium difficile target for 2016/17 is no more than 53 cases

There have been 37 cases year to date

There were 4 incident reported during January which achieved the monthly trajectory of no more than 5 cases



Health Group Performance:

Clinical - 0
Family&Women - 0
Medicine - 3
Surgery - 1

Further information is included in the Board Quality report

EFFECTIVE

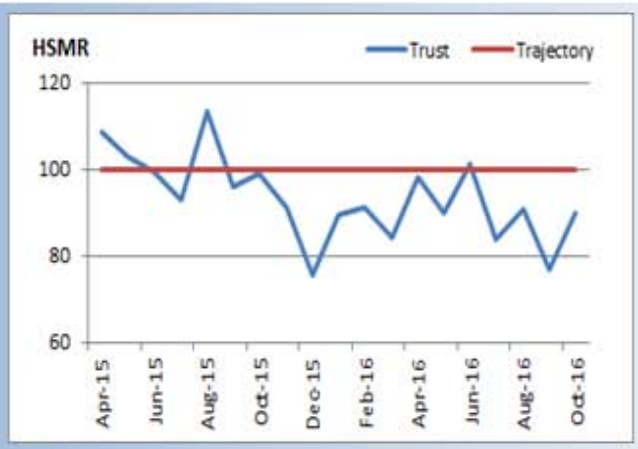
Description	Aggregate Position	Trend	Variation

HSMR

HSMR is a ratio of observed number of in-hospital deaths at the end of continuous inpatient spell to the expected number of in-hospital deaths (x by 100) for 56 Clinical Classification System (CCS) groups

October 2016 is the latest available performance

The standard for HSMR is to achieve less than 100 and October 2016 achieved this at 89.9

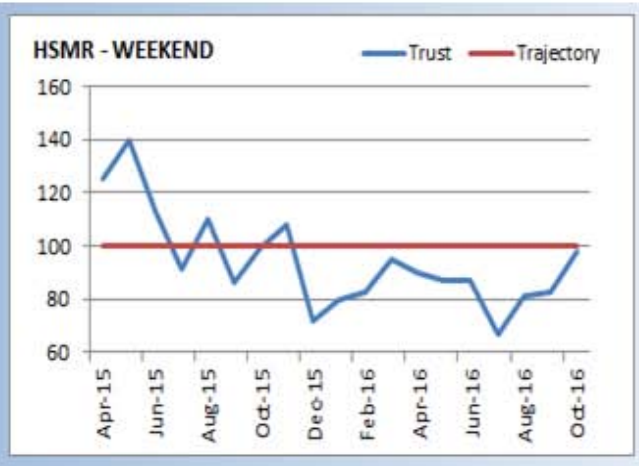


HSMR WEEKEND

Monthly Hospital Standardised Mortality Ratio for patients admitted at weekend

October 2016 is the latest available performance

The standard for HSMR at weekends is to achieve less than 100 and October 2016 achieved this at 98.0



EFFECTIVE

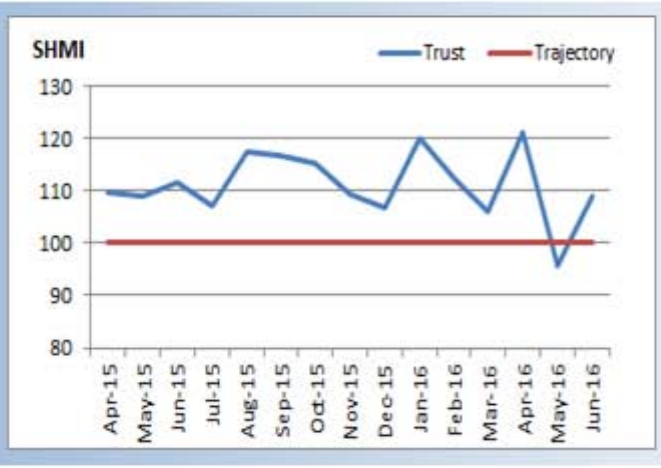
Description	Aggregate Position	Trend	Variation

SHMI

SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and up to 30 days after discharge and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

June 2016 is the latest published performance

The standard for SHMI is to achieve less than 100 and June 2016 failed to achieve this at 108.9

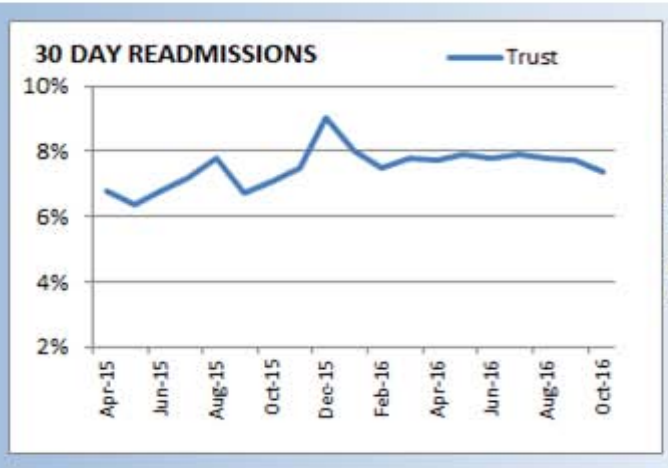


30 DAY READMISSIONS

Non-elective readmissions of patients within 30 days of discharge as % of all discharges in month

The latest available performance is October 2016

The readmissions performance is measured against the peer benchmark position for 2015/16 to achieve less than 7.8%. The Trust achieved this measure with performance of 7.4%



Health Group Performance:

Clinical Support	8.9%
F&WH	5.2%
Medicine	14.1%
Surgery	4.2%

CARING

Description	Aggregate Position	Trend	Variation

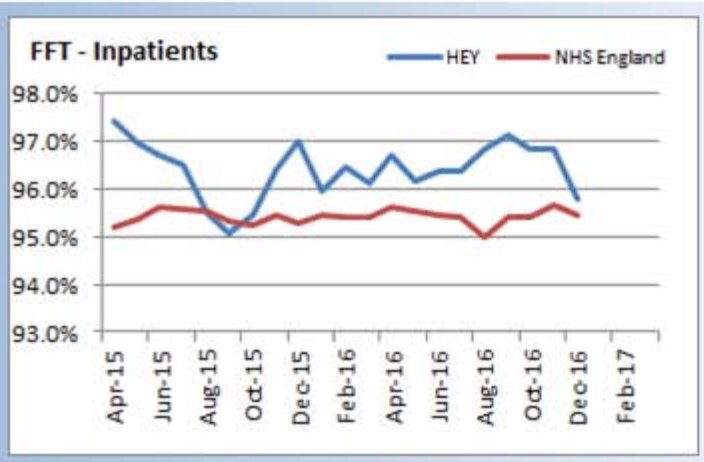
Inpatient Scores from Friends and Family Test - % positive

Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for December was 95.79%

The latest published data for NHS England is December 2016.

January 2017 will be published 9th March 2017.



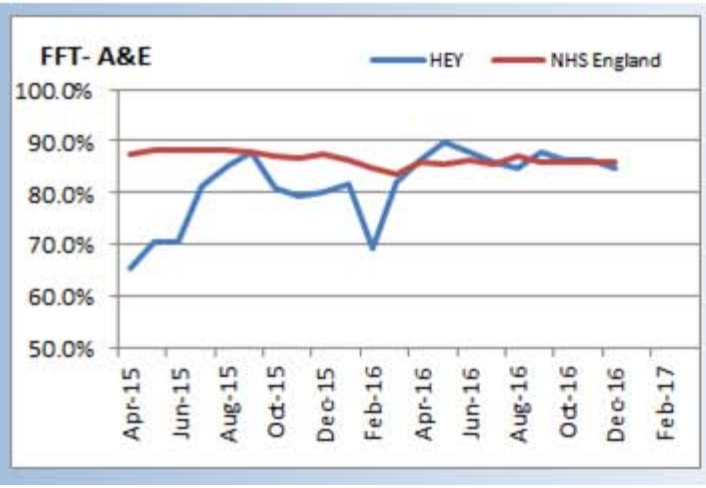
A&E Scores from Friends and Family Test - % positive

Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for December was 84.79%

The latest published data for NHS England is December 2016

January 2017 will be published 9th March 2017.



CARING

Description	Aggregate Position	Trend	Variation

Maternity Scores from Friends and Family Test - % Positive

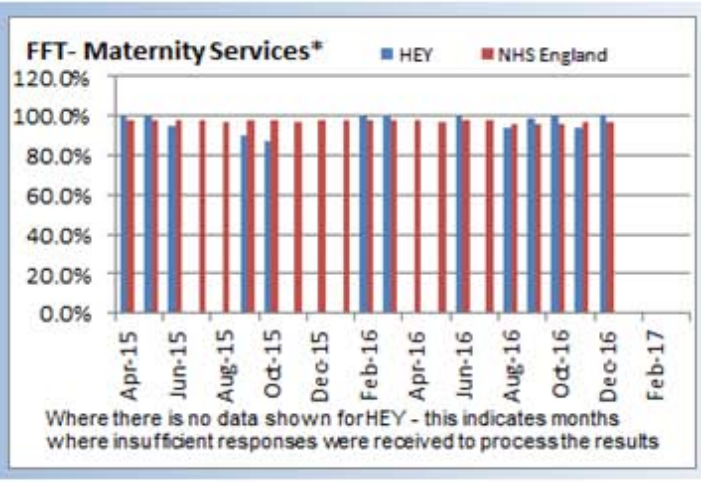
Percentage of responses that would be Likely & Extremely Likely to recommend Trust

Performance for December was 100%

The latest published data for NHS England is December 2016

January 2017 will be published 9th March 2017.

Months with no data for HEY is due to insufficient responses



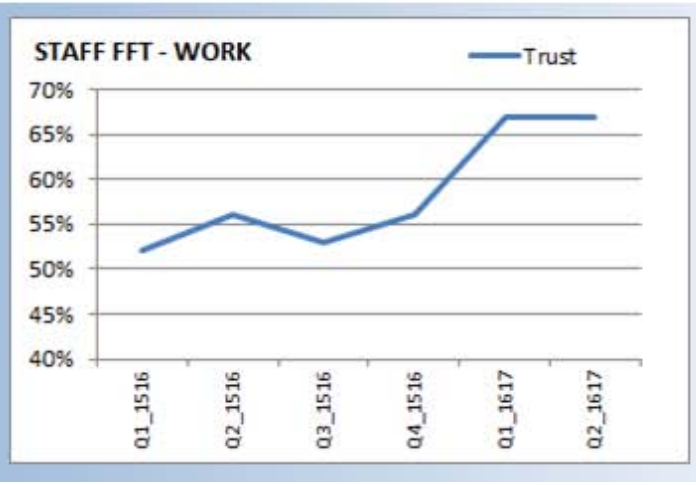
* Question relates to Birth Settings

Relative Position in Staff Surveys

Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place to work?

The latest Friends and Family Test position is Quarter 2 2016/2017 shows that 67% of surveyed staff would recommend the Trust as a place to work, this remains consistent with 67% for Quarter 1.

Quarter 3 performance is part of the annual staff survey and will be reported when published.



The overall response rate for Quarter 2 was 20.3%

CARING

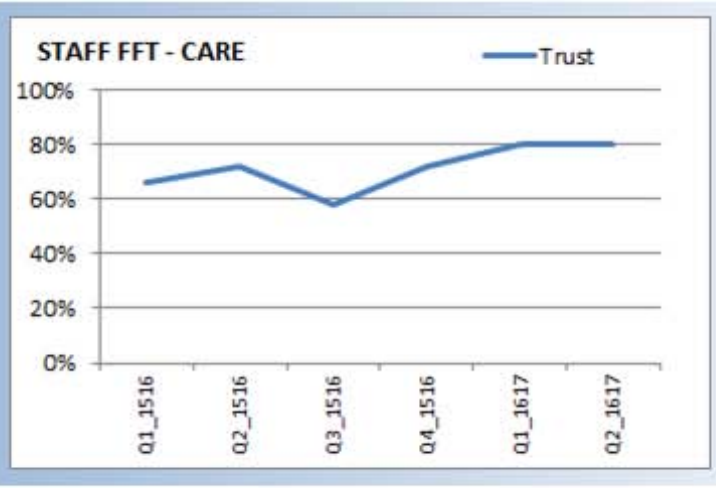
Description	Aggregate Position	Trend	Variation

Relative Position in Staff Surveys

Staff are asked the question: How likely are you to recommend this organisation to friends and family as a place for care/treatment?

The latest Friends and Family Test position is Quarter 2 2016/2017 shows that 80% of surveyed staff would recommend the Trust as a place to receive care/treatment, this remains consistent with 80% for Quarter 1.

Quarter 3 performance is part of the annual staff survey and will be reported when published.

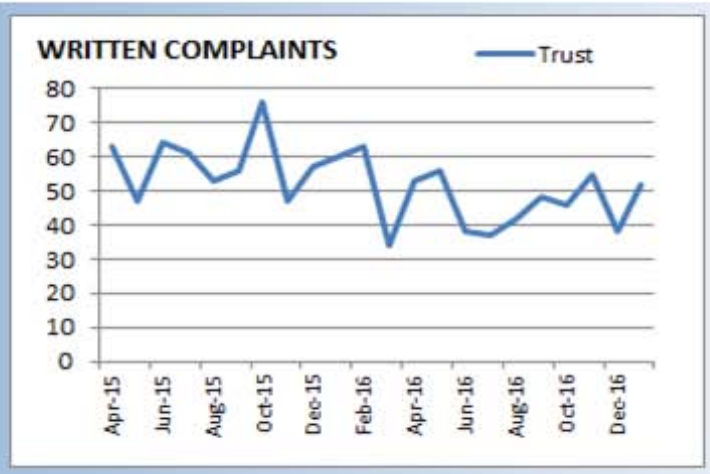


The overall response rate for Quarter 2 was 20.3%

Written Complaints Rate

The number of complaints received by the Trust

The Trust received 52 complaints during January, this is an increase on the December position of 38 complaints



There have been 465 complaints year to date

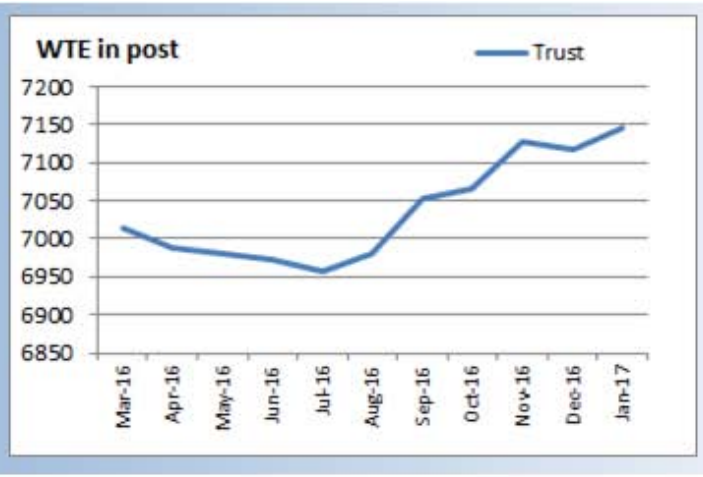
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

WTEs in post

Contracted WTE directly employed staff as at the last day of the month

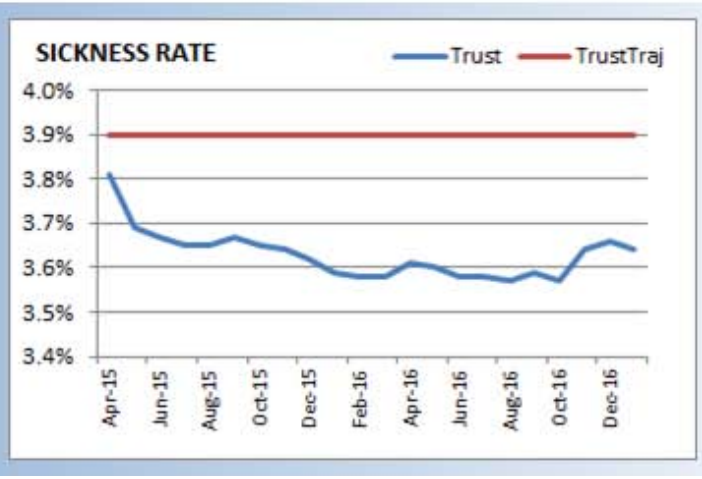
Trust level WTE position as at the end of January was 7145.5



Sickness Absence Rates

Percentage of sickness between the beginning of the financial year to the reporting month. Target is 3.9%.

Performance for January achieved the standard of less than 3.9% with performance of 3.64%



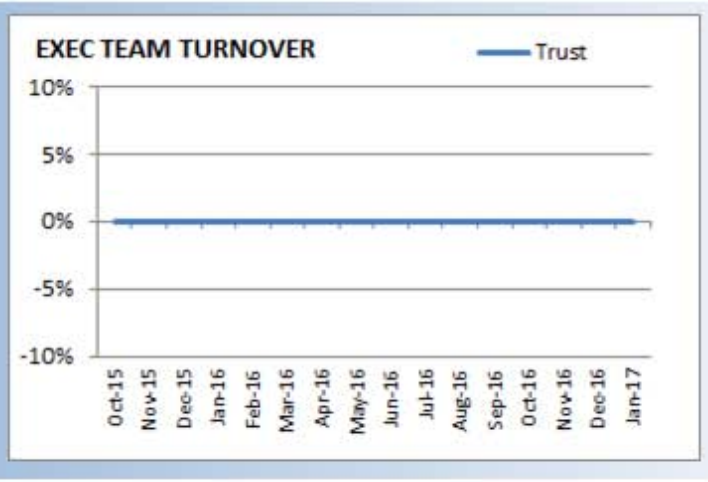
ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

Executive Team Turnover

Percentage turnover of the Trust Executive Team

Turnover has been 0% for the Executive team within the last 12 month period.

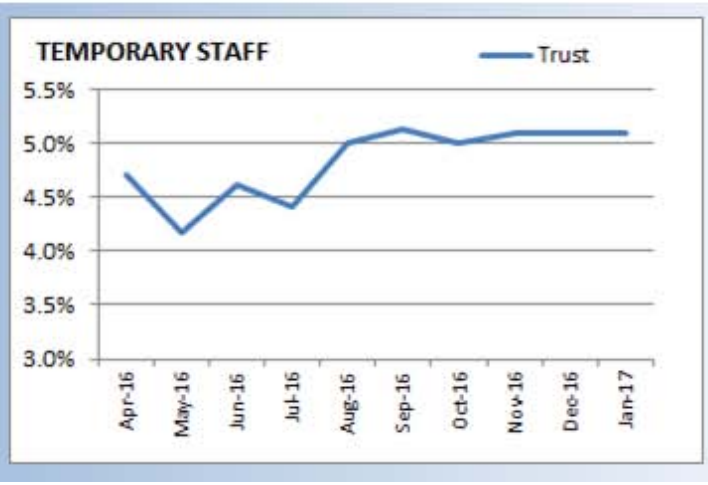


Proportion of Temporary Staff

% of the Trusts pay spend on temporary

Performance is measured on a year to date basis as at the month end

January performance was 5.1%



FINANCIAL SUMMARY: 10 MONTHS TO 31st JANUARY 2017

1. At the end of month 10 the Trust is reporting a deficit of £0.09m which is in line with plan. Improvement during the month is based on the assumption that the Trust's appeal against the STF performance fines will be successful.

2. Excluding STF, Health Group positions are now £11.64m overspent. This is a £1.6m increase in month and £0.4m above forecast. All of the Health Groups reported a deterioration against their forecasts in month of circa £0.1m. **The Trust is unlikely to achieve its control total unless the rate of overspend decreases.**

3. Actions have been taken Corporately to offset some of the cost pressures by delaying the implementation of new schemes, securing additional income, and reducing centrally held expenditure provisions. This has enabled the Trust to report delivery of the financial plan to month 10. The Trust has released 86% of its reserves in the year to date and has just £2.1m left. If Health Groups deteriorate at the same rate as month 10 (£1.6m) then current forecasts indicate a deficit of approximately £1m at the year end. **ACTION: Health Groups must reduce their costs in the final 2 months if the trust is to be able to achieve its control total.**

4. The Trust continues to forecast delivery of its control total (break-even) by year end. This assumes that the Trust is successful in its appeal against the STF fines and is also able to contain costs within the final 2 months such that the potential £1m risk is eliminated . **The consequence of not achieving this would be the loss of the final quarters STF funding (£3.5m) and the loss of any reward funding on offer from NHSI for meeting Control Totals. In addition we would lose a further £1.6m of CQUIN funding in 2017/18 as a direct result.**

5. In Month the Trust has traded below its income plan by £0.6m. This is driven by the continued under trade in elective activity which has been particularly impacted in month by the volume of non-elective admissions and the level of elective cancellations required to accommodate this work. The Trust has now agreed a year end forecast outturn position with its 2 main local commissioners. It is also close to agreeing a similar deal with NHS England on the same basis.

6. The Trusts cash position remains weak. This is impacting on supplier relationships and has impacted on the Trust's performance against the Better Payment Practice Code. The 2 main local Commissioners have paid £6m of the agreed £8m additional payments in early February so this will ease the pressure. The remaining £2m cash and around £4m from NHS England will be received in March 17.

7. As per previous months the non delivery of CRES remains a significant concern. At month 10 the Trust is reporting a £3.9m shortfall against a £15.5m plan with an anticipated outturn of £4.4m (23%) below plan. Offsetting this, the Trusts financial plan included a risk provision (reserve) totalling almost £5m recognising the risk inherent within the CRES program. In addition, the plan made a further £5m allowance against the risk of non delivery of the RTT recovery plans. In total the Trust is forecasting a deficit of approximately £6.2m against the planned activity targets. **The bigger issue is the growth in the Health Group cost base above budgeted levels without delivering the funded levels of activity. This is particularly an issue in Surgery but to a smaller extent also FWH.**

8. **The Trust's underlying financial position is now a £25.4m deficit. This is a deterioration of £5.8m in year and is one which urgently need to be reversed.**

ORGANISATIONAL HEALTH

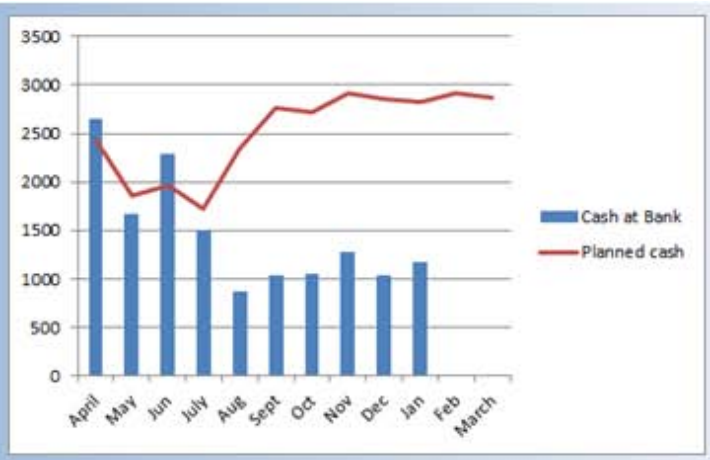
Description	Aggregate Position	Trend	Variation

Cash Balance

Cash on deposit <3 months deposit

Cash at the end of January was £1.178m.

The level of cash is not permitted to fall below £1m or exceed on average £13.4m whilst the Trust is drawing against its revolving working capital loan facility. There is still intense pressure on cash and the Trust is not able to meet obligations to suppliers as they fall due.

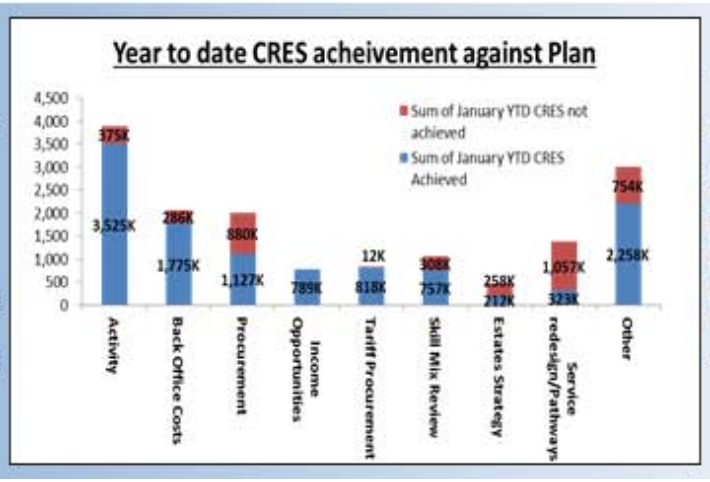


CRES Achievement Against Plan

Planned improvements in productivity and efficiency

As at month 10 the Trust has achieved £11.6m of CRES savings against a plan of £15.5m, an adverse variance of £3.9m.

The breakdown of the CRES programme by major work streams is shown on the chart with the red and blue combined reflecting the overall plan as at October, the blue section being that which has been achieved and the red being that which has not.



The Health groups have been tasked with finding additional schemes to cover their CRES shortfall.

ORGANISATIONAL HEALTH

Description	Aggregate Position	Trend	Variation

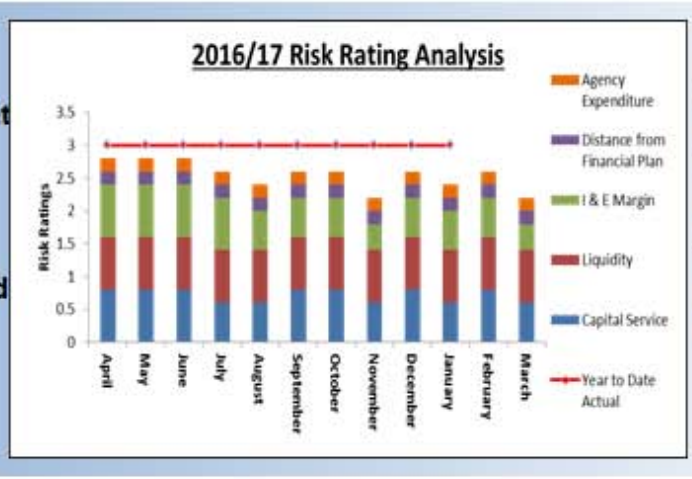
Risk Rating

Financial Sustainability Risk Rating

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess risk.

The risk rating analysis shows the planned risk rating for the year and how each of the metrics contribute towards that overall risk rating plan. These are based on how NHSI now assess risk.

Risk ratings range from 1 to 4 with 1 being the best score and 4 the worst (this is a change from previous rating metrics which had 4 as the best score and 1 the worst). The Trusts risk rating is currently 3.



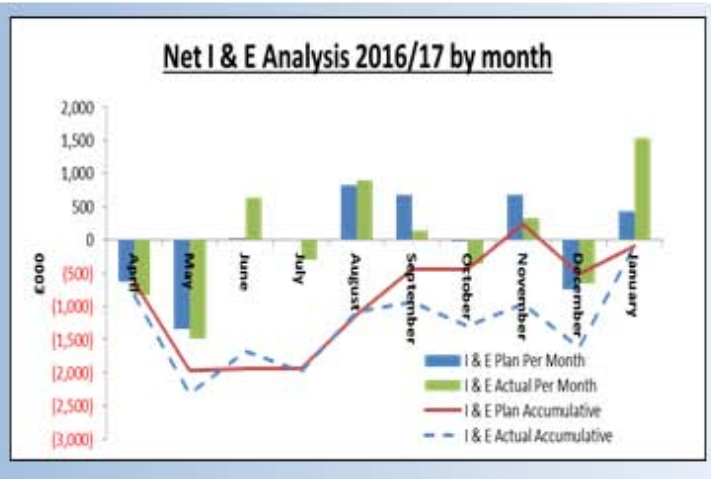
The Trust has made an improvement in terms of it's I&E position in month and is now in line with plan, however the overall risk rating remains a 3.

Income & Expenditure

Net income and Expenditure

The Net I & E analysis shows how the trust has performed in each month in terms of the overall performance surplus plan. The bars showing each months performance and plan in isolation and the lines showing the accumulative position of plan and actual.

At month 10 the Trust is in line with plan, the planned position being £0.1m deficit



HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

INTERIM REVOLVING WORKING CAPITAL SUPPORT FACILITY

Trust Board date	7 March 2017	**Reference Number**	2017 – 3 – 13
Director	Lee Bond – Chief Financial Officer	**Author**	Samantha Graves – Planning Accountant
Reason for the report	The purpose of this report is to request Trust Board ratification for the signed Board Resolution to enable the transfer of the Interim Revolving Working Capital Support Facility (IRWCSF) to an Interim Revenue Support Loan.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Board is asked to support the application process for transferring the Interim Revolving Working Capital Support Facility to an Interim Revenue Support loan and to ratify the Board Resolution submitted on 2 February 2017. The Board is also asked to provide assurance on the Trust's forecast outturn position at Month 9					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance	✓	Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s): W2 Governance					
	Assurance Framework Ref: F1	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** Y		
5	**BOARD/BOARD COMMITTEE REVIEW** This ratification is reserved to the Trust Board under Standing Orders					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

INTERIM REVOLVING WORKING CAPITAL SUPPORT FACILITY

1. PURPOSE

The purpose of this report is to request Trust Board ratification for the signed Board Resolution to enable the transfer of the Interim Revolving Working Capital Support Facility (IRWCSF) to an Interim Revenue Support Loan.

2. INTRODUCTION

The Trust currently has an Interim Revolving Working Capital Support Facility in place. This enables the Trust to drawdown funds to assist in the cash flow financing on a monthly basis. The current facility drawn down is £5.396m. It is intended that £2.771m will be repaid in February 2017 and the balance £2.625m will be repaid in quarter 1 of 2017/2018. This facility carries an interest rate of 3.5%.

3. INTERIM REVENUE SUPPORT LOAN

The Trust has been notified that the Department of Health is making loan facilities available to replace IRWCSF where providers are on target to meet their control totals. The loan facility carries a lower interest rate of 1.5% compared to the 3.5% for IRWCSF.

The offer is provided on the condition that the Trusts forecast outturn position at Month 9 remains in line with the control totals set by NHSI.

The loan will be fully repayable on 18 January 2020.

In order for the loan transfer to occur the Trust must complete:

- A signed and dated Facility Agreement supported by a Board Resolution. The required Board Resolution is attached at Appendix 1.
- A signed variation letter

In order to progress the transfer of the loan the Department of Health required the Board resolution and signed documents by 2 February 2017. Therefore it has been necessary to submit the documents to the Department of Health in advance of this meeting.

4. RECOMMENDATION

The Board is asked to support the application process for transferring the Interim Revolving Working Capital Support Facility to an Interim Revenue Support loan (fully repayable in January 2020) and to ratify the Board Resolution submitted on 2 February 2017. The Board is also asked to provide assurance on the Trusts forecast outturn position at Month 9

Lee Bond
Chief Financial Officer
February 2017

APPENDIX 1

Board Resolution

Statement from the Vice Chair and Chief Executive of Hull and East Yorkshire Hospitals NHS Trust regarding the Trust Board approval of transferring the Trust Interim Revolving Working Capital Support Facility (IRWCSF) to an Interim Revenue Support Loan (IRSL).

Due to the need to take an urgent decision on the Revenue Support funding for the Trust and submit the relevant paperwork to the Department of Health, we have acted on behalf of the Trust Board. This is in accordance with the Trust's Standing Orders.

A paper will be presented to the Trust Board for scrutiny regarding the proposed transfer of IRWCSF to an IRSL.

This recommends the transfer of the current IRWCSF £5.396m to an IRSL at a reduced interest rate from 3.5% for IRWCSF to 1.5% for IRSL.

On behalf of the Board, we accept this recommendation and therefore approve the transfer of the IRWCSF to IRSL, on behalf of the Trust Board.

We also:

- approve the terms of, and the transactions contemplated by, the Finance Documents to which it is a party and resolving that it execute the Finance Documents to which it is a party;
- authorise the Chief Finance Officer to sign and despatch all documents and notices, including the Variation Request.

We certify that a paper will be presented to the Trust Board for scrutiny regarding the proposed IRSL and that this will be circulated to *all* Trust Board members.

Andrew Snowden — Vice Chair, Non-Executive Director,
Hull and East Yorkshire Hospitals NHS Trust

Chris Long - Chief Executive, Hull and East Yorkshire Hospitals NHS Trust

Dated: 2February 2017

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AGREEMENT OF THE ALIGNED INCENTIVES CONTRACT

Trust Board date	7 March 2017	**Reference Number**	2017 – 3 - 14
Director	Lee Bond, Chief Financial Officer	**Author**	Lee Bond, Chief Financial Officer
Reason for the report	In recent months the Board have received a number of reports concerning the development of 2017/18 financial plan. This paper focusses specifically on the agreement of a new type of contract for the coming financial year – the Aligned Incentives Contract, with our two largest local commissioners.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board are asked to note the contents of this paper and support the agreement of the AIC as a landmark step in the development of the Trusts 2017/18 financial plan. In addition the Board are asked to note the significant change in system-wide relationships and working that this contract requires as we move into the delivery phase of the 5 year forward view.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework Ref:	**Raises Equalities Issues?** No	**Legal advice taken?** No	**Raises sustainability issues?** No		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AGREEMENT OF THE ALIGNED INCENTIVES CONTRACT

1. BACKGROUND

In recent months, the Board have received a number of reports concerning the development of 2017/18 financial plan. Within these updates has been a regular commentary concerning the progress made with the agreement of a contract with two of our largest local Commissioners, Hull and East Riding CCGs.

By way of recap, the financial plan update considered most recently shows the Trust planning to deliver a deficit on its revenue plan of £16.8m in 2017/18. This plan is predicated on a contract agreed with the Hull and East Riding CCGs (hereafter known as the Commissioners) totalling £304m and a further, non-contracted, income assumption of an additional £4m based on a belief that, under a cost and volume contract, the Commissioners would not be able to restrict activity to the contracted level of £304m.

Whilst the contracted level had been agreed in principle with the Commissioners, a physical contract had not been signed as a number of residual concerns existed concerning the split of the activity included within the contract, principally these concerns revolved around a difference of opinion on the level of non-elective activity which the Trust would be required to provide in the forthcoming year.

2. PROGRESS: THE ALIGNED INCENTIVES CONTRACT (AIC)

Over the past month the contracting discussions have reverted back to the actual contract value and a recognition that demand for healthcare services at the proposed contract levels (particularly non-elective), would cause all parties significant distress both in terms of operational delivery as well as financial affordability.

To that end, and in-line with emerging experience from another health economy facing similar challenges, a revised approach to the setting of the contract has been explored and ultimately agreed.

The contract has been agreed with an overall fixed value of £312m. This arrangement provides a minimum income guarantee for the Trust which is roughly equivalent to the 2016/17 forecast outturn level with an amount of growth included to enable the Trust to tackle the backlog issues in Ophthalmology (notably Wet AMD and Glaucoma).

Attached at Appendix 1 is an excerpt from the 2017/18 contract which describes the AIC in a little more detail and identifies the 4 prime constituent elements within the contract and the approach to be taken regarding each of those areas and the services therein.

Whilst the Trust has had experience of operating “block” arrangements historically, most recently in 2015/16, this agreement marks a fundamental departure from national prescribed guidance and the PBR supported contract models which have proliferated across the NHS for the past 17 years. It is hoped that the experience and learning from the Bolton health economy, where this arrangement has been in operation for the past 2-3 years can be replicated. In particular, this contract agreement requires a fundamentally different approach to the way in which Commissioners and Providers work together as it provides all parties with a common goal: the effective management of patient pathways irrespective of organisational boundaries.

3. FINANCIAL RISK

The AIC provides the Trust with an income guarantee which is set at a reasonable level. It does not allow for significant growth over and above 2016/17 outturn levels and as such, there is a requirement for the Trust and Commissioners, working together as a system, to manage demand in a more effective manner in order to prevent significant growth and to enable the overall health system to live within this financial envelope.

The AIC does recognise the risk of excessive demand for service going forward. In such an event, and in the absence of effective mitigations, the Trust may have to incur costs in excess of plan in order to deliver services. In such an event, the AIC provides for the reimbursement of actual costs incurred thus mitigating, in part, the exposure of the Trust.

Financial risk under the AIC is not confined to the Trust alone. In agreeing the AIC at this level, the Commissioners have had to include a £5m savings assumption into their financial plans. The Trust, as part of the contract agreement, is committed to working with system partners to identify and deliver savings which will deliver this value as a minimum. Failure to achieve this will be seen as a system wide failure and will be borne by all parties under the contract.

In a similar manner, the financial risks posed by the Trust CIP programme are recognised by the AIC. Here again, the system is committed to working together to support re-design and transformation such that this risk can be managed effectively. Once again, failure to achieve would be seen as a system failure and would be borne by all parties.

As part of the AIC, it has been agreed that the Commissioners will look to dismantle much of the existing machinery which exists to support the now redundant contracting process. Resources released through this process will be redirected to work on the joint delivery of the Provider CIP and Commissioner QIPP programmes.

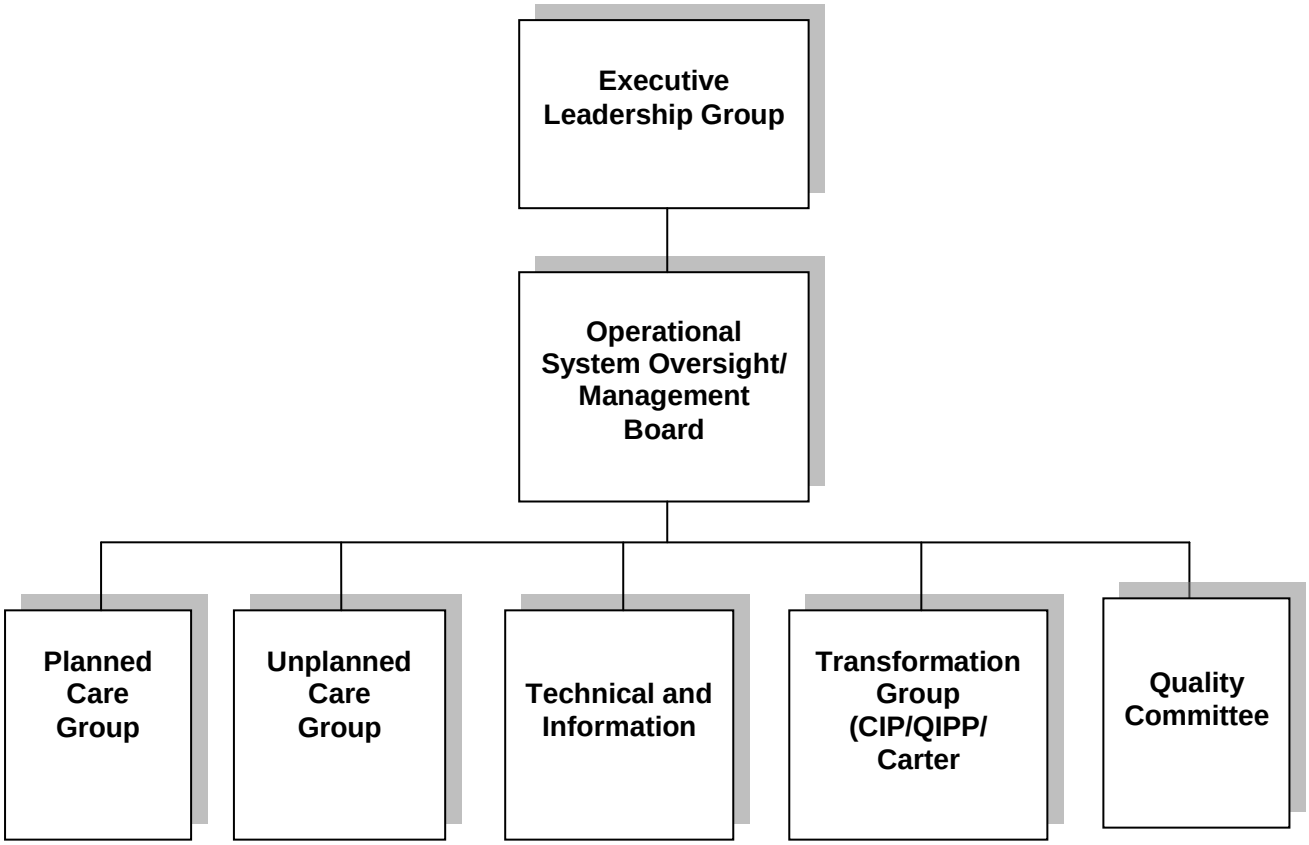
4. CONSTITUTIONAL STANDARDS

Work is underway to understand what impact the AIC will have in terms of its impact on the delivery of the constitutional access standards. The biggest concern is the impact on RTT if demand isn't managed effectively and there is no additional money, besides that set aside for Ophthalmology, to undertake additional activity as a means of improving RTT performance. This remains a significant unknown at the present time. As a system we are required to agree revised trajectories for each of the constitutional standards, this work is currently underway.

5. SYSTEM GOVERNANCE

The focus of contract management going forward is simplicity and a commitment to system-wide service improvement. Fundamental to this approach is a review of the governance framework that surrounds the many varied interactions that currently exist between Provider and Commissioner with a view to creating a revised structure which centres around this principle of simplicity and a belief that we should seek to rationalise and streamline assurance processes wherever possible.

The diagram below describes a simplified model which is currently under development:



The two largest component parts of the AIC, the planned and unplanned care elements, would each be managed through their own Group or Board. A key challenge in the short term will be the agreement of appropriate, cross sector membership, such that cross fertilisation of ideas and clinical practices between primary, secondary and community care can take place. This is absolutely essential if this new approach to working is to be successful.

Further groups would be added as necessary, but as a minimum it is likely that some sort of technical/information group would need to be constituted to deal with the many varied technical challenges facing our services. A further group to review and support the multi-faceted transformation agenda is also likely to be required.

From a quality assurance perspective, the existing Quality Committee is likely to remain in the short term. Over time it may be possible to incorporate or amalgamate the Trusts internal quality assurance processes with that of the Commissioners however that will require some time as systems and relationships mature and become embedded.

In the very short-term, a process will be instigated which looks to quickly identify all of the existing groups and forums in operation in order to evaluate their effectiveness and to streamline the process as far as possible. Where possible existing groups or networks will be co-opted to fulfil the functions required of the Planned and Unplanned Care Groups. For example, the existing ED Delivery Board could become the vehicle for all of the discussions regarding unplanned care?

Overall system leadership will be provided under this model by a small group compromising the three Chief Executive Officers and Executive Officer support.

6. CULTURAL CHANGE: COMMUNICATION AND ENGAGEMENT

The agreement of the AIC and the successful implementation of the changes to the way in which the system partners will be required to interact going forward represents a major cultural change. The abandonment of the cost and volume, tariff based contract system is a major change and is one which will require significant re-education of our clinical teams. The behaviours which the PBR based system fostered need to be left behind with a new outlook focussed on system integration and partnership working taking its place. To that end, a significant programme of communications and engagement is required across the entire health system. Clinicians in all settings will need to recalibrate their thinking about how we deliver health care across the whole system and not just within the confines of their won individual fiefdoms. A series of stakeholder events and workshops will need to be delivered in the coming weeks if we are to successfully generate the impetus and momentum required to generate the change required to make the AIC a success.

7. IMPACT ON THE FINANCIAL PLAN

The agreement of the AIC at £312m is a positive step for the Trust. The agreement of a minimum income position at this level gives the Trust greater freedom to plan changes to service. From a financial planning perspective, work is now underway to agree activity baselines with the clinical health groups and to then agree the expenditure envelopes required to deliver that service. It is expected that this will also lead to a nett benefit in terms of the Trust overall deficit position planned for 2017/18. This process is to be completed in the next couple of weeks as a revised financial planning submission is required by NHSI sometime in March. Discussions around control totals and the availability of STF funding will also then be able to take place.

From a Commissioner perspective their overall affordability problem in 2017/18, as assessed by NHSE, lies somewhere around the £1m mark. At this point, the Commissioners are being asked to revisit their financial plans in order to remove this risk.

8. CONCLUSION

Whilst not being a perfect solution to all of the local health systems finance and performance challenges, it is hoped that the agreement of the AIC and the changes that are implicit within that agreement relating to system wide ownership and accountability marks a a significant step forward.

Agreement of the contract itself represents just the first small step on this journey together. The development of the revised governance framework in which we are to operate, together with a programme of re-education for our clinical teams are sizeable challenges which require urgent attention. Clearly, the AIC doesn't eliminate financial risk for any party, however, it does endeavour to categorise where that financial risk lies and what our respective roles are in regard to that risk in a simple, and transparent manner.

It is hoped, that learning from the experiences of others we are able to make the changes necessary to deliver the required health outcomes demanded of our local population.

9. RECOMMENDATION

The Board are asked to note the contents of this paper and support the agreement of the AIC as a landmark step in the development of the Trusts 2017/18 financial plan. In In addition the Board are asked to note the significant change in system-wide relationships and working that this contract requires as we move into the delivery phase of the 5 year forward view.

Lee Bond
Chief Financial Officer

28 February 2017

-

APPENDIX 1

Hull and East Yorkshire Hospitals, Hull CCG and East Riding CCG

Aligned Incentives Contract- shared risk, shared opportunity, shared vision

The contract has been agreed with an overall fixed value of £312m for 2017-18. This arrangement provides a minimum income guarantee for managing activity in line with forecast 16/17 levels, with growth for Wet AMD and backlog follow-ups for Glaucoma.

This is no longer an organisational based contract, but a system contract which is divided into the following quadrants, each with a work programme to deliver the "local vision" for the Hull and East Riding System (the system) – ultimately ensuring patients receive the right care, in the right setting, as efficiently as possible.

The focus of contract management is simplicity. There is a commitment to system wide service improvement, with the following values and behaviours to support this approach:-

- Fairness,
- Transparency
- Honesty.
- Trust
- Integrity
- Objectivity
- Doing the "right thing" – for the System.

Unplanned Care £131.9m (Cost reduction incentive)	**Scheduled Care £145.3m (Lower Activity incentive)**
Principle- Level of payment guaranteed. In the event of activity above plan the System will take joint responsibility and develop action plans.	**Principle-** Level of payment guaranteed. Opportunities exist for demand management, to streamline & modernise pathways and to introduce health optimisation programmes, including education and prevention packages.
PODs & Services • A&E • ACU/PASSU • Critical Care • Non-Elective	**PODs & Services** • Elective IP/Daycase • All O/P PODs • Diagnostic Imaging

There will be a jointly agreed clinically – led programme to transform pathways of care. Risk will be shared and where appropriate transitional funding will be agreed to support pathway changes, based on transparent **costs** which are shared and mutually agreed. ED trajectory to be agreed between parties, delivering improvement in line with constitutional standard.	• Direct Access • Wet AMD (growth included) Where clinically appropriate and economically beneficial, services could transfer or reduce in a planned way, with transitional arrangements to support any stranded fixed costs. In the event of activity and/or demand above plan the System will take joint responsibility and develop action plans within agreed cost envelopes. RTT trajectory to be agreed between parties, delivering improvement in line with constitutional standards.
Pass-Through £12.7m **Principle-** Opportunities for cost reduction and innovative procurement. **PODs & Services** • PBR excluded Drugs & Devices • CPAP If costs reduce then the Trust will retain any benefit for an agreed period. In the event of cost / demand above plan the System will take joint responsibility and develop action plans within agreed cost envelopes. This is intended to put rewards into the system for reducing costs in this area.	**Fixed Income £22.1m** **Principle**– Services where activity and costs are relatively controllable or non-volatile and can be prioritised within available resources. **PODs & Services** • Historical “Block” services • Readmissions/MRET • Best Practice Tariffs • Audiology • Maternity Pathway • CQUIN The payment level is fixed for the year. A programme to undertake a review of services in –year to assess effectiveness and whether contract type is appropriate in the longer term.

System Based Working
From an affordability perspective it is acknowledged that funding the contract at this value requires the release of savings from other CCG expenditure lines totalling a minimum of £5m. The System will jointly develop and agree a programme to deliver these savings. Any shortfall will be split equally between parties.

There will a single monitoring system, provided by HEY, with jointly agreed key performance indicators linked to service improvement, and improved patient outcomes. In the spirit of the AIC, the Trust will review all transactional KPIs and update where agreed with all Commissioners.

Information leads will agree schedules and flows to enable system wide understanding of patient activity, cost drivers and other health system dynamics. The focus will be on working together to understand the health system and data quality in relation to counting and coding.

Single source monitoring will release transactional costs which will be redirected to support the transformational efforts in the system.

New ways of working across the System will be explored with CCG and Trust Staff, with a view to reconfiguring informatics, finance, commissioning and contracting.

Jointly owned QIPP & CIP governance programmes will be introduced to drive through savings and to deliver the £5m minimum affordability gap which exist on the contract. Any shortfall on the CIP programme will be split equally between parties

Jointly agreed constitutional standard trajectories will be developed before the end of March.

Scheduled Care
There are two specific areas of focus for scheduled care:

1. An agreed action plan will be developed on referral management which will look to keep referrals and waiting times/numbers at 2016/17 levels as a maximum. This work will be clinically led and data targeted. In the event that activity/demand is not reducing in line with expectations, the system will work to understand the cause. If this growth is due to GP referrals or other factors not relating to activity shift, this will be discussed at the Planned care group to discuss options available. This may include the introduction of referral support schemes, pathway changes, or the funding of additional activity based on actual costs incurred. Joint governance will be developed to ensure the capacity and capability to remove activity where it is clinically & economically appropriate to do so.

2. Working together the System needs to develop a plan to reduce the flow of planned care into the private sector within the patch. The System will need to be able quantify the shift and its impact on the RTT position in particular. Actions would then need to be discussed and agreed to ensure that the system manages this patient cohort economically, and in line with constitutional expectations.

Unplanned Care
An agreed transformation plan relating to the totality of the non-elective pathway will be developed through the Unplanned Care Board, with oversight from the ED Delivery Board. This is expected to cover pre-hospital, in hospital, and the post hospital elements of the pathway. The ultimate aim of this plan will be to reduce, as far as possible, the volume of non-elective admissions to the Hospital. Activity rising above expected levels and resulting in

additional cost over 16/17 forecast outturn levels will be managed by the System working jointly on operational solutions to control the risk. Joint governance will be developed to ensure capacity and capability to remove activity where clinically & economically appropriate.

Activity Shifts
The System will monitor shifts in activity flows into the Trust and other providers. Where these have changed due to Commissioning decisions, patient choice, or other material factors, the Chief Finance Officers will agree a financial adjustment to be made to reflect the change in cost. Plans to shift activity out of the Trust will be discussed in advance, with implementation and risks considered. An appropriate adjustment will be made to reflect any changes in cost.

Penalties
Penalties triggered due to performance issues will be quantified and agreed and system level actions agreed. The minimum income guarantee will not be affected.

CQUIN
Approved CQUIN schemes will operate during the year. Where schemes are not succeeding, the underlying reasons will be ascertained and reported to the Quality Board. The minimum income guarantee will not be affected by any CQUIN under-performance.

Governance
Governance of the System will be undertaken by revisiting existing structures, such as the Planned and Unplanned Care groups, and by maintaining the work currently being done by the existing Quality Board. The current Contract Management Board will be reconfigured to provide a technical forum where all monitoring can be shared and where system wide issues such as the role out of Electronic Referral System (ERS) or Directory of Service (DOS) issues can be coordinated. A Chief Executive sponsored Executive Group will maintain monthly oversight of the AIC. This revised Governance structure will be in place by the end of March 2017

Signed on behalf of Hull and East Yorkshire Hospitals NHS Trust

Signed on behalf of Hull CCG

Signed on behalf of East Riding CCG

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD REPORTING FRAMEWORK

Trust Board date	7 March 2017	**Reference Number**	2017 – 3 – 15
Director	Carla Ramsay – Director of Corporate Affairs	**Author**	Rebecca Thompson - Assistant Trust Secretary
Reason for the report	The purpose of the report is for the Board to review the schedule of work for 2017/18.		

Type of report	Concept paper		Strategic options		Business case	
	Performance		Information		Review	✓

1	**RECOMMENDATIONS** The Board is requested to review and agree the schedule of work set out for 2017/18.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					✓
	Valued, skilled and sufficient staff					
	High quality care					
	Great local services					
	Great specialist services					
	Partnership and integrated services					
	Financial sustainability					
4	**LINKED TO:**					
	CQC Regulation(s): W1 – Clear vision and credible strategy to deliver good quality.					
	Assurance Framework Ref:	**Raises Equalities Issues?** N	**Legal advice taken?** N	**Raises sustainability issues?** N		
5	**BOARD/BOARD COMMITTEE REVIEW** This report to be received on an annual basis to the Board.					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

BOARD REPORTING FRAMEWORK

1. PURPOSE OF THE REPORT

The purpose of the report is to present the Board Reporting Framework for 2017/18 to the Board for approval.

Board members are asked to reassess the reports they receive to ensure that they are being given the right type of information to steer the organisation towards its key objectives.

2. AREAS OF FOCUS

The framework (attached at Appendix 1) sets out a number of areas the Board should focus its attention, which are, strategy, quality, regulatory and corporate. Within these areas are the suggested items to be reported and the date of the Board meeting the items are expected.

3. FRAMEWORK PREPARATION

The list of items have been prepared from previous Board meeting agenda items, regulatory requirements and any new items required since the framework was last presented. The Board is asked to consider if any other items should be added or if any items should be removed or updated.

4. RECOMMENDATION

The Board is asked to review and agree the schedule of work for 2017/18.

Rebecca Thompson
Assistant Trust Secretary

February 2017

Trust Board Annual Cycle of Business 2017														2018		
Focus	**Item**	**Frequency**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Strategy	Operating Framework	annual								x						
	Operating plan	bi annual				x							x			
	5 year business plan	annual						x								
	Financial plan	annual				x										
	Capital Plan	annual				x										
	Performance agst operating plan	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Winter plan	annual							x							
	IM&T Strategy & progress	annual								x						
	Nursing strategy	annual										x				
	Trust Strategy Implementation Update	annual				x										
	People strategy inc OD	annual									x					
	Estates strategy	annual														x
	R&D strategy	annual			x											
	Quality Strategy	annual				x										
	Risk strategy (SOs)	annual					x									
Quality	Patient story	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Quality performance (CPR)	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Nurse staffing	monthly	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Fundamental Standards (Nursing)	quarterly		x			x			x			x			x
	Quality Accounts	bi-annual					x					x				
	National Patient survey	annual														x
	Other patient surveys	annual				x										
	National Staff survey	annual			x											
	CQC progress	quaterly	x			x				x				x		
	Infection control annual report	annual								x						
	Safeguarding annual report	annual							x							
Regulatory	Annual accounts	annual					x									
	Annual report	annual					x									
	Responsible Officer Report	annual								x						
	Guardian of Safe Working Report	quarterly		x			x			x			x			x
	Audit letter	annual					x									
	Mortality	quarterly				x				x				x		
	Race Equality	bi annual				x					x					
	Modern Slavery	annual					x									
	Emergency Preparedness TBC	annual					x									
	H&S Annual report	annual							x							
Corporate	Chairman's report	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Chief Executive's report	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Board Committee reports	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Well-Led Self Assessment	annual					x									
	Standing Orders	each meeting	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Board cycle of business	annual			x											
	Board calendar of meetings	annual									x					
	Board Assurance Framework	quarterly	x			x			x		x			x		
	Review of directors' interests	annual				x										
	Pay Gap	quarterly				x			x			x			x	
	Fit and Proper person	annual					x									
	Anti-Bullying	quarterly			x				x				x			
	Freedom to Speak up Report	quarterly				x				x				x		
	Going concern review	annual					x									
	Review of Board & Committee effectiveness	annual						x								

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE

Meeting Date:	30 January 2017	**Chair:**	Mr S Hall	**Quorate (Y/N)**	Y

Key issues discussed:

- Financial plan – Control total sign off
- Winter plan delivery – Progress report, planning for 2017/18
- Performance – Emergency Department, Referral to treatment times
- Outpatient Recovery Plan – Plan and timescales discussed.
- Finance – CRES shortfall, agency spend controls, Patient Admin Plan
- HEY Improvement Plan – Updated position
- Capital Resource Allocation Committee update – GS1 inventory control system updated

Decisions made by the Committee:

- To receive further update from HIP team with a particular focus on consolidation and validation of benefits
- Paper to be presented to provide details of the Regional position on agency spend
- Wait for first clinician - an update on the Plan-Do-Study-Act (PDSA) cycles relating to service improvements
- Committee to receive updates on the level of outpatients reviews due to Clinical Research

Matters escalated to the Board for action:

- Reinforcement of level of rigour to be applied to improve end of year position

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
PERFORMANCE & FINANCE COMMITTEE
HELD ON MONDAY 30 JANUARY 2017
THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr S Hall (Chair)	Non-Executive Director
	Mrs E Ryabov	Chief Operating Officer
	Mr M Gore	Non-Executive Director
	Mr L Bond	Chief Financial Officer
	Mr S Nearney	Director of Workforce & OD
IN ATTENDANCE:	Mrs V Walker	Non Executive Director
	Ms C Ramsay	Director of Corporate Affairs
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

No Item **Action**

1. APOLOGIES FOR ABSENCE

Apologies were received for Mrs T Christmas, Non Executive Director.

2. MINUTES OF THE MEETING HELD ON 19 DECEMBER 2016

The minutes were approved as an accurate record of the meeting held 19 December 2016.

3. ACTION TRACKING LIST

The Committee received the action tracker.

4. WORKPLAN 2016/17

Mr Hall stated that due to operational commitments, attendance by the Health Groups was out of line with the workplan. Family and Women's Health Group would attend in February 2017 for their performance update.

5. MATTERS ARISING

There were no matters arising.

6. FINANCIAL PLAN 2017/18 UPDATE

Mr Bond updated the Committee and advised that Hull and East Riding CCGs were drafting heads of terms in readiness to sign off the contracts. Mr Bond also reported that meetings with the Health Groups to discuss their new CRES plans were in place.

There had been no response from NHS Improvement regarding the Control Total but Mr Bond was expecting communication week commencing 30 January 2017. He advised that 2/3 of Trusts had now signed up to their Control Totals.

Resolved:

The Committee received the update and would receive further information when available.

7. DELIVERY OF WINTER PLAN

Mrs Ryabov reported that the winter plan had been sufficiently robust. Next year's plan was being discussed as part of financial planning as was the learning from concerns raised and subsequent actions put into place. Mrs Ryabov also reported that a plan for the Easter break was being

progressed. A changed configuration of the assessment model was being developed which would not rely on the bed base and would take into account diagnostic issues.

Mr Bond reported that a new MRI scanner had been purchased but this was a replacement for an old scanner and not an additional one.

Resolved:
The Committee received the update and Mr Gore expressed his thanks to the teams involved in delivering the winter plan.

8. PERFORMANCE REPORT

Mrs Ryabov presented the report and highlighted that A&E performance had improved in December 2016 (87.3%). She advised that from Boxing day onwards performance had dipped again. Mrs Ryabov reported that audits had been carried out on 6 days of admissions from the Emergency Department and that the admissions were appropriate.

Referral to Treatment times performance had plateaued and the waiting list had increased slightly. There was a recruitment campaign to recruit theatre nurses and ODPs and work was ongoing to establish mixed skilled roles.

There had been 5 x 52 week wait patients and these were due to incorrect pauses in pathways of care.

Mr Gore asked why day case income was not in line with the budget and Mr Bond advised that the day case plans had been overstated initially.

Resolved:
The Committee received the report and noted the Trust's performance in month 9.

9. OUTPATIENT RECOVERY

Mrs Ryabov gave the presentation which highlighted the national issue of the volume and length of waiting lists and the recovery plans in place to address the backlogs.

The Ophthalmology outpatient list was the largest due to the size of the service. The main issue was the impact of the NICE approved Lucentis injections required by patients.

Mrs Ryabov reported that the key risks were clinical harm due to patients waiting for treatment, rising demand creating bigger lists and limited independent providers. Consultants wanted to work longer hours to clear the backlogs but could not due to contractual arrangements. Diagnostic capacity issues were also slowing down the processes. A better service provision in the Community was required and was not helped by the shortage of GPs with specialist interests. Work was being done with the Commissioners but no investment on their part was being made.

Mrs Ryabov spoke about the internal governance structures in place and how the recovery plan was being monitored through the Executive Management Committee and the Performance and Activity meeting.

The key objectives in place were to manage the clinical risks, eliminate

timescales and have no follow up appointments that had been waiting over 12 months by the end of March 2018. Each specialty had a phased recovery programme.

Resolved:
The Committee received the presentation.

10. CORPORATE FINANCE REPORT

Mr Bond presented the Executive summary to the Committee and highlighted the continuing deterioration of the financial plan. Mr Gore asked what plans were in place to address the issues and whether the organisation was still viable. Mr Bond assured him that there were other Trusts that were worse off but that he was concerned about the last 3 months of the year and the potential loss of the STF money if the Trust missed its financial year end target.

Mr Gore stated that Health Group support was required (specifically the Surgery Health Group) and would it be sensible to appoint a Financial Director to help with the last 3 months. Mr Bond agreed that financial support was required and that he was already putting measures in place to address this.

Mr Hall expressed his concern regarding the financial situation and suggested more rigorous controls being put onto agency expenditure. Mr Nearney reported that a number of controls were in place including a cap of £120/hr and this required sign off from the Chief Executive. Mrs Ryabov added that waiting list initiatives had been stopped in order to save money.

There was a discussion around bulk buying of supplies and how the Trust approached purchasing of equipment and materials and Mr Bond assured Mr Hall that the Supplies Department were working to ensure the best value for money was achieved.

Resolved:
The Committee received the report and Mr Bond agreed to share the cash flow forecast with the Non Executive Directors and the upcoming Audit Committee.

10.1 – CRES 2016/17

Mr Bond presented the report which highlighted that the Trust had achieved a CRES of £10.1m at month 9. This was £3.6m short of plan.

The Health Groups were forecasting a year end CRES shortfall of £4.7m.

Mr Hall asked about bedwatch security and whether this could be reviewed and Mrs Ryabov advised that security was needed for patients (especially violent patients), but work was ongoing to review how security was managed on the wards.

Resolved:
The Committee received the report and noted the Trust's position at month 9.

10.2 – AGENCY REPORT (FINANCE)

Mr Nearney presented the paper and reported that at month 9 the Trust was

overspent by £2.3m on agency costs. He advised that a number of plans were in place to address the issues such as a stop on all admin agency spend, no agency staff employed with contracts above £120/hr and a reduction in RMO doctors. Work was ongoing to reduce agency spend further. Mr Gore asked for clarity around the £90k patient admin in district records and Mr Nearney agreed to check this and report back to the Committee.

Resolved:
The Committee received the report. Mr Nearney to check the item relating to patient admin in district records. **SN**

10.3 – PATIENT ADMIN RECOVERY
Mr Bond presented the report to the Committee. He reported that the Health Groups were reviewing patient admin and outpatient services and looking for an overarching approach. He advised that he would bring back a further report when available.

Resolved:
The Committee received the update and noted the progress made to date.

10.4 – HEY IMPROVEMENT PLAN – UPDATE
Mrs Joyce attended the Committee to give an update regarding the improvement work being carried out by the team. She reported that additional income activity of £224k for outpatients had been achieved and that the improvement work in theatres would equate to £1.5m recurrently.

Mr Bond expressed his concern that the number of outpatient cancellations had not reduced and asked why no progress had been made. Mrs Joyce advised that the project had been paused due to other teams in the Trust working in this area to avoid duplication of work. Mr Gore added that the Trust had twice the national average of outpatient cancellations.

Mr Hall asked about the theatre project and how the benefits would be validated. Mrs Joyce advised that she had recruited project managers to work with the theatres to ensure maximum efficiency and productivity. A report would be brought back to the Committee at year end with validated benefits to the Trust.

Resolved:
The Committee received the report and agreed to put a follow up report on the tracker for a review of the projects at year end.

11. CAPITAL RESOURCE ALLOCATION COMMITTEE
Mr Bond reported that the business case for implementation of the GS1 inventory management system had been approved and would be introduced in theatres and then rolled out to other areas. Mr Bond advised that savings would be made but patient safety and quality of care would be prioritised.

Mr Bond also reported that the capital programme spend programme was on track to meet its year end target.

12. ITEMS DELEGATED BY THE BOARD
12.1 – BOARD ASSURANCE FRAMEWORK
The Board Assurance Framework had been discussed at the Board meeting

in January 2017. The Board had agreed the changes proposed and the Committee had nothing further to add.

13. ANY OTHER BUSINESS

There was no other business discussed.

14. DATE AND TIME OF THE NEXT MEETING:

Monday 27 February 2017, 2pm – 5pm, The Committee Room, Hull Royal Infirmary

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

PERFORMANCE & FINANCE COMMITTEE

Meeting Date:	27 February 2017	**Chair:**	Mr S Hall	**Quorate (Y/N)**	Y

Key issues discussed:

- Financial Plan 2017/18 – new contract offer from local commissioners, impact on CRES requirements and deficit position
- Processes in train to review budgets and expenditure for 2017-18
- Capital plan headlines for 2017-18
- Process to agree control total for 2017-18
- Performance and Finance Committee Work Plan for 2017-18 and new proposal on Health Group attendance on performance issues/as point of escalation – principles to be worked up in more detail
- New proposal for a Joint Working Agreement
- Review of month 10 financial position, including CRES achievement
- Verbal update on patient level costing work in progress

Decisions made by the Committee:

- Agreement to the principle of a new Joint Working Agreement with an existing supplier
- Shared understanding of contract offer and outline financial plan work for 2017-18

Matters escalated to the Board for action:

- No points of escalation – following review by Performance and Finance Committee, the Trust Board will be briefed on the contract offer for 17-18 and outline financial plan work

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Meeting Date:	7 February 2017	**Chair:**	Mr A Snowden	**Quorate (Y/N)**	Y

Key issues discussed:

- Receipt and review of the Financial Report– detailing income, expenditure and investment details which provided the relevant level of information and assurance
- The progress being made on various fundraising activities and charitably funded projects in which the Trust is involved or associated

Decisions made by the Committee:

- The Committee agreed to withdraw the Administration Charge paper from the agenda and receive an updated paper at the next meeting
- Formally agreed funding sources for the hospital radio station and Mental Health and Disability Study Day
- approved a funding request for training

Key Information Points to the Board:

- Nothing to escalate, key issues discussed captured above

Matters escalated to the Board for action:

- Nothing to escalate, key issues discussed captured above

DRAFT

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

HELD ON TUESDAY 07 FEBRUARY 2017
THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr A Snowden (Chair), Vice Chair, Non Executive Director Mr L Bond, Chief Financial Officer Mrs V Walker, Non Executive Director
IN ATTENDANCE:	Ms C Ramsay, Director of Corporate Affairs Mrs L Roberts, Corporate Affairs Administrator (Minutes)

ACTION

1 APOLOGIES FOR ABSENCE

Apologies were received from Mrs D Roberts, Deputy Director of Finance and Mr D Haire, Project Director – Fundraising.

The Committee expressed their condolences to Mr Haire on his recent loss.

2 DECLARATIONS OF INTEREST

There were no declarations made.

3 MINUTES OF THE MEETING 17 NOVEMBER 2016

The minutes were approved as an accurate record of the meeting.

4 MATTERS ARISING

Minute 9 – Financial Report as at 30 September 2016

Mr Bond advised the Committee that Mrs D Roberts had clarified and amended the figures in appendix C, Top 5 – Income and Expenditure Transaction table in the Financial Report presented at the last meeting. A revised appendix was tabled for review by the Committee. Mr Bond gave an explanation of the differences in the figures and the Committee agreed to accept the revisions.

Resolved:

The Committee received the table and accepted the revisions.

5 ACTION TRACKER

Mr Bond advised the Committee that the final costings for the Midwifery Led Unit had been received by the Trust. He would clarify the exact figures and inform the Committee in due course. **LB**

It was agreed that the action from June 2016 in relation to the e-Obs system could be removed from the tracker as some funds had been identified and work was ongoing. **LR**

The Committee noted the actions that were due in the action tracker and agreed that the items marked completed could be removed.

Resolved

The Committee:

- would receive the final costings of the Midwifery Led Unit **LB**
- agreed to remove the e-Obs system item from the action tracker **LR**

DRAFT

6 WORK PLAN 2016/17

The Committee noted the workplan.

Mr Snowden enquired if the Charitable Funds Policies and Procedures were now in place. Mrs L Roberts advised that this action was an agenda item for the next Committee in May 2017. **LR**

7 PROJECT DIRECTOR'S REPORT

Mr Bond presented the report and the Committee noted its contents.

Hull & East Yorkshire Hospitals Health Charity

The Committee agreed that Mrs Lockwood, Chair of the Working Independently to Support HEY Hospitals (WISHH) charity should be invited to attend the next Committee meeting. **LR/DH**

Creating a Dementia Friendly Environment – Wards 8 and 80

Mrs Walker enquired if the dementia friendly reception area to Wards 8 and 80 was now fully functioning. Ms Ramsay advised the Committee that the reception was now staffed and operational. It was agreed that Ward 80 would be asked what use the staff are making of the ward facility that had received charitable funds. **CR**

Proposed Paediatric Development

The Committee were informed that the proposal for paediatric development had been referred back to the Health Group for reconsideration.

Midwifery Led (Self Care) Unit

The Midwifery Led (Self Care) Unit had been discussed under item 5 – Action Tracker of this agenda.

Other Projects

Mr Haire is currently liaising with the Osprey charity regarding its ongoing support to the Osteoporosis Service.

Resolved:

The Committee:

- received the report and noted its contents
- agreed that the Chair of the WISHH charity would be invited to attend the next Charitable Funds Committee meeting **LR/DH**
- would receive further information regarding usage of facilities on Ward 80 **CR**

8 FINANCIAL REPORT AS AT 30 NOVEMBER 2016

Mr Bond presented the report which set out the income, expenditure and investment details of the Trust's Charitable Funds as at 30 November 2016.

The Committee was informed that the Charitable Funds currently held £1.6m in net assets as at 30 November 2016.

Mr Haire continues his work with the Health Groups to manage funds and encourage the merger of funds containing smaller amounts of cash into one larger fund.

There was a discussion around how the current funds were held and the processes in place to spend them. Mr Bond advised that the funds were held appropriately and the correct processes followed.

DRAFT

Mr Snowden commented that the work been done to improve the transaction description column was an improvement in the table of appendix D Expenditure Transactions greater than £100. The Committee also debated the value of understanding such a level of detail on expenditure.

Resolved:
The Committee received the report and noted its contents.

9 FUND BALANCES AND SPENDING PLANS

Mr Bond presented the paper which detailed the Health Groups fund balances, identified any slow moving funds and gave assurance that funds have spending plans in place or are being prompted by Mr Haire to complete spending plans.

A discussion was held in relation to Appendix D of the report, Health Group Spending Plans – Balances over £20,000. This appendix showed that the majority of funds already had spending plans in place and how the funds were allocated. Mr Snowden stated that it would be useful if the comments section of the appendix could be expanded upon to include dates of expected outcomes and a flow of activity for the fund. Mr Bond advised that once the appendix had been advanced it would be transferred over to the Project Director's Report in this Committee.

Mr Bond advised that Mr Haire had been working with the Health Groups in relation to their spending plans. The Clinical Support Health Group had merged some of the smaller funds and work was ongoing with two other health groups. A report was expected to be presented at the next Committee meeting detailing the outcome of the discussions with the Health Groups. **DH**

Resolved:
The Committee:

- noted the contents of the report
- agreed to receive a paper on the Health Group discussions **DH**

11 ADMINISTRATION CHARGE

The paper was presented to the Committee by Mr Bond.

Further information was sought regarding the increased administration charge for 2016/17. Mr Bond agreed to bring the paper back to the next meeting containing additional information regarding the increased costs. **LB/DR**

Following discussion it was agreed by the Committee to withdraw this item from the agenda.

Resolved:
The Committee agreed to withdraw this item from the agenda and receive an updated paper at the next meeting. **LB/DR**

12 FUNDING APPROVALS AND REQUESTS

The content of the Funding Approvals and Requests paper was discussed by the Committee.

The funding sources for the hospital radio station and Mental Health and Disability Study Day which had been previously approved were formally agreed following confirmation of allocation of funds.

DRAFT

The Committee approved the funding request for a Tissue Viability Nurse to attend Expert Witness Training in conjunction with her role.

Mr Snowden advised that at the last Trust Board meeting an action had been delegated to the Charitable Funds Committee. The Organ Donation Team had expressed an interest in presenting a memorial to the Trust. Following discussion it was agreed that Ms Ramsay would seek guidance from the memorials policy and liaise with the Organ Donation Team. **CR**

Resolved:
The Committee:

- noted the contents of the report
- formally agreed funding sources for the hospital radio station and Mental Health and Disability Study Day
- approved the funding request for training
- agreed for Ms Ramsay to liaise with the Organ Donation Team **CR**

13 CHAIR'S SUMMARY OF THE MEETING
Mr Snowden summarised the meeting.

14 ANY OTHER BUSINESS
There was no other business discussed.

15 *DATE AND TIME OF THE NEXT MEETING:*
Tuesday 16 May 2017, 3:30pm – 5:00pm, The Committee Room, Hull Royal Infirmary.

DRAFT

DRAFT

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE

Meeting Date:	27 February 2017	**Chair:**	Prof T Sheldon	**Quorate (Y/N)**	Y

Key issues discussed:

- Discussion around producing a single document incorporating the Quality Accounts and the Annual Report. External audit to confirm the statutory requirements.
- An update was received regarding the CQC Report. The ratings and action plan for improvement was discussed. The overall aim is to gain feedback at the Quality Summit on 17 March 2017 to understand the key measures that will move the Trust in to 'good' overall
- Mortality case reviews presented. The Quality Committee received a briefing on the new case note review process, initial findings from the first month of reviews and next steps.
- Documentation and patient records to be reviewed as a theme at a future meeting.
- Emergency readmissions – Mr Phillips to prepare a report to be presented after the audit and clinical review had been carried out.
- The Quality Strategy was presented as part of the Trust Strategy. This would be reviewed in more detail at the next Board Development day.
- Board Assurance Framework – Quality risks to be discussed in detail at the next meeting.
- WHO Checklist – Work was ongoing to change perceptions of the checklist. PDSA cycles carried out with theatre teams.

Decisions made by the Committee:

- A report to be received regarding record keeping and documentation – this would include any impact on quality due to poor record keeping and what was being done to address the issues
- Quality Strategy and overall approach to improvement to be discussed at the next Board Development Day
- Delays in diagnostics and patient flow issues impacting on Quality to be discussed at a Board Development Day or future meeting

Matters escalated to the Board for action:

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

QUALITY COMMITTEE MINUTES
HELD ON MONDAY 27 FEBRUARY 2017
IN THE COMMITTEE ROOM, HULL ROYAL INFIRMARY

PRESENT:	Prof. T Sheldon (Chair)	Non Executive Director
	Mr A Snowden	Vice Chair/Non Executive Director
	Mrs V Walker	Non Executive Director
	Mrs J Ledger	Deputy Chief Nurse (For Chief Nurse)
	Mr K Phillips	Chief Medical Officer
	Ms C Ramsay	Director of Corporate Affairs
IN ATTENDANCE:	Mrs S Bates	Interim Deputy Director of Quality, Governance and Assurance
	Dr M Purva	Deputy Chief Medical Officer
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

1. APOLOGIES **ACTION**

Apologies were received from Mr M Wright, Chief Nurse and Mrs A Green, Lead Clinical Research Therapist

2. MINUTES OF THE MEETING OF 30 JANUARY 2017

Mr Phillips confirmed the correct spelling of the word 'fetus'. With this correction, the minutes were approved as an accurate record of the meeting.

3. ACTION TRACKING LIST/WORKPLAN

The Chaperone Policy – Mr Phillips confirmed that there was a policy in place, it had been reviewed and would be presented to the Operational Quality Committee in March 2017. Approval of the policy would be reported to the Quality Committee.

3.1 – QUALITY ACCOUNTS

Mrs Bates advised that the Quality Accounts were being prepared for 2017/18 and would be merged where possible with the Annual Report, but would meet all of the Quality Account statutory requirements. The Quality Accounts would be presented to the Board in May 2017.

4. MATTERS ARISING

Quality Impact of CRES – Ms Ramsay suggested that an update on the high-risk CRES schemes or any schemes with significant risks to quality or safety be received by this Committee in June 2017, following formulation and assessment of the CRES plan. Mr Snowden asked if the Trust should approach CRES differently by looking at quality improvement schemes (with efficiency driven savings) rather than just financial saving schemes. **MW**

Medicines Administration – The Committee confirmed that there are two separate actions – one on medications linked with discharge delays and a separate action on understanding missed medications. It was confirmed that David Corral will bring back a report on the latter. The first action on discharge delays and medications will require further review. **DC MW/KP**

Major Trauma Report – Mr Phillips advised that the report was now available and would be presented to the Operational Quality Committee and

then the Quality Committee for assurance. **KP**

e-Observations – Mrs Ledger advised that a number of new devices had been bought due to some charitable funds and this meant that the e-Obs would be rolled out across a number of wards per the e-Obs plan. Due to the WiFi strength the NEWs scores could be calculated but would not be escalated. Mrs Walker expressed her concern regarding the escalation process and how the doctors acted upon any deterioration of patients. Dr Purva added that a cultural change was vital to maximise detection, escalation and management of patients.

4.1 – CQC UPDATE

Mr Phillips reported that the final CQC Report had been received and the overall score for the Trust was 'Requires Improvement'.

There was a discussion around nurse and medic staffing and the recruitment programmes in place, as staffing is one of the key themes of the report. Mr Snowden asked where the assurance that the actions in place were being delivered and achieved against this CQC report. Mrs Bates advised that an updated Quality Improvement Programme (QIP) would incorporate all of the actions. Mr Snowden asked if a summary of the key challenges relating to the CQC report and how these are mapped to the updated Quality Improvement Plan could be shared with the Non Executive Directors and Mrs Bates agreed to prepare this. Mrs Bates shared that the approach to the updated Quality Improvement Programme will learn from the current process around the QIP, in that some of the actions planned would not achieve the overall desired outcome and that there are human factors and cultural issues to take into account when planning in detail. In response to questions on governance, Ms Ramsay advised that the updated QIP should be signed off and monitored for achievement and assurance by the Quality Committee and be 'owned' by the Trust Board. **SB**

The CQC would be holding a Quality Summit on 17 March 2017 and this will include a number of external stakeholders and NHS Improvement as the chair. A presentation would be given by the Trust as well as the CQC presenting their findings and recommendations.

Resolved:

The Committee received the update and summary of the key issues to be shared with the Non Executive Directors.

5. TRUST STRATEGIC GOAL – MORTALITY REDUCTION

5.1 – EMERGENCY READMISSIONS

Mr Phillips presented the item and advised that the audit that had recently been undertaken was against contractual measures and did provide the results that an internal review would require. He has requested an updated audit, facilitated by the clinical audit team with clinicians reviewing the data, and will bring this back in May 2017. Mrs Walker stated that it would be useful to have some feedback from patients and what they experienced; Mr Snowden observed that social factors and patient experience may have an impact on the reasons for re-admission. Mr Phillips confirmed that the audit he has requested will be looking at the clinical reasons for re-admission and whether there are specific services with a higher readmission rates. **KP**

Dr Purva stated that the methodology used was important and may identify discharge information and social issues as part of understanding the clinical reasons for readmissions.

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Resolved:
The Committee received the update and agreed to receive a further report once the audit had been completed.

5.2 – THEMES AND TRENDS REPORT – STRUCTURED JUDGEMENT MORTALITY REVIEWS

Mr Phillips gave the presentation which detailed the number of structured case note reviews of patient deaths (57) that had been carried out so far. The reviews included pre-hospital reviews to establish any underlying issues. Prof. Sheldon asked how cases were chosen for review and Mr Phillips advised that, as a starting point for implementing this new tool and review process, all surgical deaths will be reviewed and a selection of high volume medical specialities where the evidence suggests that reviewing all deaths is not worthwhile, but a selection to understand common learning points. Mrs Bates confirmed that all selected deaths undergo a Tier 1 review and those triggering a particular score go on to a more detailed Tier 2 review. This may include consideration as being logged as a serious incident, depending on the details of the case. Mrs Bates agreed to circulate the criteria that determine when a serious incident is declared. **SB**

Mr Phillips reported that the Trust has been reporting itself as an outlier on avoidable deaths, but has checked the reporting threshold and has undertaken benchmarking exercises with other Trusts and confirmed that this Trust is not an outlier. The Trust had reported that 7.2% of deaths had an element of being avoidable but analysis of these deaths were carried out to avoid recurrence. There was a discussion around normal deaths and Mrs Walker stated that sometimes the care system intervened too much and end of life care was much less invasive in some cases.

Mr Snowden was encouraged by the new case note review system as it was shown in real time, harm could be reviewed appropriately and would be more relevant than the Summary Hospital-level Mortality Indicator data which was 6-12 months behind.

There was a discussion around documentation and record keeping and Dr Purva stated that staff use documentation to protect themselves and it would be more advantageous to have paperwork to compliment clinical care. Mrs Walker expressed her concern regarding the transitional paperwork and the lack of coordinated decision making. Prof. Sheldon suggested that documentation be discussed at a future meeting.

Resolved
The Committee received the update and agreed:

- Mrs Bates to circulate SI criteria **SB**
- Documentation review to be discussed at a future meeting **SB**

6. ITEMS DELEGATED FROM THE BOARD:
QUALITY STRATEGY

Ms Ramsay presented the section of the Trust Strategy that related to the Quality Strategy. There were 5 key goals which were linked to the Trust's long term objectives. A strategy and plan would be developed to sit underneath the 5 key goals incorporating the ward to board model and how improvements were recorded, monitored and outcomes achieved. A Health Foundation Tool reviewing key questions would be used to ensure action plans were on track. The tool to be circulated to all members of the Committee.

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Ms Ramsay suggested that the Quality Strategy should be discussed at the next Board Development day and welcomed input from the Non Executive Directors.

Mrs Walker stated that she liked the principles being proposed and requested that alignment with patient journeys should be included.

Resolved:
The Committee received the update and agreed to have the Quality Strategy on the next Board Development day agenda.

7. RECEIVED FOR ASSURANCE

7.1 – BOARD ASSURANCE FRAMEWORK QTR 3

Ms Ramsay presented the report and highlighted the high risks relating to quality which included learning lessons and workforce. She advised that the Q4 BAF would be presented to the Board in April 2017 for review.

Resolved:
The Committee received the BAF and noted the risks relating to quality.

7.2 – QUALITY IMPROVEMENT PROGRAMME

Mrs Bates presented the Quality Improvement Programme. There was discussion around children with mental health issues, pressure ulcer nurse training and VTE. The quality of health records and the processes was raised as a concern and it was agreed that this would become an agenda item to be discussed in more detail at a future meeting. Mrs Walker requested that the report be more outcome focussed when incorporating the CQC actions into it.

7.3 – INTEGRATED PERFORMANCE REPORT

The Integrated Performance Report was received and it was agreed that delayed diagnostics and patient flow would be discussed in more depth at a Board Development Day.

7.4 – OPERATIONAL QUALITY COMMITTEE REPORT

The Committee received the report and Mrs Walker expressed her concern regarding the item relating to catheterisation and staff having the correct level of training. Mrs Ledger advised that ward audits were to be carried out and any training identified.

7.5 – HEALTHCARE DELIVERY IMPROVEMENT GROUP

Dr Purva gave a verbal update regarding the WHO checklist and the work ongoing. A number of PDSA cycles had been carried out and fedback to frontline teams. This work had been rolled out to theatres and work was ongoing to change underlying concepts and attitudes towards the WHO checklist to make it more robust and followed appropriately.

8. ANY OTHER BUSINESS

There was no other business discussed.

9. CHAIRMAN'S SUMMARY TO THE BOARD

Prof. Sheldon agreed to summarise the meeting to the Board.

10. DATE AND TIME OF NEXT MEETING:

Monday 27 March 2017 – 9am – 11am, The Committee Room, Hull Royal Infirmary

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HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AUDIT COMMITTEE

Meeting Date:	7 February 2017	**Chair:**	Mr M Gore	**Quorate (Y/N)**	Y

Key issues discussed:

- Hull City Council mortuary debt – issues dealt with
- Performance & Finance minutes – discussion regarding the contract signing and control total negotiations
- Quality Committee minutes – e-Observations and the WiFi system renewal
- Technical update from KPMG
- Audit Plan received from KPMG – Risks highlighted.
- Internal Audit – completed audits and assurance ratings
- Bank and Agency costing audit – Trust response and actions in place
- Draft Internal Audit Plan
- Internal Audit follow up reviews – Governance team to check leads
- Effectiveness review of MiAA – External report received
- Information Governance Update – IG Toolkit progress
- CNST high level claims presented
- Effectiveness of Clinical Audit Report
- Board Assurance Framework risks reviewed
- Board Expenses received for Q1,2 and 3 2016/17
- Outstanding debt report received – Finance team managing debts

The Committee discussed the liquidity and solvency of the Trust and asked for confirmation on the plans in place should the Trust miss its control targets. Mr Bond assured the Committee that plans were in place and would provide a 'Going Concern' paper to the April 2017 Committee.

Decisions made by the Committee:

- Receipt and acceptance of all reports

Matters escalated to the Board for action:

None. The Board will receive an update on the Trust's financial position for 2016-17, which was subject to challenge and confirm at the Audit Committee in relation to solvency.

DRAFT

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AUDIT COMMITTEE MINUTES
HELD ON TUESDAY 7 FEBRUARY 2017
IN THE BOARDROOM, HULL ROYAL INFIRMARY

PRESENT:	Mr M Gore (Chair)	Non-Executive Director
	Mr S Hall	Non-Executive Director
	Mrs T Christmas	Non-Executive Director
IN ATTENDANCE:	Mr L Bond	Chief Financial Officer
	Mr J Prentice	KPMG
	Mr G Baines	MiAA
	Ms C Ramsay	Director of Corporate Affairs
	Mrs S Bates	Interim Deputy Director of Quality Governance and Assurance
	Mr S Nearney	Director of Workforce & OD (Item 7.5 only)
	Mrs R Thompson	Assistant Trust Secretary (Minutes)

Action

1. APOLOGIES
There were no apologies received.

2. DECLARATIONS OF INTEREST
There were no declarations of interest.

3. MINTES OF THE MEETING 15 DECEMBER 2016
The minutes of the meeting were approved as an accurate record of the meeting.

4. MATTERS ARISING/ACTION TRACKER/WORKPLAN
Mr Bond advised that the issues relating to the mortuary debt had come to a satisfactory conclusion with the Council.

Mr Prentice advised that he had contacted West Sussex Hospital Trust to arrange a meeting with him and Mr Bond to discuss financial initiatives. **JP**

Mr Gore and Ms Ramsay had arranged a meeting to discuss the committee effectiveness review. **MG/CR**

Tracker - Mr Bond advised that the accruals for legal fees had been reviewed and would reduce towards the end of the year.

Workplan – It was agreed that the Terms of Reference would be reviewed at the financial year end. **CR**

5. BOARD COMMITTEE MINUTES
5.1 – PERFORMANCE & FINANCE 19.12.17
Mr Bond was asked to update the Committee regarding the contract negotiations. He advised that discussions with the Commissioners were ongoing and there were still areas of disagreement but would report back to the Committee once agreed.

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5.2 – QUALITY 15.12.16
The Committee discussed e-Observations and the Trust inadequate WiFi system and the level of outpatient cancellations compared to the national figures.

Mr Bond also suggested re-wording the minute relating to item 5.2 as the escalation process was not in place as stated. Mr Bond agreed to review the rewording of the minute.

Mrs Bates updated the Committee regarding the WHO checklist policy. The checklist was being standardised and the policy was being updated.

6. EXTERNAL AUDITORS

6.1 – TECHNICAL UPDATE
Mr Prentice presented the report and highlighted the HFMA improvement programmes and its work with Finance Directors to review efficiencies within the NHS.

There was a discussion around the CHKS checklist indicators and Mr Bond agreed to prepare a report for the next Performance & Finance Committee. **LB**

6.2 – EXTERNAL AUDIT PLAN 31 MARCH 2017
Mr Prentice explained that the process was unchanged for the audit plan and the risks highlighted were the financial position of the Trust and the valuation of land and buildings and any impairments raised as in the previous year's accounts. Mr Gore asked if the accounts would be available on time and Mr Bond assured him that East Lancashire Financial Services were preparing them and the year end process was in place and would be presented to the Board at the end of May 2017.

Resolved:
The Committee received the reports and noted the year end process for presenting the annual accounts was in place.

7. INTERNAL AUDITORS

7.1 – INTERNAL AUDIT PROGRESS REPORT
Mr Baines presented the report which highlighted that 4 audits had been closed since the last meeting. The quality spot check audits reviewing key areas such as VTE assessments and resuscitation trolley checks had received limited assurance.

There was a discussion around the systems in place and how the Trust ensures that staff were following procedures. Mrs Bates assured the Committee that monthly internal audits were also carried out. Mrs Christmas asked about accountability and how poor performance was managed. Mrs Bates advised that an escalation process was in place and that the Chief Nurse would review any repeated poor performance.

The other audits completed by MiAA (safeguarding, data quality and workforce planning) had received significant assurance.

Resolved:
The Committee received the report and noted the assurance ratings.

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7.2 – DRAFT INTERNAL AUDIT PLAN 2017/18
Mr Baines presented the draft plan and advised that a number of areas had been agreed for 2017/18. The areas included bank and agency costs, job planning, gifts and hospitality and the governance framework.

There was a discussion around executive buy in of the audits and improving communications and sign off procedures. Mr Bond agreed to raise the issues at the weekly executive meeting and coordinate any responses. Mr Bond also suggested that MiAA review the 2017/18 budget and cost improvement programmes after the first quarter of the new financial year. **GB**

The CQC report and actions was discussed and any issues would be highlighted to the Committee in due course.

Resolved:
The Committee received the report. A copy of the CQC report and action plan to be received when available. **CR**

7.3 – FOLLOW UP AUDIT ACTIONS
Mr Baines presented the report to the Committee. Mrs Bates reported that the piece of work to follow up audit actions was ongoing as there had been staff changes and a general lack of ownership. She advised that the 19 high risk areas would be managed through the Health Group governance meetings. Mr Gore was concerned regarding the IT issue in the Pathology Department and Mr Baines agreed to follow this up. It was agreed that Ms Ramsay, Mrs Bates and Mr Bond would review the follow up actions and make sure that the correct managers were responding to the issues raised.

Resolved:
The Committee received the report and:

- Agreed to review the IT issue in the Pathology Department **GB**
- Review the follow up report to ensure the correct staff were accountable and taking the actions forward. **CR/SB/LB**

7.4 – MiAA EXTERNAL EFFECTIVENESS REVIEW
Mr Baines presented the external effectiveness review which had been carried out by CIPFA in line with external public sector standards. No areas of non-compliance had been identified and Mr Baines confirmed that all minor actions had been dealt with.

Resolved:
The Committee received the report.

7.5 – BANK AND AGENCY COSTS
Mr Nearney joined the meeting to present the report which outlined the actions in place to address the recommendations from the bank and agency costs audit carried out by MiAA.

Mr Nearney advised that there were 3 agency systems in place for nurses, medics and all other staff. He reported that managers can still bypass the systems but these will be captured when the invoices appear on the Basware system. One of the main issues was the lack of a policy although there were guidelines and processes in place.

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Resolved:
The Committee received the report and agreed to receive a follow up audit in 6 months time to review progress made. **GB/SN**

8. INFORMATION GOVERNANCE UPDATE

Ms Ramsay presented the report and advised that progress had been made to provide robust evidence to support the audit on 26th February 2017 by MiAA. Ms Ramsay stated that not all standards are audited but a suite of evidence was being prepared against each one anyway as they may be audited at a future time.

Ms Ramsay spoke about the Registration Authority and that Mr Bond was the lead executive with responsibility overall for the Smartcards.

Mr Gore asked about IG Training compliance and Ms Ramsay assured him that the Trust was at an acceptable level. There was a discussion around the back office function at Humber FT and Ms Ramsay reported that the team were working well and that there were no issues at present. The contract would be reviewed in 2018.

Resolved:
The Committee received the report and noted the progress made against the IG Toolkit evidence to be submitted.

9. CNST TOP CLAIMS BY VALUE

Mrs Bates presented the list of highest value claims that had been agreed up to 2012. Mr Gore asked if the Health Groups were given details regarding the outcomes of claims and Mrs Bates assured him that they did.

Ms Ramsay advised that the Trust was carrying out more of the initial administration in house rather than running up large solicitor fees externally. Mrs Bates advised that the Trust was working with local solicitors to minimise the impact of claims received. Mr Bond added that through the Lord Carter work there was a review of back office functions with a view to having regional litigation.

Resolved:
The Committee received the list of CNST claims by value.

10. EFFECTIVENESS OF CLINICAL AUDIT

Mrs Bates presented the report and updated the Committee regarding clinical audit and NICE processes. She spoke about the mandatory Technology Appraisals and Interventional Procedures and these were reviewed at the Clinical Effectiveness, Policies and Practice Development Committee. Mr Gore stated that it would be useful to have an assurance paper regarding NICE guidelines on an annual basis to be reviewed at the Quality Committee. Mr Gore also requested to meet the Clinical Audit Team to discuss their work further.

Resolved:
The Committee received the report and:

- Mrs Bates to provide an assurance paper to the Quality Committee regarding NICE guidelines on an annual basis. **SB**

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- Mrs Bates to arrange a meeting with the Clinical Audit Team and Mr Gore. **SB**

11. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework was reviewed by the Committee. The Committee noted the reduction in the capital programme risk and also the fact that all other risks had remained static for the year.

Resolved:

The Committee received the Board Assurance Framework and agreed to review the different areas of risks at the relevant committees. **CR**

12. BOARD EXPENSES Q1,Q2 AND Q3 2016/17

Mr Bond presented the report to the Committee and advised that there were no items to escalate other than a relocation package and when it would be claimable. Ms Ramsay agreed to clarify this at the next meeting.

Resolved:

The Committee received the report and requested clarity regarding the relocation package discussed. **CR**

13. REVIEW OF DEBTS>£50K AND OVER 3 MONTHS OLD

Mr Bond presented the report to the Committee. He advised that the mortuary debt had been resolved but there were still issues with North Lincolnshire and Goole NHS Foundation Trust and City Health Care Partnership. These areas were being addressed and would be reported back to the Committee once resolved.

Resolved:

The Committee would receive an updated report in due course. **LB**

14. ANY OTHER BUSINESS

Mr Gore raised the issue of what the Trust's plans would be should the end of year control totals were missed and the Sustainability Transformation Funding was not received.

Mr Bond assured the committee that the Trust would continue to operate as it could draw a series of working capital loans from the Treasury if its cash position deteriorated further. He advised that the loan application criteria had been expanded and this was being driven by severe pressure within the system and other Trusts in similar financial positions.

15. DATE AND TIME OF THE NEXT MEETING:

The next meeting will be held Thursday 27 April 2017, 9am - 12pm, The Committee Room, Hull Royal Infirmary

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