Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust

Hull Royal Infirmary

Quality Report

Hull Royal Infirmary, Anlaby Road
Hull HU3 2JZ
The Minor Injuries Unit, Beverley Community Hospital
Swinemoor Lane, Beverley HU17 0FA
Tel:01482875875
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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	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

This is an updated report from the February 2014 inspection of Hull Royal Infirmary. It has been partly updated to reflect the findings from a responsive unannounced inspection of some services on the Hull Royal Infirmary site in January 2015. Details of both inspections are highlighted within the report.

Inspection February 2014:

Hull Royal Infirmary is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates acute services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at Beverley Community Hospital. Hull Royal Infirmary houses the main emergency provision for the trust, including accident and emergency services, critical care, acute medical and surgical services as well as the Women and Children's Hospital. As part of our assessment of the emergency services, we visited the minor injuries unit at Beverley Community Hospital.

We found the hospital was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing number of admissions, particularly patients referred to the hospital as an emergency. The shortage of nursing and medical staff, particularly junior doctors, was impacting on the care patients received, leading to delays in assessment and treatment. Staffing levels and skill mix did not always meet recommended guidance for example by Royal Colleges. There was a winter plan in operation, whereby additional beds had been opened at both hospital sites. Despite this, the high volume of admissions resulted in patients being moved around internally and across to Castle Hill Hospital, often through the night. Not all national targets, such as referral-to-treatment times in some specialties were being met. Backlogs had built up and a large number of outpatient appointments had been cancelled.

Actions had been taken to address the problems associated with staff shortages and other identified risks. Patient safety briefings and an escalation plan had been introduced to deal with issues as they arose. The trust board had agreed in November 2013 to invest £450,000 to recruit more nurses across the trust.

Staff were working hard to ensure the safety and welfare of patients, and wanted to offer a good quality of service. Some staff were proud to work at the hospital. However, others reported that they were stressed and working additional hours to cover the shortages. Doctors were covering a number of areas and did not always have the necessary competencies for the speciality. Staff reported that they were put under intense pressure to undertake additional work and meet performance targets.

Generally, patients reported that they had received good care, particularly in the critical care units and women's service, although concerns were raised about access to treatment and the quality of care in the accident and emergency department and admissions assessment unit.

There were arrangements in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found all areas that we visited were clean. There were systems in place for assessing, monitoring and addressing risk, with lines of reporting to the trust board. Following a recent review of incidents, these processes had been strengthened. However, many members of staff told us that they did not have the time to report incidents, and therefore this information could not be taken into account for future learning.

There had been a major refurbishment programme in the A&E department to improve facilities, and a planned development to increase capacity for dealing with major injuries and illnesses was expected to be completed by August 2014. At the present time, the department did not have the capacity in terms of facilities and staff to deal with the

Summary of findings

number of patients attending. There was a lack of appropriate senior clinicians and the children's accident and emergency department, which had recently been refurbished, closed at midnight. The treatment of children then moved to the adult areas, with only the children's waiting area open. The resuscitation area was kept open and appropriately qualified staff were made available when this was needed.

Despite the new consultation initiatives and strategies introduced, many staff did not feel engaged, particularly with the senior management team, although support from local managers was generally reported as good.

We found the hospitals in breach of Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 15 (premises), 22 (staffing) and 23 (staff support) for the regulated activities treatment of disease, disorder or injury and diagnostic and screening procedures.

Inspection: January 2015

Following concerns raised to CQC and analysis of other evidence an unannounced focussed inspection took place on the 28 and 29 January 2015 of some services on the Hull Royal Infirmary site. The core services we inspected in January 2015 included accident and emergency, medical care and surgery. There is additional content highlighted within these specific core services of the report following this inspection. Other core services were not inspected at this time and therefore the report for those areas remains unchanged.

The focus of the inspection was the care of patients in the emergency department and the patient flow onto the wards. We found the Trust was not operating an effective system to ensure appropriate initial clinical assessment of patients therefore patients were exposed to the potential risk of harm. On the 30 March 2015 we issued a section 64 letter to the trust and requested further information about the assessment of patients in the accident and emergency department and staffing numbers.

Improvements required

Following the February 2014 and January 2015 inspection there were areas of poor practice where the trust needed to make improvements. Importantly, the trust must:

From the Inspection February 2014:

- Ensure that there are sufficient numbers of suitably qualified and skilled staff and experienced people across all health groups including medical and nursing staff, particularly A&E, AAU, and medical wards.
- Ensure that staff are suitably supported and receive appropriate training, including safeguarding Level 3 where appropriate, and post registration qualifications in critical care.
- Ensure all staff have completed their mandatory training.
- Ensure that junior doctors are appropriately supervised and not taking on roles and responsibilities for which they have yet to complete competencies in.
- Ensure that there are suitable arrangements for on-call, and that junior doctors are not responsible for multiple pagers across different areas.
- Review why staff feel that they are experiencing bullying and feel pressure to undertake additional hours, and put meeting targets above patient care.
- Ensure that staff who are involved in caring for patients living with dementia are suitably trained, for example portering staff.
- Ensure that only staff employed for caring duties, including dealing with patients exhibiting challenging behaviour due to mental health illness or dementia, support patients.
- Review incident reporting to ensure that staff report incidents appropriately and in a timely manner.
- Ensure that staff receive feedback from incidents reported, including never events and complaints.
- Ensure lessons learned are disseminated across divisions.
- Ensure that children are assessed and treated in an appropriate environment, in line with national guidance.

Summary of findings

- Ensure that patients have access to hospital appointments and cancellation of outpatient clinics is kept to a minimum.
- Review the patient flow within and across hospital sites to ensure that patients are not experiencing multiple moves, including through the night.
- Ensure that patients' assessment and treatment is based on best practice guidelines and delivered in a timely manner.
- Ensure patients receive appropriate fluid and nutrition to meet their needs. We found patients particularly in A&E and AAU were going without drinks and food for several hours.
- Ensure that there are suitable arrangements in place for pharmacy provision across all areas to provide clinical overview and reconciliation of patient medications.
- Ensure that patient records are appropriately maintained.
- Provide family friendly facilities for parents on Ward 130 and the high dependency unit to enable parents to support their children.
- Ensure that the environment is safe within the children's and young people's services by ensuring that clinical rooms have only appropriate equipment and that waste bins are appropriately stored.

From the January 2015 Inspection:

- Ensure there is an effective system in place so that patients attending Accident and Emergency have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011 or such other recognised professional processes or mechanisms as the trust commits itself to.
- Review the patient pathway into the hospital, particularly the A&E department, to ensure that patients are assessed and treated appropriately to meet their needs.

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	Requires improvement 	**Inspection February 2014:** There had been a major refurbishment programme in the A&E department to improve facilities, and a planned development to increase capacity for dealing with major injuries and illnesses was expected to be completed by August 2014. The adult A&E at Hull Royal Infirmary was open 24 hours a day, seven days a week. In the last year, the A&E treated over 131,000 people and was experiencing an ever-increasing demand for its services. At times, the A&E department did not have the capacity in terms of facilities and staffing to deal with the number of attendances. Patients had long waits for treatment and some were on trolleys in corridors for a significant length of time. There was not always the necessary level of skills mix and experience to manage patients. Staff worked hard and were committed to the care and welfare of patients, but struggled to respond to patients' needs. The patient flow through the department and onto wards increased the pressure on staff because medical and surgical patients, including those referred by GPs, were often sent first to A&E rather than directly to the ward. The children's A&E department closed at midnight, except for the waiting area, which meant that children were then cared for in an adult environment, which did not meet national guidance. At times, there was a lack of appropriate senior clinicians. While staff felt supported at a departmental level, they felt less supported by managers above matron level and the trust as a whole. Some staff told us they felt bullied and made to feel as if they had failed in their job if patients exceeded target waiting times. **Inspection January 2015:** At the time of the January 2015 inspection the refurbishment was still in progress. There was not an effective system to ensure that patients attending Accident and Emergency had an initial assessment of their condition carried out by

appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011 or such other recognised professional processes or mechanisms. The patient pathways into the hospital, particularly from the A&E department, were not always effective in ensuring that patients needs were assessed and treated in a timely manner.

Medical care

Requires improvement

Inspection February 2014:
We found staff were committed and hardworking, but struggling to provide safe or effective care, particularly for patients on the acute assessment unit (AAU) who had been referred by their GP. Staff across wards and departments raised concerns about staffing levels. Staff on the AAU, Ward 10 and Ward 70 were particularly concerned about the lack of nursing, support workers and medical staff on duty at night and weekends. The low number of junior doctors, combined with the lack of available beds, led to long delays in patients accessing assessment and treatment, and resulted in the frequent movement of patients internally and across to Castle Hill Hospital.
The wards used care bundles to ensure that patients with particular conditions received appropriate care. Intentional rounding had been introduced (or around-the-clock care) to check that patients were reviewed every hour, and this had resulted in an improvement in fluid balance monitoring. The medical wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, to drive improvement in performance.
The hospital provided stroke Level 1 services and was meeting national targets. The wards were well-led at the point of service delivery and staff felt supported, although some staff told us that there was a "disconnect" between the Board's executive team and the wards.
Inspection January 2015:
During the focused inspection in January 2015 we had concerns regarding nurse staffing on AAU. We

Summary of findings

found the actual numbers of registered nurses had improved in the months of February and March. Staff we spoke with on Ward 120 which was a winter pressures ward told us they did not know the patients and felt that they could not provide patient centred care. There was no stock of oral morphine, which is a controlled drug, on ward 120 and staff were borrowing this from other wards. A risk register was in place. A risk identified was recognition and management of deteriorating patients on AAU which was due to be reviewed at the end of November 2014. The trust provided information that showed seven control measures had been implemented to manage this risk. The risk was last reviewed in March 2015. We also saw nurse staffing had been identified as a high risk within the Medicine Health Group and had nine controls/ actions identified to address the risk.

Surgery

Requires improvement

Inspection February 2014:
Ward areas and theatres were clean and guidelines were followed to prevent or reduce risks from infection. Appropriate safety checks and risk assessments were taking place and concerns were escalated appropriately. The World Health Organisation (WHO) surgical safety checklist was used to ensure the safety of patients while undergoing procedures.
Wards and theatres were very busy and, to meet patients' needs, staff were often redeployed to different areas. Patients reported that, at times, this led to long waits for call bells to be answered, causing distress. Junior doctors felt pressured and stretched to meet the demands of the service; senior clinicians confirmed that junior doctors' workload was high.
Appraisals had taken place for medical and nursing staff. However, junior doctors reported that departmental teaching was limited, and not all staff had completed their mandatory training.
Patients' privacy and dignity were respected, and consent was appropriately discussed and obtained.
The surgical divisions held regular governance meetings and staff felt well supported by their immediate line managers. Staff showed

commitment to providing good quality care to patients. However, staff were unaware of practices and initiatives across other surgical divisions, resulting in limited shared learning.
Medical and nursing staff reported that communication with the senior management of the trust was poor and the senior team were not visible.
Inspection January 2015:
During the focused inspection we had concerns regarding nurse staffing on the acute surgical unit (ASU / ward H6). However, the actual numbers of registered nurses had improved in the months of February and March 2015. During the focussed inspection we visited the ASU where concerns were raised regarding the lack of effective procedures to prioritise and manage patients who requiring admitting to a bed. This meant that on occasions patients were sat in the waiting room for a number of hours. Two doctors we spoke with told us it was difficult to assess and examine patients in the waiting room.
Staff we spoke with on the wards 6 and 60 were not able to describe the policy for admission into the acute surgical units and were not aware the trust had a policy to manage admissions. We also found there was no routine monitoring of the policy to ensure compliance.

Critical care

Good

The hospital provided a comprehensive, consultant-led critical care service with 24-hour cover, seven days a week. There were good safety checklists in place for staff to deliver a safe and effective service. Infection prevention and control was well managed. Clinical audits were carried out regularly and feedback was shared with the teams during handover. The critical care team provided an outreach service to ward areas.
The trust had recently introduced the national early warning score (NEWS) for acutely ill patients, which had led to an increase in referrals. At times, the team experienced difficulties meeting demand as there was no back-up support available.
The staffing levels, experience and skills mix of the nursing team was sufficient, but did not meet the

standard for having at least 50% of nurses with a post-registration qualification in critical care. There were enough medical staff but it was felt that the consultant on call rota was onerous.
Patients and families said care was good and they were very positive about their experience; they described staff as kind, caring and thoughtful. Patients' privacy and dignity were respected and patients and families were kept fully involved in all decisions about treatment and care.
Critical care teams were well-led and staffed with a dedicated cohesive clinical team. Staff felt supported by the clinical team and line managers. However, staff reported that communication with the trust's senior management was poor.

Maternity and gynaecology

Good

Maternity services monitored and minimised risk effectively and the World Health Organisation's surgical safety checklist was used to ensure patients were safe undergoing caesarean sections. Staff were aware of the process for reporting and there was learning from incidents. There were learning processes in place for effective professional clinical practice.
Figures showed midwifery staffing ratios were below national recommendations and the service had recently recruited eight midwives and aimed to increase staffing further to meet guidance. There was a shortage of junior medical staff and the availability of consultants on the labour ward was below national recommendations. However, there were effective systems in place to ensure sufficient cover to meet patients' needs. In addition, the trust planned to increase medical cover through the appointment of locum consultants and changes to the rotas.
The service participated in national and local clinical audits. Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Risk assessment tools were used to ensure the timely referral of women developing critical illness during or after pregnancy.
Women and their families spoke positively about their treatment and the standard of care. Privacy and dignity were respected. Women felt involved in developing their birth plans and had sufficient information to enable them to make choices.

Summary of findings

The service was well-led. Staff were involved and engaged with service development. Staff were supported and could approach senior staff if they had concerns.

Services for children and young people

Requires improvement

Nurse staffing levels on the children's wards were identified as a major risk by the trust and we found at times they fell below expected minimum levels, which placed staff under increased stress and pressure.

Children's services were effective, with examples of evidence-based care pathways kept under review and positive multidisciplinary working within the departments and externally. Staff had been able to access mandatory training and the majority had received an appraisal.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. However, we found the service had a limited ability to provide holistic family-centred care due to the poor quality of parent and family facilities available on Ward 130, the assessment unit and high dependency unit in the tower block. Parents were not always able to sleep next to their child or they had been given inadequate sleeping facilities, such as uncomfortable chairs.

We found the service responsive and accessible in the management and care of the critically ill child. Service development included working with external partners.

The service was well-led with a clear leadership structure in place. There were governance systems and processes in place. However, the trust did not have a board-level lead for children in accordance with national guidance.

End of life care

Good

End of life services support was provided to patient areas across the trust by a dedicated palliative care team. The team consisted of palliative care consultants, specialist nurses and an end of life care facilitator. The team was available Monday to Friday with a helpline service during evenings and weekends. Individual wards had end of life care champions.

In line with national guidance, the trust had stopped using the Liverpool Care Pathway for end of life care in January 2014 and replaced it with

trust-developed guidelines on personalised management planning for the dying patient, symptom management and palliative rapid discharge pathway.
Patients received safe and effective end of life care, which involved patients and relatives/carers. Care was flexible and responsive to individual needs and there were good systems to facilitate preferred place of care. The hospital gathered patients' and families' views to improve care and treatment.
Bereavement services were supportive and staff who worked in the bereavement centre had received specialist training and were supported by the Cruse Bereavement Care service charity.
The service was well-led and staff felt supported. The service was working towards national gold standards of best practice.

Outpatients and diagnostic imaging

Requires improvement

There were systems in place to assess risk and escalate concerns. Staff were aware of how to report incidents and met regularly to discuss learning. The outpatient areas were clean and staff were using good infection prevention practices.
Some clinics that we visited were very busy, cramped and hot. Staff were concerned about patients, particularly the frail elderly, becoming dehydrated with the hot conditions. There was a shortage of space in some clinical areas, which compromised patients' privacy and dignity.
Staff received patient records in a timely manner, which allowed them to review information and plan for the visits. A local initiative had been introduced to identify if a patient had a special need, such as a learning disability or dementia. This was to ensure the patient did not have to wait too long or whether to arrange an alternative location to wait if appropriate. The department had taken account of increased frailty of patients and had introduced outpatient clinics in the community.
Clinics were regularly cancelled by the hospital and there were delays in meeting outpatient appointments. There were insufficient slots on the NHS Choose and Book electronic appointment system, causing delay and failure to meet referral-to-treatment time targets.
Patients felt involved in their care and treatment and staff explained processes. Patients reported

Summary of findings

that staff had a good knowledge of the specialty, which reassured them. However, patients commented on poor parking facilities, which could be crowded, particularly around visiting times and could be costly when clinics overran.

Hull Royal Infirmary

Detailed findings

Services we looked at

Urgent and 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 and 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 serves a population of 660,000 and provides a range of acute services to the residents of the 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 has around 700 beds and in addition to acute medical and surgical services provides accident and emergency (A&E) services. The A&E services were seeing year-on-year increases in attendance, and treated over 131,000 people in 2013. The Women and Children's Hospital located at Hull Royal Infirmary houses the maternity and children's services, including neonatology with a 28-cot neonatal intensive care unit. The obstetrics department provides maternity services to women of Hull and East Yorkshire. The trust is accredited as an Endometriosis Centre in the North East of England.

In addition, the hospital provides critical care services, with 22 beds available for intensive care and high dependency, close to a nine main theatre complex. From 2012 to 2013 the trust treated 154,437 inpatients and saw 611,482 outpatients. The trust employs 8,000 staff.

Hull Royal Infirmary was inspected in July 2013 and found in breach of Regulation 13 (medication) for the regulated activities diagnostic and screening and treatment for disease, disorder or Injury. In December 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding), for the same regulated activities. Compliance actions had been set for all three breaches and the trust was working to action plans to become compliant.

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Our inspection team

Inspection: February 2015

Our inspection team was led by:

Chair: Dr Chris Gordon , Programme Director NHS Leadership Academy

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: The team of 45 included CQC senior managers, inspectors and analysts, senior and junior doctors, nurses, midwives, a student nurse, a pharmacist, a theatre specialist, patients and public representatives, Experts by Experience and senior NHS managers.

Inspection: January 2015

This was a focussed unannounced inspection. Our team was led by an inspection manager and consisted of inspectors and specialist professional advisors with experience of working in accident and emergency departments.

How we carried out this inspection

Why we carried out this inspection

Inspection: February 2014

Hull and East Yorkshire Hospitals NHS Trust was selected as one of the first trusts to be inspected under the CQC's revised inspection approach. The trust was selected for inspection having started a formal application in 2013 to achieve foundation trust status.

Inspection: January 2015

A further unannounced inspection was carried out in January 2015 because of concerns raised with CQC from a variety of sources including the public, staff and local commissioners. The main concerns were with regard to the care and treatment of patients in the Emergency Department including delays in handover times from ambulances, lack of timely access to resuscitation facilities and assessment and triage. There were also concerns about the length of time patients were in the ED and delayed transfers to wards within the hospitals.

How we carried out his inspection

Inspection: February 2014

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 inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS

Detailed findings

Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits on 03, 04, and 05 February and an unannounced visit on 10 February 2014.

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held two listening events on 03 February 2014 in Hull and at Cottingham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. We also held a community focus group in partnership with Choices and Rights Disability Coalition, so that we could hear the views of harder to reach members of public.

Inspection: January 2015

The inspection was limited to the ED department, the acute assessment unit and the acute surgical unit and ward 120.

Before visiting we reviewed a range of information. During the visit we spoke with patients, relatives and staff including consultants, nurses and managers.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The accident and emergency department at Hull Royal Infirmary opened in 1967 and was designed for a capacity of 60,000 patients. There had been a year-on-year increase to over 131,000 patients in the last year. The emergency department consisted of two separate areas, one for adults and one for children's emergencies.

Inspection February 2014: Adult A&E

The adult A&E was open 24 hours a day, seven days a week. The department was divided into four main areas: an area for minor injuries and illnesses (Minors) an area for major injuries and illnesses (Majors) an initial assessment unit (IAU) and resuscitation unit. On average, 155 patients each day were treated in Minors and 125 patients treated in Majors and resuscitation.

The Majors area was undergoing a large refurbishment and rebuild programme, which would eventually see the capacity within the department almost double. For example, the number of resuscitation beds would increase from five to 10. During the refurbishment and rebuilding programme, some temporary buildings had been erected to try and lessen the impact of the building work on patients and staff. The Minors department had also recently been refurbished, which had improved the environment in waiting areas.

People who arrived by ambulance were taken directly to Majors. People who arrived without an ambulance could check themselves in using a new computer system called Clarity. This was used to check which patients needed more immediate attention, known as triaging. For those people who were unable to use the Clarity system, such as people who were injured, disabled or elderly, a receptionist was available to assist them.

Inspection January 2015: Adult A&E

At the time of the January 2015 inspection the rebuilding and refurbishment was still ongoing. In addition to the refurbished minors area there was in place four resuscitation cubicles and six high observation bays. The refurbishment was now expected to be completed in April 2015 and would then include ten resuscitation cubicles. There were temporary structures in place for the "Majors" area which included 15 cubicles for 'majors', seven of which were used for assessment.

Inspection February 2014: Children's A&E

The children's A&E department was next door to Minors, which had recently been completely refurbished. The department closed at midnight; however, the paediatric waiting room remained open 24 hours a day. It was monitored by a security guard between the hours of 11.30pm and 8.30am. The children's A&E treated an average of 60 patients each day.

We spoke with over 60 people who were patients, relatives, ambulance crew or staff working in the departments. We observed care and treatment within the department and checked 17 records. We visited the department on four different days, including two visits in the late evening. One of the visits in the late evening was unannounced.

Inspection February 2014: The Minor Injuries Unit – Beverley Community Hospital

Urgent and emergency services

The minor injuries unit was part of the accident and emergency department of Hull and East Yorkshire Hospitals NHS Trust and located in a purpose built community hospital. The unit was led by nurse practitioners, who were independent prescribers. The unit treated people with a minor injury or referred them to other services such as their GP, or if more their condition is more serious to the accident and emergency department at Hull Royal Infirmary. The unit comprises of two treatment rooms, an x-ray department and adult and children's waiting areas.

Summary of findings

Inspection February 2014: Adult A&E

There were times when the department could not cope with the volume of patients attending. As a consequence, patient safety and the quality of care was compromised. The department had not originally been designed to meet the needs of the high volume of patients now attending, and when busy, regularly had patients waiting in corridors because there were no cubicles left for them to wait in.

The department was in the middle of a refurbishment programme, whereby work on the Minors' area and children's A&E area had been completed. Work on a large extension to the Majors and resuscitation areas were not due to be completed until August 2014. This was expected to improve the facilities within the department and allow for better patient care. We were concerned, however, about the arrangements in place in the interim.

Staff worked hard and were committed to the care and welfare of patients, but struggled to respond to patients' needs. The patient flow through the department and onto wards increased the pressure on staff as medical and surgical patients, including those referred by GPs were often sent first to A& E rather than directly to the ward. Once the initial assessments had taken place, there were long waits to be seen by medical staff. The self-checking in process in the Minors area meant there was a risk that not all patients would report the appropriate and most serious symptoms they were experiencing to alert staff that they needed to be seen sooner. However, patient feedback on their experience, through surveys and at inspection, was positive.

Staffing levels and skills mix did not meet national guidance and some staff did not have the necessary skills to meet the demand, such as phlebotomy (blood taking). Access to and completion of training was not always consistent, for example, junior doctors had no formal training programme in place, other than e-learning. We found that security staff were called when caring for vulnerable patients who were confused and exhibiting challenging behaviour. These security

personnel were independently contracted by the trust and had not received specific training in dealing with vulnerable adults, for example, people with a mental health illness or dementia.

While staff felt supported at a departmental level, they felt less supported by senior managers and the trust as a whole. They were unaware of many of the initiatives within the trust to engage with staff. We found that, within the department, there were times when there was a lack of oversight and leadership. Staff felt pressurised into trying to meet targets rather than make sure people received the care they needed. Some staff told us they felt bullied and made to feel as if they had failed in their job if patients exceeded target waiting times.

Inspection January 2015: Adult A&E

At the time of the January 2015 inspection the refurbishment was still in progress.

There was not an effective system to ensure that patients attending Accident and Emergency had an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011 or such other recognised professional processes or mechanisms.

The patient pathways into the hospital, particularly from the A&E department, were not always effective in ensuring that patients needs were assessed and treated in a timely manner.

Inspection February 2014: Children's A&E (Paediatric)

The trust had recently completed a refurbishment of the children's A&E facilities, which had improved the experience for children and their families. However, the children's A&E closed at midnight, which meant that children were being assessed in the same initial assessment unit as adults. The children's waiting area remained open after midnight, but there was no qualified clinical staff overseeing this area overnight; a security guard monitored the area

There were no registered children's nurses working in the A&E department overnight. . There were, however, appropriately skilled nurses elsewhere in the hospital who could be called upon to advise on the nursing of children. There were occasions when it was difficult to get consultant cover because there was no dedicated paediatric A&E consultant within the A&E department.

Staff dealt with patients and parents in a caring and understanding manner. They took time to speak with relatives and reassure them. Staff were, however, under pressure and one staff member told us that they didn't always feel that they could spend as much time as they wanted to with patients and their relatives.

The department could not always respond to the needs of children or young people with mental health problems. Staff told us that it was difficult to access psychiatric support for young people after 5pm. Most patients were asked to return to the department during the opening hours of the Child and Adolescent Mental Health Service (CAMHS). Staff told us that, if they had concerns about a patient, they would call the adult on-call psychiatrist for an assessment.

Staff told us that morale in the department was low because staff were under pressure. They told us that there were not enough staff on duty in the department to manage the number of patients to be seen. One of the impacts of this was that staff didn't have time to reflect on cases, or lessons learned. Doctors told us that there was little joint working with the children's department within the trust and that they didn't feel supported by the paediatric department. Staff did not feel supported and thought that the department lacked leadership. Access to training was difficult, with limited opportunities for additional development training, although nursing staff were able to attend mandatory training. Staff had attended Level 2 safeguarding training but more needed to attend Level 3.

Inspection February 2014: The Minor Injuries Unit – Beverley Community Hospital

Assessment and reporting systems were in place to identify risk, take action and learn lessons from incidents or complaints. There were suitable arrangements for the safe administration, handling, storage and recording of medication.

Urgent and emergency services

The unit was clean. Arrangements were in place for cleaning. The decontamination of equipment and waste disposal were effective. Personal protective equipment such as gloves and aprons were in good supply. Care was given in accordance with best practice and national guidance. There were clear clinical, organisational, governance and risk management structures in operation. Staff had confidence in the management and clinical support they received.

Patients reported that they were happy with their care and treatment and that staff were kind, courteous and helpful.

Are urgent and emergency services safe?

Requires improvement

Safety and performance

Inspection February 2014: Staffing

When we visited, we had concerns about the levels of staffing in the A&E, particularly in Majors. There were only five full-time equivalent band 7 senior nurses to cover 14 shifts in A&E. Some staff told us that band 6 nurses were expected to cover any shifts, but that they received no extra training to enable them to do this. Staff in Majors and the initial assessment unit told us that there were not enough staff on duty to meet people's needs safely, especially during peaks in attendances and admissions.

When we carried out our unannounced inspection, we found that there were two teams of two nurses working in Majors, each comprised of one qualified nurse and one auxiliary. Staff told us that there should be three teams, each comprised of three staff working this area, not two. There was a qualified nurse and a clinical support worker in the initial assessment unit, two qualified nurses in the resuscitating area, two qualified nurses and one clinical support worker in Minors and two qualified nurses in paediatric A&E. There was one consultant on call, two registrars (one after midnight) one locum working until midnight and five junior doctors. At the time of the unannounced inspection, there were 96 people waiting for treatment. This demonstrated that patients' safety was compromised by inadequate staffing levels, and by the lack of staff with the appropriate skills to meet patients' needs.

A senior manager and the matron told us that plans were in place to increase the levels of staffing within the department, including consultants, over the coming months. They also explained that they were looking at improving staff's skills to ensure they had all the skills they needed to work as part of the A&E team. One consultant told us that some of the staff were unable to take blood and this sometimes led to consultants carrying out this task because there were no nurses available with these skills.

Inspection January 2015: Nurse staffing

During the focused inspection we had concerns regarding nurse staffing within the Accident and Emergency department (ED). We spoke with the nurse in charge who

told us there should be ten registered nurses (RNs) and three support workers on each shift. One member of staff told us staffing numbers were an issue "it can be very bad and there will be two, three, four people down on a shift."

There had been a business case drafted regarding nurse staffing in ED to increase the number of nurses per shift at the time of inspection there had been no outcome from the business case.

As part of the inspection we asked the trust to provide information on the planned and actual numbers of staff from September 2014 to January 2015. From the information the trust provided this indicated there should be 12 registered nurses on each shift.

Early shifts

- During September 2014 - October 2014 we found there were only three days where the department met the planned number of RNs on the early shift. At its lowest staffing levels dropped to 7 RNs with a prolonged dip in staffing levels between 27th and 29th September.
- Between November 2014 - January 2015 we found there were only 33 occasions out of 92 days where ED met or exceeded the planned number of RNs on the early shift. At its lowest staffing levels dropped to 8 RNs on 25 December 2014.

Late Shifts

- During September- October 2014 in the two month period there was only one day where ED met the planned number of RNs on the late shift. However only 34.4% of shifts were covered by at least 11 RNs compared to the planned number of 12.
- At its lowest staffing levels dropped to seven RNs. There were also two full weekends with RN staffing levels at eight throughout the weekend (2-14 September 2014 and 27-29 September 2014).
- Between November 2014- January 2015 we found the late shift continued to be the best staffed shift with an average of 11 RNs per shift. In the 3 month period there were 28 occasions out of 92 days where ED met or exceeded the planned number of RNs on the late shift.

Night shifts

- During September 2014 - October 2014 we found the night shift was the shift with the least staff with an average of 9 RNs per shift. In the two month period the night shift was never fully staffed and only two shifts were covered by at least 11 RNs (compared to the planned number of 12). We found 86.8% of night shifts were covered by 9 or more RNs.
- At its lowest staffing levels dropped to 6 RNs on Tuesday 2nd September 2014.
- Between November 2014 - January 2015 we found the night shift continued to be the shift with the least staff with an average of 10 RNs per shift. In the 3 month period there were 20 occasions out of 92 days where ED met or exceeded the planned number of RNs on the night shift.

On the 30 March 2015 we issued a section 64 letter to the trust and requested further information on nurse staffing numbers for February and March 2015. We saw the actual numbers of registered nurses had improved in the months of February and March 2015.

- In February we reviewed information on the planned numbers of staff required for each shift and the actual number of nurses who worked during the month. We saw 87% of shifts had been at the planned numbers. At its lowest staffing levels dropped to 9 RNs on 1 February 2015 on six occasions for day shifts and 7.5 RN's on a night shift on 15 February 2015.
- In March 2015 we saw the planned numbers of registered nurses for day shifts had increased to 14 and had increased to 13 for a night shift. We saw the actual number of nurses who worked during the month meant 74% of shifts met the planned numbers. At its lowest staffing levels dropped to 8 RNs on 25 March 2015.

However we did see there were still shifts where the number of registered nurses were significantly lower than the planned numbers. For example, we saw there were days during February where the actual number of nurses was 9 against a planned number of 12. We also saw on the early shift of 25 March 2015 there was 8 nurses against a planned number of 14.

Staffing information was available for the bed meetings which occurred between 8:00am to 20:00pm. There were four bed meetings per day. Any staffing issues after 20:00 were managed by the 1st and 2nd on call nursing staff. Following the inspection the trust told us staff were asked to move to areas that required support and that when this has happened this would not necessarily be reflected in the staffing numbers on the off-duty.

Urgent and emergency services

Inspection February 2014: Medical staffing

The Royal College of Emergency medicine (CEM) 2011 operational handbook stated that every ED department that have over 100,000 attendances per year should have a minimum of 16 consultants.

At the time of the unannounced focused inspection the actual number of consultants was nine WTE consultants plus two part-time consultants one of which was on maternity leave and due to return to work within two months. We found there was usually was only one consultant working in the department at any given time. We also found the consultants were covering gaps in the registrar rota's.

We issued a section 64 letter to the trust and requested further information on medical staffing numbers for February and March 2015. The trust told us there was six WTE vacancies at consultant level within the ED department. The trust was actively recruiting to the consultant posts and had arranged one locum consultant to cover for three months between April- July 2015.

We were told the planned number of registrar level doctors within the ED department was 10 WTE which was based on historical practice rather than planned need. From March 2015 the actual number of registrar level doctors in the department was 4.1 wte. and the number of registrar vacancies this was 4.8wte.

Inspection February 2014: Equipment

We identified some concerns about the equipment available in majors. We spoke with two members of staff about the availability of resuscitation equipment such as portable defibrillators. They told us that there were no defibrillators in Majors and that, if one was needed, it would be taken from the resuscitation area. This meant that there was a risk to patients because of the lack of availability and accessibility of equipment needed in emergency situations.

Inspection January 2015: Equipment

During the unannounced focussed inspection we found appropriate equipment such as defibrillators were now in place and were being appropriately checked to ensure they were safe to use.

Inspection February 2014: Cleanliness

When we visited in the evening, we found some of the rooms had not been cleaned properly. In the resuscitation area, we saw blood on the floor. It was not cleaned up before the next patient was brought in to the bay. Staff told us this was because there was no cleaner on duty in A&E overnight. They told us that there was a cleaner on call in the trust overnight, but they had not attended to clean the bays we saw. This meant that there was a risk to patients of cross-contamination.

Learning and improvement

Inspection February 2014: Incident reporting

Staff were aware of the need to report accidents, incidents and near misses. Most staff were able to describe risk-reporting procedures but acknowledged that they did not always report, mainly because of time pressures. Complaints, safety incidents and near misses were not discussed and staff told us of their reluctance to report incidents because they never received feedback about the outcome of investigations.

Inspection January 2015: Incident reporting

During the unannounced focussed inspection we found there had been 10 serious investigations recorded on the Strategic Executive Information System (STEIS). We found six of these incidents related to 12 hour breaches, two related to sub-optimal care of patients, one slip, trip or fall and one unexpected death.

Of the ten incidents we found two occurred on the 23 December 2014 and 16 January 2015, and three occurred on the 23 January 2015. We found all of the incidents were being investigated and one had been completed.

Between 1 October 2014 to 29 January 2015 we found there had been a total of 693 incidents reported in the department. The main themes from these incidents were 40 related to access, admission, transfer and discharge, nine medication issues, 39 organisational issues including staffing and 42 were related to treatment of care included 26 omissions of care. We also saw five of these incidents related to blood transfusions the investigations into three of the incidents found there was a lack of awareness of agreed policy and procedures by staff. This indicated that learning from incidents was not being effectively communicated to staff.

We saw in the minutes of the Safety Experience and Effectiveness meeting in January 2015 that between

December 2014 -January 2015 there had been a total of 56 incidents across the trust which met the requirements of Duty of Candour, six of the incidents related to A&E department. Within these minutes it had been documented that only three had evidence indicating the date a verbal apology was given to the patient/relative. Of the 56 reported incidents seven had been escalated as serious incidents.

We also saw within the breakdown of incidents that, between 1 October 2014 and 29 January 2015, there were 327 pressure ulcers which had been reported in the ED department. Two were confirmed as being hospital acquired pressure ulcers.

Inspection February 2014: Mandatory training

Nursing and medical staff had mixed views about the training available in the department. One senior doctor told us that they found it difficult to access training to make sure they were up to date with their current practice. Two consultants reported that junior doctors had to complete weekly online training, or e-learning, including safeguarding vulnerable adults and children. However, junior doctors told us that, other than their three-day induction and a hand book, there were no formal arrangements for them to receive training; sometimes, senior doctors arranged ad hoc training sessions, but these were sporadic and the department was often too busy for them to take time away to attend. This meant that there was a risk to patients that staff did not have the appropriate and up-to-date skills and experience to meet their needs.

Nursing staff said that, other than their mandatory training, they found it difficult to attend further training. Mandatory training attendance for the A&E stood at 74.7% with appraisals at 78.3% (the trust target was 85%). Staff felt supported by their line managers, but that, other than their annual appraisal, they found it difficult to have more than an occasional 10 minutes with them. This meant that nursing staff were not receiving formal support or overview of their performance on a regular basis. Patients were therefore at risk of receiving treatment from staff whose competency was not assessed on a regular basis.

Porters told us that they received the mandatory training for their role, but had not received any training about how to work with patients with dementia, who they often had to move from the A&E to wards. Security staff were contracted to the A&E to deal with people who posed as a security risk. However, we found that they were being called to support staff when dealing with patients with mental health illness or was living with dementia, who were disturbed or displayed challenging behaviour. Security personnel had not received any training about how to assist people with dementia. This meant that patients, particularly those with dementia, were at risk of receiving inappropriate or unsafe support because some staff had not received training about how to meet their specific needs.

Systems, processes and practices

Inspection: February 2014

The department had a number of systems and processes in place to protect patients and assist staff. There were treatment pathways, a triage process in Minors and an escalation process for reporting incidents and concerns about staffing and capacity. However, we were told that the day before our inspection, one patient who had been admitted to A&E, after referral by their GP, was dehydrated on admission but did not receive the care they needed to rehydrate them until the following day when they were admitted to the AAU more than nine hours after admission to the A&E. Additionally they had not been given any food which could have caused them harm due to their diagnosis of diabetes, nor had they been seen by a doctor. This showed that patients admitted to A&E while waiting to be transferred to a ward were at risk of not receiving the care and treatment they needed.

We saw at times in Majors that staff communication was poor. We witnessed a very poorly patient brought to A&E by an ambulance; staff had to hand over information to different consultants three times. This showed that there were times when communication among staff was not effective.

Inspection January 2015: Initial assessment and treatment

In December 2014 1330 out of 2148 ambulance handovers (62%) were triaged in under 15 minutes. In January 2015 we found 1329 out of 2211 ambulance handovers (60%) were triaged in under 15 minutes.

Black breaches are defined as the time between an ambulance arriving at a hospital to the patient being formally handed over to the trust which is longer than 60

minutes. During December 2014 there were 450 handovers over 60 minutes of which 73 were greater than two hours. In January 2015 there were 411 handovers over 60 minutes of which 48 were greater than two hours.

The trust provided further information following the section 64 letter which showed that there had been 308 black breaches in February and 423 during March 2015.

The CQC national survey report on A&E patient experience 2014 indicated that the trust scored the same compared to other trusts for questions regarding for arrival at ED, tests, hospital environment and facilities and leaving ED. However the trust scored worse when compared to other trusts for waiting times, doctors and nurses, care and treatment and overall experience.

Inspection January 2015: Assessing and responding to risk

The trust had developed a standard operating procedure (SOP) for escalation within the ED department. The SOP utilised a traffic light system to identify the escalation actions required for certain situations for example the length of time to see a doctor or the time to transfer to a bed.

The ED department had trialled a rapid assessment and treatment (RAT) system which had operated to provide an early assessment by a consultant to patients attending the department by ambulance. This was trialled for a period of six months from April – Sept 2014. A comparison audit of RAT and majors was undertaken which showed the times for triage, to be seen by a doctor and the decision to admit were all improved after implementation of RAT.

Staff told us the RAT system had been stopped as the department did not have enough consultants to operate it as it required two consultants to be on duty in the department. Information within the RAT staffing audit presentation indicated that robust staffing was the key to the efficiency and sustainability of RAT and in July 2014 the current staffing model did not provide the robust staffing model needed.

We saw on the January 2015 divisional risk register it had been identified that some high risk patients may be discharged from the Emergency Department without senior in-put. The risk had been elevated from moderate to high due to RAT not being in place and reduction in senior clinicians at any one time.

Inspection February 2014: Minors' check in processes

The Clarity self-check-in software system was in use in Minors. It prioritised how quickly a patient needed to be seen, based on the information put in by the patient. A number of staff of all disciplines told us that they had concerns about the system and how well it was able to identify the severity of someone's condition. The system did not allow people to add all of their symptoms; therefore, the programme made a decision based on whichever symptom the person thought was most serious. The system was only available in English, so patients who spoke other languages had to rely on the assistance of the receptionist and an online translation programme to describe their symptoms. This meant that there was a risk to patients that they would not be seen as quickly as they needed to be.

Inspection February 2014: Safeguarding

Staff had training in safeguarding and were able to follow the process to ensure that the correct action was taken when a safeguarding concern was discovered.

Inspection February 2014: Children's A&E

The children's A&E closed at midnight. Patients arriving by ambulance were taken to the same admissions unit as adults and waited alongside adults in the initial admissions unit. Children who arrived on foot waited in the paediatric waiting area after registering on arrival in the Minors department.

There were no qualified clinical staff overseeing this area overnight; instead, a security guard monitored the area. Any patients whose health was a cause for concern were moved to the Minors department so they could be monitored by staff until they could be seen by a doctor. Patients who attended the department during opening hours were attended by band 5 nursing staff and specialist registrar. Staff told us that there should be three band 5 nurses on duty, but that regularly there were only two. When we inspected unannounced, we found that there was only one experienced band 5 nurse on duty, and one bank (overtime) nurse as well as a doctor. Staff told us that getting consultant support out of hours was difficult. The department was very busy late in to the evening. Staff told us that they would have difficulties seeing all of the patients before the department closed and that some patients would have to be seen in the Minors department.

Urgent and emergency services

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Inspection February 2014: Using evidence-based guidance

The A&E used evidence-based guidelines – for example, there were a number of care pathways in the department for patients with specific conditions to follow, such as the stroke and sepsis pathway. One member of staff told us that there was a need for some other pathways, such as for back pain. Ambulance staff told us that there were criteria to follow when they made a decision about which hospital to take people to. They were concerned that some of the criteria were too strict, meaning some patients were taken to A&E when they would have been more appropriately placed in, for example, the cardiology department. They told us that this had an impact on the volume of patients in A&E, which in turn meant that patients in A&E had to wait longer to be seen.

We spoke with doctors and nurses about the implementation of National Institute for Health and Care Excellence (NICE) guidelines. They told us that, as NICE guidance was issued, they made sure that any relevant to the A&E were implemented and that staff were aware of the requirements. NICE guidance was discussed at governance meetings which senior staff attended.

Inspection February 2014: Performance, monitoring and improvement of outcomes

Over the past five years, the department contributed to the trust's participation in national clinical audits, such as the asthma, the feverish child, the vital signs and the consultant sign-off audits. This allowed them to benchmark their performance against that of other trusts. It also meant that the service could measure its own performance over time to ensure that any areas for improvement were identified, action taken and improvements made. The results of the follow-up audits showed that generally they were making improvements in meeting standards over time – for example, with the feverish child, the department had improved at re-audit, although it had deteriorated with the vital signs audit.

One senior member of staff told us that senior staff met regularly to discuss mortality in the department as a way of identifying any concerns or areas for improvement. This showed that senior staff were aware of the importance of analysing the causes of death as a way of improving the treatment that patients received in the department.

Are urgent and emergency services caring?

Requires improvement

Inspection February 2014: Compassion, dignity and empathy

Analysis of survey and patient feedback data showed a mixed picture. A recent survey by Healthwatch highlighted some concerns about the attitude of staff within A&E, stating that they weren't always polite. A number of people had experienced poor attitudes from staff. Information from our listening events also raised concerns about the attitude of staff within A&E.

Information from the NHS Friends and Family Test showed that, although A&E had a lower response rate than the national average, 9.7% compared to 13.8%, the average score for the trust – 68 – was higher than the national average of 55. This meant that, overall; patients who had used the A&E services were likely to recommend this A&E to their friends and family.

We observed the way people were treated by staff in both the Majors and Minors departments, although we did not carry out these observations while people were being given clinical care. From our observations, staff were under a lot of pressure because the departments were busy. We saw that staff were polite, but they did not have time to spend with people. They tried to deliver treatment in a caring, compassionate way that promoted people's dignity, but this was not always possible.

For example, at one point there were 10 trolleys waiting in the corridor because all of the cubicles were full. We saw one person on a bed, in a cubicle with the door left open. They were not properly covered by a blanket. We saw a number of staff walk past the room, but none went in to cover the person properly. This meant that the person was

left exposed in view of all in the department. We also saw a man on a trolley in the corridor who had no top on and no blanket to cover him. He was left exposed in view of all in the department.

We had concerns about people's dignity when they needed to use the toilet. We saw one person inform several staff that they needed the toilet several times before they were given assistance. Staff told the patient that they were busy and would come back as soon as they could. Because the person was on a trolley in the corridor, staff had to move someone out of a cubicle, take the person in, then, once they had finished, take them out of the cubicle and move the original person back. This was unsettling for both patients and did not promote their dignity. A member of staff told us it wasn't uncommon for people to have to wait 30 minutes for a commode.

Within the Minors department, we observed that patients were treated with compassion by staff. On the whole, staff were polite and took time to speak with patients. When we spoke with patients in Minors, they were complimentary about the treatment they received. They told us that they thought they had been treated with empathy and their dignity was preserved.

Inspection January 2015: Compassion, dignity and empathy

During the unannounced focussed inspection we saw patients were held on trolleys in the reception area when arriving in the department by ambulance. We observed patients waiting in this area for long periods of time until a cubicle was available. Staff told us patients also waited on trolleys in the atrium area until beds on wards were available.

Inspection February 2014: Involvement in care and decision making

The people in Minors told us that their treatment was discussed with them. They were aware of what the options were for the next stage of their patient journey. People in Majors were not always clear what was happening to them or whether they were able to make choices about the treatment they received.

Inspection February 2014: Trust and communication

We spoke with a number of patients about their patient journey. They told us that sometimes they felt as though they had been forgotten about because of the time they were left waiting. Some were not really aware of what was happening to them and did not know why they were waiting. Other people in Majors told us they weren't sure whether they were being sent for tests, waiting for test results, or waiting to be admitted to a ward. Patients told us they did not feel as though staff kept them informed about the reasons for delays.

When we spoke with patients in Minors, they all told us that they felt safe and had confidence in the treatment they had received. They thought that staff kept them informed of the reasons for any delays and they were aware of what would happen next in their patient journey.

Inspection February 2014: Emotional support

Staff tried to support patients and their relatives as much as they could in the time they had, however, staff were very busy during our inspection and were therefore unable to spend a lot of time with people. Patients and relatives thought that the staff were helpful if they were approached.

Inspection February 2014: Children's A&E

From our observations, staff dealt with patients and parents in a caring and understanding manner. They took time to speak with relatives and reassure them. There were no specific concerns identified about the manner or attitude of staff in the children's A&E highlighted in the NHS Friends and Family Test results.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Inspection February 2014:

Trusts in England are tasked by the government with admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The department had met this target between April 2012 and August 2013. However, in April 2013 performance declined to 90%. The A&E was within expectations for ambulance handover. The A&E was tending towards better than expected for the percentage of patients who wait in A&E less than four hours, the percentage of non-admitted patients who wait in A&E less than 4 hours and leaving A&E

without being seen. The A&E was performing within expectations for the unplanned re-attendances, including the transition from the ambulance into the department. However, of the four measures for waiting times in the NHS A&E survey the department was performing worse than expected for the first conversation with a doctor or nurse and waiting for information about waiting for an examination. The department was performing within expectations for time taken to be examined and length of time in A&E.

There were systems in place to monitor the performance of the department, such as the triage and waiting time targets. The results of these were shared nationally and one senior manager told us that the results were used to assist with making decisions about the department.

In recognition of the failure to meet the national four-hour waiting time target of 95% of patients being admitted, transferred or discharged within four hours in the last quarter of 2012/13, the hospital sought support from external bodies including a review of the emergency pathway by local providers. In addition, the trust invited in the Emergency Care Intensive Support Team and had been working to an action plan to address issues over capacity and constraints within the department.

The time patients waited between arrival and full assessment, including pain score, met the target of 15 minutes for every month from July 2013 to December 2013. Use of the computerised Clarity triage system in Minors meant that people arriving at the department were triaged quickly. There was no data to show any differences between the Minors and Majors units. Patients referred to Majors were met for initial assessment by a clinical support worker and nurse.

Inspection: January 2015. Access and flow

During our focussed inspection we observed ambulance handovers to staff within the ED department. We found that some patients admitted by ambulance did not always have prompt initial clinical assessments to identify their individual needs. In the NHS Confederation document Zero tolerance making ambulance handover a thing of the past (2012) it states ambulance handover and turnaround delays are not good for anybody least of all patients.

National policy direction on this issue states that long delays in handing patients over from the care of ambulance crews to that of emergency department (ED) staff is detrimental to clinical quality and patient experience.

We spoke with seven ambulance crews who told us they frequently had to wait in excess of 15 minutes to handover patients to ED staff. One paramedic told us “yesterday we had to wait 90 minutes to handover our patient which is normal”. Another member of ambulance staff told us “the other day we queued outside the ED department for 30 minutes and had to wait 97 minutes to handover the patient.”

The College for Emergency medicine (CEM April 2011) in their triage position statement state “Triage is a face to face encounter which should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact.” Following our inspection CQC wrote to the trust and asked the trust to provide information on the initial assessment of patients on the days of 28-29 January 2015. The trust responded and told us their high level review indicated that there were 14 patients not assessed within 15 minutes over the two days of the CQC inspection (234 patients attended the Department via ambulance over these two days). The trust also stated that times had not been recorded for all patients and the validation process would confirm these assessment times. However when the trust provided CQC with the validated information it showed of the 235 patients, who had attended on 28-29 January, 130 patients had been assessed within 15 minutes this equated to 55% of patients who attended the department.

We reviewed further information provided by the trust on ambulance handover times between December 2014 and January 2015.

- We found there were 2148 ambulance handovers in December 2014 and 2211 ambulance handovers in January 2015.
- There were the highest numbers of daily handovers,107 on the 12 January 2015; 44 of which waited in excess of 15 minutes. There were 36 patients who waited between 30-120 minutes to be handed over to ED staff from ambulance crews.

- The 26 January 2015 had the least number of ambulance attendances at 31, However nine handovers out of 31 waited in excess of 15 minutes. Two patients waited between 60-120 minutes to be handed over to ED staff from ambulance crews.
- In December 2014 1330 out of 2148 ambulance handovers (62%) were triaged in under 15 minutes. In January we found 1329 out of 2211 ambulance handovers (60%) were triaged in under 15 minutes. Patients may have been at risk of receiving delayed care and treatment in ED because of length of time waiting for an ambulance handover.

We reviewed information on the number of breaches in the ED department between 01 October 2014 and the 4 February 2015.

- Performance data indicated that the Trust was not achieving the four hour target. For December 2014 it was 71.4%, in January 2015 it was 73.2% in February 74.6% and in March 73.6%. These figures were compared to the benchmark of over 89%
- For this time period there had been 39,646 patients who had attended the ED department. There was a total number of 12,260 breaches (31%) of the four hour target.
- On average there was a daily attendance in the ED department of 312 patients in this period with an average of 80 patients each day which breached four hours in the department.
- Between November 2014 and December 2014 there was a 57% increase in the number of four hour breaches.
- Between 23 December and 23 January 2015 there were six patients who had waited longer than 12 hours on a trolley in the ED department.
- On 28 January 2015 there were 81 delayed discharges across the Trust which may have impacted to the flow through the ED department. The number of patients attending the department on this day was within the normal range for the trust. At 9PM there were eight people who had been seen and treated within ED and identified for admission however there were breaching the 4hour target. This was due to a lack of bed capacity within the hospital.
- There was evidence from complaints received about ED that these delays had impacted on patient care, for example, delays in waiting times for procedures or investigations and waiting on a trolley.

Inspection February 2014: Performance monitoring

A senior manager told us, “There are times when we can’t care for our patients properly”. This was for a number of reasons, including the lack of availability of beds elsewhere in the trust causing patients to have to wait in A&E, resulting in overcrowding, incorrect staff skills mix, volume of attendances at A&E and too few staff. We witnessed occasions when people’s pain needs were not met. We also saw one person who could not speak English and had complex needs, who was not provided with any information because an interpreter had not been contacted. Patients who had been in A&E overnight told us that they were not routinely offered drinks or snacks. One person who had been admitted to the department overnight had not been offered food or a drink until lunchtime the following day.

There were also some tensions between teams of staff about where responsibilities lay for patients. For example, - staff told us that often patients who had been referred to the hospital by their GP were moved to A&E because there were no beds on the ward they needed to go to. Patients were not always seen by a doctor for many hours, with only a nurse undertaking basic observations such as blood pressure, pulse and temperature. Staff told us that responsibility for these patients lay with the acute assessment unit (AAU). This meant that there was a risk to these patients that they would not receive the care and treatment they needed in a timely manner. Some patients we saw during our inspection were waiting well in excess of four hours (the national maximum target) and, on one occasion, we were aware of at least two people waiting over nine hours. Staff told us this was not an unusual occurrence.

Inspection February 2014: Vulnerable patients and capacity

Staff understood consent procedures and the requirements of the Mental Capacity Act 2005 for them to act in people’s best interest if they had temporary or permanent cognitive impairment. Most interventions in the A&E department required informal or verbal consent. A nurse told us this might involve speaking with relatives if the patient did not have capacity, and there were also resources to assist staff when dealing with people with dementia or learning difficulties. There was a system in place to discreetly inform staff of patients who were identified as having dementia on admission.

Urgent and emergency services

Staff were concerned about the support they received for patients who had mental health problems. They told us that, for patients identified as having mental health problems who were in need of a psychiatric assessment, there were often long delays of over three hours. This was the case for both adults and young people. Staff told us that the psychiatric services were managed by another trust; however, this still meant that people who attended A&E with a mental health problem who needed psychiatric assessment did not receive treatment in a timely manner. We contacted the Humber Foundation Trust who said, "The Humber NHS Foundation Trust operates a Psychotic Liaison Department within Hull and East Yorkshire Hospitals, this includes a rapid response to A & E. Hours of operating are 8.00 am - 8.00 pm Monday to Friday. From 5.00 pm to 9.00 am week days and 24 hours on a Saturday and Sunday referrals are received by the Crisis Team. On occasion if the Crisis Team is busy within the Community there may be a response of three hours or more. As you will appreciate patients in A & E are in a safe environment and therefore do not take priority over people in their own homes. We do have regular dialogue with the A & E Department when such occasions arise and always try to meet the four hour deadline.""

Inspection February 2014: Facilities

During our inspection we observed that though some of the facilities available in the A&E were good, and some were not fit for purpose. Facilities in Minors had been refurbished and were clean and tidy. When we visited Majors, we found that this was not the case. There were insufficient cubicles for people waiting to be treated and men and women had to share toilet facilities.

Inspection February 2014: Leaving hospital

We attended the bed meetings, held at 9am and 12pm to provide an overview of the number of beds available in the trust and to identify any sources of delay to discharges. Staff told us that, when people were well enough to leave hospital unaccompanied, they were able to leave whenever they wanted to. A receptionist told us that they often assisted people to order taxis and organise transport home. However, staff told us that they would avoid discharging people very late at night or very early in the morning unless they were sure that the person had someone to accompany them or stay with them at home.

Inspection February 2014: Learning from experiences, concerns and complaints

There were action plans put in place to respond to comments received from feedback from patients as part of the 'I want great care tool'. Two issues had been raised, one on communication (October 2013), the department responded by including discussions of the results of the Family and Friends Test, and how to make communication more effective in team meetings. The second issue was about the length of time in the waiting area. An action taken to address this involved the development of a new one way system changing the flow from initial assessment.

The trust had systems in place to learn from concerns and complaints. One senior nurse told us that details of these were fed back to staff at team meetings. They told us that team meetings were supposed to take place every two months, but sometimes they did not take place because the department was too busy to release staff to attend.

We asked staff whether they received information about complaints and concerns. They told us that they were not regularly informed about them. They told us that lessons learned were not discussed at team meetings and they were unaware of whether the trust produced any kind of information for them to read. This meant that patients were at risk because staff were not regularly informed about concerns, complaints or lessons learned about how to avoid repeats of the same incidents in the future or improve practice.

Inspection January 2015: Learning from experiences, concerns and complaints

We received information form the trust as part of the focussed inspection which showed that ED department had received 44 complaints between October 2014-February 2015. We saw the themes and trends had been identified and the largest number of complaints (four) related to waiting times for procedures or investigations and waiting on a trolley.

Inspection February 2014: Children's A&E

The children's department had recently been refurbished and provided good facilities for children and young people.

There were occasions when the department was not able to respond to the needs of patients, for example, when children or young people attended the department with mental health problems. Staff told us that it was difficult to

access psychiatric support for young people after 5pm. One member of staff told us that most patients were asked to return to the department during the opening hours of CAMHS. If they had concerns about a patient, they would call the adult on-call psychiatrist for an assessment. We contacted the Humber Foundation Trust regarding the service provided and they told us that currently they do not have an out of hours crisis team for children and young people. There is a CAMHS consultant on call as well as a CAMHS manager both of these can be contacted out of hours particularly when a child is at risk. The trust is liaising with the commissioners for a crisis service. However, they do not have any tier 4 CAMHS beds locally and there has been a couple of recent occasions when they have had to liaise with the paediatricians for a child bed at Hull and East Yorkshire Hospitals NHS Trust. This only occurs when the child or young person can be kept safe in that environment and it does not impact on other patients.

Staff told us that there were occasions when it was difficult to get consultant cover in the children's department when the adult department was busy. This was because there was no dedicated paediatric A&E consultant within the A&E as a whole. Staff told us that there was a problem with where to place patients aged 16 and 17 years and that these patients were admitted to adult wards, which were not necessarily the most appropriate places for them.

Are urgent and emergency services well-led?

Requires improvement

Inspection February 2014: Vision, strategy and risks

Forward planning had taken place to address the significant shortfalls in the size and capacity within the A&E. The trust was part of the way through the improvement programme, having completed the refurbishment of the Minors area and the children's A&E department. The extension of the Majors area is due for completion in quarter three in 2014. To alleviate the risk, and in recognition of winter pressures, a temporary facility was installed to increase capacity from 14 to 20 beds.

Some staff felt that there was no strategy in place to deal with very busy times, when patients were left waiting on trolleys in corridors. They told us that senior managers were on call and would come to the department if requested, however, they told us that they didn't find this helpful or effective in sorting out any problems. A senior manager provided us with a copy of the 'Procedure for managing inpatient flow'. They were also able to describe at length the arrangements in place to manage peaks in volume of activity in A&E. They did, however, tell us, "The escalation process doesn't work as it should".

Inspection January 2015: Vision, strategy and risks

At the time of the January 2015 inspection the refurbishment of the majors area was still ongoing and was not expected to be completed until April 2015.

Inspection February 2014: Governance arrangements

Within the trust, we found that there were governance structures and processes in place, however, when we spoke with A&E staff, they were unaware of these structures. We found that there was a disconnect between staff in the department and the staff involved in the governance aspect of the medicine health group.

A&E had management structures in place; however, some staff in the department told us that no one senior clinician had an overview of the department on a shift by shift basis. This meant that it was not always clear to junior staff who to approach for assistance. Nursing staff told us that there was always an A&E coordinator overseeing the nursing care. There were more senior staff available for support if needed. On the whole, staff felt that the arrangements within the department were "OK"'. But they did not feel that this was the case for management arrangements above matron level. Staff felt that managers above matron level did not have a good understanding of what it was like to work in A&E.

Inspection January 2015: Governance arrangements

During the unannounced focussed inspection most staff told us they would report incidents on the trusts reporting system however staff told us they did not routinely get feedback from the incidents they had reported.

We saw there had been a cluster of incidents regarding blood transfusions within the ED department, AAU and ASU. The trust provided information on what actions had been taken relating specifically to these incidents. These were then reported into the appropriate governance meeting where lessons learnt were discussed.

Urgent and emergency services

After the focussed inspection we reviewed the department's risk register and found medical staffing including consultant and registrar vacancies were identified as high. We saw the register identified mitigating actions and review dates so the risks continued to be monitored. However we did not see information on the risk registers which identified the nurse staffing risks to the department.

Inspection February 2014: Leadership and culture

We spoke with nurses, clinical support workers, porters, junior doctors and consultants to find out about leadership within the department and about the culture of the department. Most staff told us that within the department, there was a sense of team working. They thought that the team pulled together in difficult times and supported each other. Some staff, however, told us that they felt under pressure to meet targets and were made to feel as though they had failed to do their job correctly by senior managers within the trust, if waiting time targets were not met. They told us they were made to feel that meeting the waiting time targets was more important than making sure patients received the correct treatment. A number of staff told us and that they felt bullied and pressurised by other team members. They felt that some colleagues were constantly pushing them to hurry to get things done so that patients could be discharged or moved to other departments within the four-hour target time. They thought that this was not always in the best interest of the patient. We saw, from information given to us by the trust, that sickness levels in the trust were higher than the national average – 1.4% for medical staff compared to 1% nationally and 4.7% for nursing staff compared to 4% nationally. There was no data available about sickness levels specifically in A&E, although, over the last 12 months, four consultants of the 12 employed by the trust had been off sick.

A senior manager told us that they were aware of the problems with stress in the A & E and a human resources lead had been given a key objective three months ago, to work alongside staff in the department to get a real understanding of the reasons for the stress. The senior manager told us they were unaware of any action taken to address staff stress levels. When we checked with the human resources department, we were told that no practical action had been taken to try to reduce staff stress.

Inspection February 2014: Staff involvement and engagement

There were a number of trust-wide initiatives in place to engage more with staff. Staff in A&E, however, did not feel engaged outside of the department and demonstrated little awareness of the various initiatives taking place across the trust. One member of staff told us that they just didn't have time to get involved in things when they were working. Some staff felt that they were not listened to, for example, - when they made suggestions about how to improve the department.

Inspection February 2014: Learning, improvement, innovation and sustainability

A senior doctor told us that there had recently been a number of initiatives to try to improve the running of the department, such as a redesign of the care pathways for patients with heart failure and chronic obstructive pulmonary disease. The aim was to improve patient access to wards that treated these conditions and so reduce the pressure on A&E.

We spoke with a senior manager within the trust about how lessons learned from incidents were disseminated across the trust. They told us that they would expect senior staff to pass this information to the rest of the team, but they said there was no mechanism in place to check that this was happening.

Inspection February 2014: Children's A&E

Staff told us that morale in the department was low because staff were under pressure. They told us that there were not enough staff on duty in the department to manage the number of patients to be seen. One of the impacts of this was that staff didn't have time to reflect on cases, or lessons learned.

Staff told us they did not feel supported by the management team. They told us that the nursing leadership in the department was poor because, when the adult A & E was under pressure, the children's department did not always receive the support and leadership it needed.

One doctor in the department told us that there was very little in-house training organised by the trust, such as simulation training. There was no paediatric training; however, the doctor said that the regional training received was adequate. Nursing staff said that they were able to attend mandatory training to make sure they remained up

to date, but that access to other training was very difficult. Staff had attended Level 2 safeguarding children training but there was a need for some staff to attend Level 3 training.

Medical care (including older people's care)

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

Information about the service

Inspection February 2014: Acute medical services were provided at Hull Royal Infirmary. We visited seven wards, including three wards providing care for older people, Ward 10 providing care for patients with diabetes and endocrinology conditions, Ward 12, the acute assessment unit (AAU), the elderly short stay unit (ESSU) and the patient discharge lounge.

We spoke with 37 patients, 15 relatives and 23 staff. We attended a number of focus groups and we observed care being delivered on the wards We looked at 27 sets of patient notes, including nursing, medical, pharmacy and multidisciplinary team notes.

Summary of findings

Inspection February 2014:

We found staff committed and hardworking but struggling to provide safe or effective care, particularly for patients on the AAU who had been referred by their GP. Staff across wards and departments raised concerns about staffing levels. Staff on the AAU, Ward 10 and Ward 70 were particularly concerned about the lack of nursing, support workers and medical staff on duty at night and weekends. The low number of junior doctors combined with the lack of available beds led to long delays in patients accessing assessment and treatment, and resulted in the frequent movement of patients internally and across to Castle Hill Hospital.

The wards used care bundles to ensure that patients with particular conditions received appropriate care. Intentional rounding had been introduced (or around-the-clock care) to check that patients were reviewed every hour, and this had resulted in an improvement in fluid balance monitoring. The medical wards were using the NHS Safety Thermometer to manage patient risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections to drive improvement in performance.

The hospital provided stroke Level 1 services and was meeting national targets. A stroke co-ordinator received patients on arrival at the hospital to commence and manage their progress along the stoke pathway. Patients told us that staff were caring and we saw

Medical care (including older people's care)

examples of compassionate care being given. The wards were well-led at the point of service delivery and staff felt supported, although some staff told us that there was a "disconnect" between the Board's executive team and the wards.

Inspection January 2015:

During the focused inspection in January 2015 we had concerns regarding nurse staffing on AAU. We found the actual numbers of registered nurses had improved in the months of February and March. Staff we spoke with on Ward 120 which was a winter pressures ward told us they did not know the patients and felt that they could not provide patient centred care. There was no stock of oral morphine, which is a controlled drug, on ward 120 and staff were borrowing this from other wards. A risk register was in place. A risk identified was recognition and management of deteriorating patients on AAU which was due to be reviewed at the end of November 2014. The trust provided information that showed seven control measures had been implemented to manage this risk. The risk was last reviewed in March 2015. We also saw nurse staffing had been identified as a high risk within the Medicine Health Group and had nine controls/actions identified to address the risk.

Are medical care services safe?

Inadequate

Safety and performance

Inspection February 2014: Incident reporting

An analysis of incident reporting for Hull and East Yorkshire Hospitals NHS Trust showed the trust was reporting less patient safety incidents than other trusts of a similar size (National Reporting and Learning System July 2012 – June 2013). Medical specialties reported 35% of 389 incidents, which resulted in moderate harm, 39 of which were attributed to the care of older people. Staff told us they did not always report incidents due to a lack of time to complete the documentation. Twenty-one staff told us they did not get feedback about learning from incidents from other health groups within the trust to identify common themes and trends. We showed four staff the lessons learned bulletin published by the trust and none had seen the bulletin before. A junior doctor told us they had witnessed a patient safety incident but had not reported it because they could not access the Datix software system used to record patient safety incidents. This meant the trust board could not be assured that data used on incident reporting accurately reflected the numbers occurring, and so taken into account in addressing risk.

Inspection January 2015: Incident reporting

During the unannounced focussed inspection we found that from 1 October 2014 to 29 January 2015 there had been a total of 555 incidents reported in the department. The main themes from these incidents were: 40 related to access, admission, transfer and discharge, 39 organisational issues including staffing, 327 pressure ulcers, five were hospital acquired and 42 related to treatment of care. We also saw four of these incidents related to blood transfusions within medicine. The investigations into three of the incidents found there was a lack of awareness of agreed policy and procedures by staff. Repeated incidents indicated that learning had not occurred within staff groups.

In the same time period there were 19 incidents recorded on ward 120 (The winter pressures ward). The main

themes from these incidents were: two related to access, admission, transfer and discharge; six organisational issues including staffing and; one related to treatment and omissions of care.

Inspection February 2014: Staffing levels

To alleviate the pressure on doctors, the hospital was introducing a 1:9 registrar rota, backfilling with internal locums and adding three more clinical fellow posts. However, medical staff told us the on-call arrangements were not safe. There were times when there were only two junior doctors for the entire tower block at Hull Royal Infirmary at night and vacancies were not filled. Junior doctors told us that they were pressured to carry more than one pager – sometimes up to three – and had not always completed the competencies in the specialty required to answer calls. Junior doctors were sometimes stepping up into registrar roles. We were shown multiple text alerts to doctors to do locum work to cover gaps in shifts. This meant that patients were put at risk as they were not always seen by appropriately experienced doctors, subjected to delayed assessment and decision making.

Staff on the AAU, Ward 10 and Ward 70 were particularly concerned about nursing and healthcare support workers and not having enough nursing and medical staff on duty at night and weekends. We looked at the weekly staffing summary for the AAU from 13 January 2014 to 27 January 2014. Week one only had 88.10% (259 shifts) fully staffed with 35 shifts unfilled; in week two 82.31% (232 shifts) were staffed with 59 shifts unfilled; in week three 87.07% (256 shifts) were fully staffed with 38 shifts unfilled. This meant that patients were at risk of not receiving appropriate care and treatment as there were insufficient qualified and experienced staff.

In October 2013, the trust carried out an acuity and dependency audit and identified that elderly medicine was very understaffed across the trust. (Acuity measures how ill a patient is and helps to decide the appropriate level of nursing/medical care required). The board was alerted to a significant risk in relation to medical staffing in the Medicine Health Group from September 2013 (Compliance and Risk Committee, October 2013). Wards were not always meeting Royal College of Nursing recommendations of (65:35 skills) mix a mix of registered nurses to healthcare assistances on a shift. The wards were experiencing nurse vacancies – for example, in November 2013 there were 101.99 whole time equivalent vacant posts (6.65% of ward nursing establishment). Staffing levels had been affected by maternity leave at 11% across wards and some areas were experiencing 11% sickness absence.

Action had been taken by the trust to reduce the risk. Patient safety briefings had been introduced, whereby senior managers and ward representatives met twice a day to identify where risks were that day and to redeploy staff to where they were most needed. The trust board had agreed investment of £450,000 for increased nursing staff across the trust. A further investment was being proposed to make ward managers supernumerary and in preparation for the expectations of the National Quality Board recommendations.

Inspection January 2015: Staffing levels

During the focused inspection we had concerns regarding nurse staffing on AAU. As part of the inspection we asked the trust to provide information on the planned and actual numbers of staff from November 2014 to January 2015.

- Between November 2014 - January 2015 we found on average there were 8 RNs per day on the early shift against a planned number of 10. Only 12 shifts (13%) out of 92 shifts in the three month period met or exceeded the planned RN staffing levels. At its lowest levels the actual number of RN's dropped to 7 on at 30 occasions.
- We found in the same time period on average there were 8 RNs per day staffing the AAU on the late shift. Only 7.7% of shifts in the three month period met or exceeded the planned RN staffing levels. At its lowest levels staffing levels dropped to 6 RNs for 8 shifts. From the 28 November 2014 the actual staffing levels had not met the planned level.
- Between November 2014 - January 2015 we found on average there were 7 RNs on the night shift against a planned number of 8. Only 7.7% of shifts in the three month period met or exceeded the planned RN staffing levels. Staffing levels reached the lowest at 5 RNs on the 1 January 2015. Only 1 shift since 1 December 2014 had been at the planned level of staff.

Medical care (including older people's care)

On the 30 March 2015 we issued a section 64 letter to the trust and requested further information on nurse staffing numbers for February and March 2015. We found the actual numbers of registered nurses had improved in the months of February and March.

- In February we saw information for the planned numbers of staff required for each shift the actual number of nurses who worked during the month. We saw 75% of shifts had been at the planned numbers. At its lowest levels staffing levels dropped to 6 RNs for 2 shifts.
- In March 2015 we saw information for the planned numbers of staff required for each shift the actual number of nurses who worked during the month We saw 66% of shifts met the planned numbers. At its lowest levels staffing levels dropped to 5 RNs for 2 late shifts.

During our visit to Ward 120 which was a winter pressures ward, matron told us the ward was closing and the patients were being moved to other wards by the 30 January 2015. Thirteen beds had been identified to move the patients to other wards in the hospital. When we asked about nurse staffing we were told the ward was staffed with nurses who had been moved from other wards. We visited ward 120 both in the evening and the following morning, all staff we spoke with told us they had not been shown where equipment or medications were stored. Staff also told us they did not know the patients and felt that they could not provide patient centred care.

Staffing information was available for the bed meetings which occurred between 8:00am to 20:00pm. There were four bed meetings per day. Any staffing issues after 20:00 were managed by the 1st and 2nd on call nursing staff. Following the inspection the trust told us staff were asked to move to areas that require support. When this has happened this would not necessarily be reflected in the staffing numbers on the off-duty.

Inspection February 2014: Mandatory training

Safeguarding training was provided but not all staff had completed the appropriate levels for their role. For example, - for safeguarding children and young people Level 3, general medicine across both hospital only 52.5% met requirements.

Not all staff groups had completed their mandatory training and the division was not meeting the trust target of 85%. The medicine division had achieved overall 72.1%, with medical staff completing 72.4% and nursing staff 76.6%. There were variations in attendance across wards and departments, for instance for the AAU, attendance was 76.4%; Ward 10 achieved 52.2%; ESSU was 64.5% and Ward 70 was 72.2% (Staffing Metrics for November 2013, January 2014). Staff reported that access to mandatory training was problematic. Ward managers told us that, due to staffing issues on the wards, staff could not always be released to access training. At the focus groups, staff told us they often had to attend training in their own time and that mandatory training did not always take place due to staff shortages. Junior doctors told us they did not always receive training due to staffing pressures.

Inspection February 2014: Cleanliness and infection control

Governance arrangements ensured that risks were identified and appropriate action taken to control the risk of infections spreading. There were systems to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. All areas visited were clean. The trust was working to locally agreed targets for infection control and had action plans in place to address any shortfalls in identified practice.

Inspection January 2015: Medications

On Ward 120 a patient asked to speak with the CQC inspector to share their concerns. The patient had been admitted on Tuesday 27 January 2015. Since admission they told us they had not had their regular medication and that the medication should not just be stopped abruptly. When we reviewed the medication chart on 29 January 2015 we found the medication was recorded out of stock but it was unclear whether the medication had been ordered from pharmacy. Staff said they were also unsure whether the medication had been ordered.

The patient had asked their relative to bring in their own medication from home because they were having withdrawal systems. The patient told us staff had not allowed them to bring in their own medication, but as they were feeling so unwell they had self-medicated that morning.

We reviewed another patient's medication chart who had been prescribed oral morphine which was a controlled drug (CD). We found there was no stock of oral morphine on the ward and staff were borrowing this from other wards. We looked in the CD order book and no oral morphine had been ordered since 5 January 2015. The time the patient received the medication varied and did not match the prescribed time. On one occasion the patient received the medication two and a half hours after the time it was prescribed for.

Inspection February 2014: Acute assessment unit (AAU)

The AAU managed and triaged (prioritised) GP referral patients. Staff from AAU were unable to oversee these patients when they were waiting on trolleys in the A&E corridor. The hospital had introduced a FAST team for managing these patients, staffed by a qualified nurse and a clinical support worker. The FAST team reviewed patients who were waiting in A&E and completed observations, ensured access to pain relief and reviewed care. However, we observed a patient who was on a trolley for over seven hours and they had not been reviewed by staff or offered a drink in that time. Four staff on the AAU and the clinical director told us they did not always have enough staff to operate the FAST team. Staff told us they did not always know GP referral patients were on trolleys in the A&E corridor. This meant there was a risk that patients could deteriorate because there was no clinical overview to ensure that they received appropriate and timely treatment.

Two side rooms on AAU could not be overseen by the nurses station and there was a risk a patient could fall and not been seen by a health professional. The waiting area for AAU patients was located in an old meeting room. The room was an internal L-Shaped room with no windows. The walls had peeling paper and there was limited furniture in the room. On the day we visited there were eight chairs and one table with six dining chairs. The waiting area could not be overseen by staff

Learning and improvement

Inspection February 2014:

The wards displayed information about patient harms, staff experience and ward staffing levels. Audits were undertaken for falls, pressure ulcers, and infection rates and staff were informed of their area's performance to drive improvement.

Inspection February 2014: Monitoring safety and responding to risk

In response to concerns that staff may not recognise the deteriorating patient, particularly on the AAU, the national early warning score (NEWS) had been introduced (corporate risk register, January 2014). Deteriorating scores where escalated to a critical care outreach team. Training for recognising the signs of a deteriorating patient had been introduced and intentional rounding had been implemented on the AAU. We checked five patient records and found their intentional rounding documentation completed.

There had been a sharp, recent rise in mortality in the diagnosis group of Septicaemia between July and September 2013. Between April and September 2013, there were 47 deaths at the trust, of which 44 (over 90%) were among patients recorded with a diagnosis (sepsis, unspecified). Forty-two of these patients were admitted to the trust as an emergency. The trust has been asked to provide further information on this to the Care Quality Commission.

In line with other health groups across the trust, the medical wards were using the NHS Safety Thermometer to manage patient risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections. This is a tool designed to be used by frontline staff to measure a snapshot of harms and 'harm free' care once a month. We observed the outcomes, including information on harm-free care days displayed on ward noticeboards. For example, on Ward 10, there had been 265 days since a reported case of Clostridium difficile (C. difficile) and 30 days since the last reported fall.

The trust used care bundles to ensure that patients with particular conditions received appropriate care. We saw completed care bundles for skin integrity, falls and nutrition. A report to the Quality, Effectiveness and Safety Committee, 13 December 2013 highlighted the trust's poor compliance in this area. The trust responded by introducing intentional rounding; this was being piloted in certain areas, which meant that every patient was

reviewed every hour, and this had resulted in an improvement in the fluid balance monitoring and the trust's compliance (Corporate Performance Report, Quality and Safety January 2014). However, we found that the monitoring of food and meal replacements was not always completed consistently in three patient notes on Ward 70, which demonstrated that there were still areas in need of improvement.

In October 2013 the trust's Safety Thermometer Newsletter identified that 97% of patients had received no new harm since their admission to hospital.

Inspection January 201:. Monitoring safety and responding to risk

Information provided by the Trust indicated that they had acted on the above sepsis concerns and an action plan was in place. At the time of the January 2015 inspection the trust were auditing the changes they had made to ensure that they were effective and mortality had reduced. CQC will review the results of the audit to determine whether any further action is required.

Inspection January 2015: Equipment and Environment

We found mobile x-ray machines were stored next to the lifts on floors 3, 6 and10. The x-ray machine on floor 10 was plugged in charging and there were mattresses, cages and other equipment in the foyer. We asked to speak with the head of radiography because we were concerned about the risk to patients and the public. We were told that the machines were stored in these areas all the time and that the machines could not be used because a key was required.

However on floor 3 the x ray machine was plugged in and had the key insitu, with a label on which stated that it should not be taken out. We raised this with the Director of Governance. The head of radiography attended and told us that you needed a code to use the machine. We requested to see the risk assessment completed for storing the x ray machines in a public area. The director of Governance told us she would have the machine moved to a meeting room for safety immediately.

Following the inspection the trust provided a risk assessment for the storage of x-ray machines in public areas and we saw this was completed the day after our inspection. We saw the risk assessment identified potential hazards and control measures in place to mitigate any risk.

Inspection February 2014: Records

The medical wards were using an electronic patient record (Cayder patient flow manager) to improve patient information, including discharge information, across the patient pathway. The system included information on a patient's full medical and social history. Staff told us this had improved information available on patients when they were transferred, particularly for the receiving ward at the point of transfer.

We looked at two patient records, one on the AAU and one on Ward 10. We found that both assessments were not consistently completed and were not reviewed in a timely manner. The patient on the AAU had a chest x-ray at 3.45am but this had not been reviewed during the medical ward round at 9am. The patient deteriorated with a perforated abdomen and was taken to theatre at 2.15pm. The anaesthetic sheet was not completed and timings were not written correctly. On Ward 10, antibiotic doses for a patient were not documented on their notes so it was unclear if the patient had received the medication prescribed. These meant patients were put at risk of not being given the appropriate treatment for their conditions in a timely way.

Are medical care services effective?

Requires improvement

Inspection February 2014: Using evidence-based guidance

The trust participated in national clinical audits such as the emergency use of oxygen, non-invasive ventilation, chronic pain, ulcerative colitis and Crohn's disease, Parkinson's disease, adult asthma, bronchiectasis, dementia, seizure management and diabetes. Action plans were in place following results of audits, for example – with Ulcerative colitis and Crohn's disease the trust had actions to devise a business case to remedy the shortage of inflammatory bowel disease specialist nurses, obtain dedicated pharmacy support and devise a business case to get a dietetic lead for the coeliac service.

Medical care (including older people's care)

The trust employed a lead nurse as a result of completing the National Audit of Dementia in General Hospitals for 2012–2013, to improve training, monitoring and management of dementia in the trust (Dementia services: Progress Report 2013).

Inspection February 2014: Staff, equipment and facilities

We found that there was a system in place for checking equipment and ensuring that it was fit for use.

The AAU was inadequate for the purpose intended due to space limitations, the lack of lighting and the open access to and from the area. The trust was aware of the deficiencies with plans in place to address the issues as part of the transfer of acute medical services to the Hull Royal site.

Inspection February 2014: Multidisciplinary working and support

There was good multidisciplinary team working within teams and across other divisions. Multidisciplinary team meetings took place with partners in community and social care for assessment, treatment and discharge. For example, - the multidisciplinary team on the Level 1 stroke unit had stroke physicians and neurologists providing a 24-hours, seven-days-a-week acute thrombolysis service, with assistance from stroke coordinators

Are medical care services caring?

Good

Inspection February 2014: Compassion, dignity and empathy

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required a similar treatment or care. Between July 2013 and October 2013, the trust was performing above the national average for inpatient scores (39 wards across the trust). However, there were three wards at Hull Royal Infirmary that were unlikely to be recommended, Ward 8, Ward 80 and the ESSU.

Patients told us they felt well cared for and staff responded promptly to call bells. We observed drinks and call bells were placed in easy reach of patients on all the wards we visited. Four patients told us that staff were caring and pleasant; however, they felt at times there were not enough staff on the wards.

Generally patients and their families reported that they were well cared for and staff were supportive. However, when we spoke with patients on the AAU and one patient felt the use of the Cayder software system was intrusive and allowed people to see personal information. This patient felt that staff on the ward did not understand their condition. They also often needed help with personal care and on occasion had to wait from 6am to 11.30am to use the commode.

Inspection February 2014: Involvement in care and decision making

NHS Choices allows patients to score services out five stars for care and involvement with one star being the lowest and five stars being the highest. Hull Royal Infirmary scored 3.5 stars for involvement in decisions overall from patients.

At the previous CQC inspection in October 2013, we were concerned about the involvement and consent of patients. The trust developed an action plan, which included implementing the use of a patient passport and improving patient-specific information in the care records. On the AAU, 28 patients and relatives confirmed that they were given good information and were involved in care. However, AAU staff told us that patient passports were not completed unless patients already had an existing passport in place.

Inspection January 2015: Involvement in care and decision making

During our unannounced focussed inspection in January 2015 there was one patient receiving end of life care on AAU. Staff told us they had been working with the family of the patient and had agreed to the patient being moved to a side room on a ward. The patient had been on AAU for 94 hours. The patient's relative spoke with a CQC inspector and told us they had concerns about the care and treatment their relative had received; they had been nursed in an open cubicle opposite the nurse's station and felt that their relative had no dignity or privacy.

During our unannounced focussed inspection a relative told us they did not feel they had been involved in the

care planning and decision making regarding their relative's care. They told us they had not had access to the palliative care team until the day their relative died and they believed this may have adversely affected the end of life care received.

Inspection February 2014: Trust and communication

We also found that patients and relatives were not always informed when patients were transferred to different wards, especially when it occurred overnight. Staff on the AAU, ESSU and Ward 70 told us that sometimes there was no time to contact relatives about patient transfers before they visited the ward.

We saw staff interacting with patients in a kind and considerate manner. Staff attitude towards patients was good and teams interacted well with relatives. Most patients on all wards praised staff for their care and support. However, some relatives on Ward 10 told us that when they rang the wards, calls were not always answered.

Inspection February 2014: Emotional support

Patients and their relatives told us that staff were caring and responsive to their needs. Patients felt that, although staff were busy, they would listen to concerns raised.

Are medical care services responsive?

Requires improvement

Meeting people's needs

Inspection February 2014: Acute assessment unit (AAU)

There were no waiting time targets for patients referred by their GP. We observed seven patients who had been waiting over four hours to be reviewed. As there was a lack of monitoring or performance measure, the trust could not be assured that patients were being seen in a timely way and so take action when problems were identified. Staff told us the trust had introduced a mobile ambulatory care (MAC) clinic for patients who needed blood tests and assessment. This was used for patients who were assessed as not at risk of deterioration so they could be seen without being admitted to the AAU. Staff felt this worked well, but the clinic was only available Monday to Friday.

Inspection February 2014: Internal transfer of patients

The hospital had identified two winter pressure wards for medical patients. However we found that medical patients were also transferred to oncology beds and neurology beds. The policy for medical patients transferred to oncology or neurology beds stated they should be able to be independent and within 48 hours of discharge. We spoke with clinical staff on Ward 4 (neurosurgery) and they told us they often had patients who needed two staff to help them mobilise and would stay on the ward for longer than 48 hours. One medical patient had been on the ward for two weeks and was still waiting for a discharge date

On Ward 16 at Castle Hill Hospital a patient told us they had been transferred from a ward at Hull Royal Infirmary with two other patients at 4am. Another patient who had suffered a head injury had been moved twice before being transferred to Castle Hill Hospital. In that time they had been in 10 different beds in five weeks. The trust was aware of the situation, and a review had taken place in December 2013 of the number of patients transferred out of the AAU after 10pm. They found that in total 583 patients had been transferred between 10pm and 6am. 196 patients had been moved between 10am and midnight and 387 transferred between midnight and 6am. This information was not validated and the trust was implementing a system to capture information on transfers within the trust (Corporate Performance Report, Quality and Safety, January 2014). This meant that patients were experiencing disruption of their care by being moved through the night, sometimes to another site, which could have a detrimental impact, particularly on the frail and elderly.

Inspection February 2014: Vulnerable patients and capacity

We received information prior to the inspection that there was concern that, when a patient had a mental health condition or dementia which resulted in them exhibiting challenging and aggressive behaviour, the trust used security guards to support patients on the wards. Staff

told us that, if a patient with dementia needed one-to-one care because they were confused and may be aggressive, then a security guard was used to manage the patient. We raised this with the medical director and chief nurse for the Medicine Health Group who confirmed that security guards were used. They told us they did not provide care, however, they were unable to tell us what training the staff had received for dementia awareness because that was provided by an external company. There was a risk that patients would not receive appropriate interventions for managing their behaviour. The trust informed us following the inspection that security guards were used for patients who exhibit challenging and aggressive behaviour (they may have a mental health condition or dementia). The trust's chief nurse received a daily report when security would have been requested (termed a 'security watch') to assist in relation to patients across the organisation and this information also went to the Safeguarding Board. We were informed that security watches were reviewed at the daily patient safety briefings to ensure that the right staff were looking after the right patients and the appropriate DoLS assessment were completed and relevant.

The trust had introduced a dementia strategy, which included the Butterfly Scheme– a system of care training provided by a not-for-profit organisation – for people living with dementia to deliver person-centred care. The trust had a dementia lead nurse who was also the lead for the Butterfly Scheme. Under this scheme, a butterfly symbol identified patients living with dementia, so that staff were alerted to a patient's specific needs and vulnerability. However, not all ward staff had received training in this scheme.

The trust had completed a dementia carer survey on Ward 70 and the ESSU at Hull Royal Infirmary and Ward 21 and 22 at Castle Hill Hospital. Thirty-three people had responded and 69% of carers felt they had been offered the chance to be enrolled in the Butterfly Scheme, and 91% of carers felt the ward team had involved them in the care of their relative (CQUIN Overview Report, Quarter 3 2013-2014, Hull and East Yorkshire Hospitals NHS Trust).

The trust was also developing a leaflet for patients and relatives to raise awareness about dementia. Dementia mapping was being undertaken on wards to help understand the shortfalls in services from the patient's viewpoint.

Inspection February 2014: Access to services

The trust had a stroke protocol designed to ensure that people identified as possible stroke victims followed a specific care pathway and accessed the appropriate services as quickly as possible. This was overseen by a stroke coordinator. The trust provided stroke Level 1 services and was meeting the national target for 90% of patients spending the majority of their time in a stroke unit. The trust scored 100% for patients who received a brain scan within 24 hours of admission, and access to physiotherapist, speech and language therapy within 72 hours.

The stroke unit provided acute care, with the multidisciplinary team and a consultant in rehabilitation medicine. The team provided daily transient ischemic attack (TIA) neurovascular clinics with rapid access to computerised tomography (CT) and vascular imaging. The team had the back up of a full-time TIA nurse specialist and had close links with providers of community stroke rehabilitation beds across the region.

There was a dedicated rehabilitation ward working towards designation as a specialist rehabilitation unit from the UK Rehabilitation Outcomes Collaborative. Further development of consultant-led, in-reach service to Hull Royal Infirmary was to be developed.

The trust had implemented seven-day working for the physiotherapy and occupational therapy services to facilitate improved access to services and better discharge planning. Staff told us that the trust had not increased staffing levels to allow for this and they worked overtime to cover the extended service, which meant working long hours and overtime, which left them feeling tired. They felt there was a risk to patient safety because staff were making decisions when they were tired. They thought patients had better access to therapy services, however, this impacted on staff training. Staff at the focus group told us they were unable to complete training because of the pressures to review patients on the wards with no extra staff.

Inspection February 2014: Leaving hospital

Staff attended patient safety bed meetings, which were useful as they provided multidisciplinary support to help

relieve pressure on beds. Multidisciplinary meetings were also held daily to discuss when people were medically fit for discharge but required support at home. This helped identify the discharge needs of patients.

Discharge planning was started when the patient was admitted to hospital. The trust had 'in-reach' staff from all wards who worked with the AAU and A&E to facilitate patient admissions and discharges. These personnel told us they could access care services and liaise with care homes to begin the discharge process from the AAU. All ward teams had trajectories for morning discharges and daily discharge numbers required. Not all areas were achieving the necessary number of morning discharges. Matrons focussed on this by undertaking daily board rounds in the afternoons to improve the discharge planning. (Corporate Performance Report, Quality and Safety, January 2014.) In-reach staff told us they felt that the coordination of the transfer of patients had improved. However, some patients felt that information about transfer to wards was not managed well. Five patients told us they had been moved at night and relatives had not been informed of the move.

Inspection February 2014: Learning from experiences, concerns and complaints

The medical services were responding to feedback from patients using the 'I want great care tool', and action plans had been developed. For example, on the ESSU, coloured crockery had been provided, visiting time's extended and better signage provided. On wards 8 and 80, access to refreshments and the lack of comfortable seating had been raised as a concern, actions had been taken to provide snacks at all times and the waiting areas had been redecorated and easy chairs provided (December 2013).

We looked at information from the trust on complaints. The trust had received 225 complaints across all health groups for the period November 2013 to January 2014. The Medicine Health Group had received 79 complaints, including 20 complaints for elderly medicine, three for chest medicine and three for stroke medicine. Treatment was identified as the primary concern in 144 complaints. Only 36 complaints had been escalated from the Patient Advice and Liaison Service (PALS) for this period.

We looked at the top 10 complaint areas for the trust. The AAU had received seven complaints and 33 PALS concerns, and Ward 10 had received five complaints and eight PALS concerns in August 2013 to October 2013. Results from the NHS Friends and Family Test indicate that the AAU is in the bottom 10 areas of the hospital to be recommended by patients. In response, the trust had introduced new initiatives to improve engagement with patients and their families. The trust was holding a Patient Big Conversation Day event, had introduced a patient experience forum and patient panel in order to understand the patient's perspective on the quality of care and build this into service development.

Inspection January 2015: Learning from experiences, concerns and complaints

We received information form the trust as part of the focussed inspection which showed that AAU had received 15 complaints between October 2014 - February 2015. We saw the themes and trends had been identified and the largest number of complaints (five) related to unprofessional or inappropriate behaviour of staff.

Are medical care services well-led?

Requires improvement 

Inspection February 2014: Vision, strategy and risks

The trust was aware that the 49 bed AAU was not a good environment and was in the process of reviewing the acute and elderly medicine service provision to develop future models of care. The trust was working with local commissioners and providers to develop more integrated care pathways. The trust's winter plan was considered a high priority and aimed at developing clinical pathways to achieve, - 'Right place, Right time' strategy for patients.

The lack of junior doctors was on the trust's risk register, and following the Deanery Quality Assurance Visit in July 2013, had developed an action plan to address concerns raised. Recruitment had taken place to fill gaps in rotas and work was underway to expand consultant cover, particularly in the AAU.

A Forward Plan 2014/15 – 2016/17 had been produced (September 2013), which reviewed the population served, and the expected rise in demand. Priorities identified included the reconfiguration of the ground floor of the Hull Royal Infirmary Tower Block, including the AAU, to

create a Medical Day Unit with space for ambulatory care services, improved discharge planning, the development of ambulatory care pathways and improvement in pathways for the frail and elderly. The timescale set was 2013/14.

Inspection February 2014: Governance arrangements

The trust arranges its services through four health groups, - clinical support health group, family and women's health group, medicine health group and surgery health group. Within each health group are a number of divisions, for example – the medicine health group is responsible for emergency medicine, general medicine and specialist medicine. Management and reporting arrangements take place up through the divisions and health group to the trust board. It was clear that there were clear lines of reporting up to the trust board, but there was a lack of engagement at ward level with the senior team and across health groups for shared learning and development.

The trust had reported serious incidents externally in line with national protocols; however, there was a significant delay in reporting incidents. For example, one case of delayed diagnosis was reported internally on 28 November 2013 but it was not reported externally as a serious incident until 17 December 2013. The national protocol states that a serious reportable incident should be reported within 48 hours from the time the incident is known. Serious incidents reported in January 2014 showed an improvement in reporting times but were still outside the 48-hour timescale. Patients could be at risk of harm because the investigation and learning from incidents was delayed.

Inspection January 2015: Governance arrangements

As part of the focussed inspection we reviewed risk registers. We saw in the January 2015 medicine safety effectiveness and experience report; the divisional risk register and there were three relating to AAU. We saw one of the risks identified was recognition and Management of Deteriorating Patients on AAU this was due to be reviewed at the end of November 2014. The trust provided information that showed seven control measures had been implemented to manage this risk. The risk was last reviewed in March 2015. We also saw nurse staffing had been identified as a high risk within the Medicine Health Group and had nine controls/actions identified to address the risk.

Inspection February 2014: Leadership and culture

We observed staff on the wards were supported by the ward managers and matrons. Staff on the wards and at the focus groups felt well supported by staff at ward level and they were very positive about teamwork. However, they did not feel supported by senior executive staff. They told us that executive staff and board members did not visit the wards. Staff of all grades (medical and nursing) told us of pressure put upon them to undertake additional work, work beyond their competencies and meet performance targets.

Inspection February 2014: Learning, improvement, innovation and sustainability

We showed staff a copy of a trust's first lessons learnt bulletin. Staff told us they had not seen a copy of the bulletin before. Staff learning from incidents was completed at local level with ward managers and matrons. However, staff told us they did not receive lessons learned about incidents from other specialties across the trust. There is a risk that patients could be at risk of harm because lessons learned and any changes in practice may not be implemented by ward staff.

Some staff told us they were not able to attend training because of staff shortages and as they were needed to maintain staffing levels to facilitate service provision. Data from the trust showed that, at 31 December 2013, in General Medicine. 72.1% of staff had completed training and 85.9% of staff had received their appraisals.

Surgery

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

Information about the service

Inspection February 2014:

The hospital provided a range of surgical services, including neurosurgery, vascular, orthopaedic and acute general surgery, and was recognised as a major trauma centre for the region. Surgery at the trust was divided into four divisions, with a clinical lead for each surgical specialty.

We visited five surgical wards, including the trauma and orthopaedic wards, the operating theatres, including the Paediatric Theatre 8 were located on floor three. We talked with 11 patients and two relatives, 15 members of staff including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (both senior and junior grades). We observed care and treatment and looked at six care records. We received comments from people who contacted us to tell us about their experiences.

Summary of findings

Inspection February 2014:

Ward areas and theatres were clean and guidelines were followed to prevent or reduce risks from infection. There were appropriate safety checks and risk assessments taking place and concerns were escalated. Surgical wards monitored and audited safety indicators such as number of new pressure ulcers, infection rates and falls; these were displayed on wards. Where there were shortfalls in performance or risks identified, action was taken to address these. The World Health Organisation (WHO) surgical safety checklist was used to ensure the safety of patients while undergoing procedures.

Staff on wards told us they were very busy and to meet patient needs, staff were often redeployed to different areas. Theatre staff told us they were also very busy and being moved to cover other areas. Patients reported that, at times, this led to long waits for call bells to be answered, causing distress. Also, staff did not have time to keep areas tidy and organised. Junior doctors felt pressured and stretched to meet the demands of the service; senior clinicians confirmed that junior doctors' workload was high.

Patients said staff were caring and compassionate, although staff were very busy. Patients' privacy and dignity were respected, and consent was appropriately

discussed and obtained. Treatment was explained to patients who were involved in decisions about their care. Discharge planning commenced in advance and patients were kept informed.

The surgical divisions held regular governance meetings and staff felt well supported by their immediate line managers. Staff showed commitment to providing good quality care to patients. However, staff were unaware of practices and initiatives across other surgical divisions, resulting in limited shared learning. Medical and nursing staff reported that communication with senior management of the trust was poor and the senior team were not visible. Clinicians spoke of a bullying culture, with pressure to meet performance targets.

Inspection January 2015:

During the focused inspection we had concerns regarding nurse staffing on the acute surgical unit (ASU / ward H6). However, the actual numbers of registered nurses had improved in the months of February and March 2015. During the focussed inspection we visited the ASU where concerns were raised regarding the lack of effective procedures to prioritise and manage patients who requiring admitting to a bed. This meant that on occasions patients were sat in the waiting room for a number of hours. Two doctors we spoke with told us it was difficult to assess and examine patients in the waiting room.

Staff we spoke with on the wards 6 and 60 were not able to describe the policy for admission into the acute surgical units and were not aware the trust had a policy to manage admissions. We also found there was no routine monitoring of the policy to ensure compliance.

Are surgery services safe?

Requires improvement

Inspection 2014: Safety and performance

The surgical divisions had recently introduced safety briefings each morning, where ward managers discussed a range of safety indicators, including the number of staff on duty on each ward and any issues which may impact on the care of patients that day. Decisions were made to minimise the risk which may compromise the care of the patient. This included redeploying staff to those areas of greatest need over a 24-hour period. This meant that action was being taken to keep people safe.

We observed patient safety boards at the entrance to each ward visited, which displayed details of specific aspects of care. This included the number of pressure ulcers, falls and infection rates for the previous month and the number of staff on duty that day. This provided information to patients and their relatives about the safety standards on the ward.

Inspection February 2014: Incident reporting

We spoke with all staff groups about incident reporting and they were able to explain the process. We observed the system in practice in the operating theatres where two incidents were reported on the computerised system.

Staff told us that they sometimes missed reporting incidents because they were just too busy to access the system. Junior medical and nursing staff told us they had received no feedback from incident reports and this had discouraged them from further reporting. However, senior medical and nursing staff reported that they received feedback on incidents related to surgery.

There had been one Never Event (a largely preventable patient safety incident that should not occur) in surgery over the period 1 December 2012 and 31 November 2013. The trust carried out an investigation and produced a report and action plan in order to learn lessons from the incident. This was shared with the relevant parties.

Inspection January 2015: Incident reporting

During the unannounced focussed inspection we found that between 1 October 2014 to 29 January 2015 there had

been a total of 555 incidents reported in the department. The main themes from these incidents were seven related to access, admission, transfer and discharge, There were 39 organisational issues including staffing, four pressure ulcers (one was hospital acquired and 12 related to treatment of care). We also saw three of these incidents related to blood transfusions.

Inspection February 2014: Staffing

We reviewed information on staffing, including surgical ward duty rotas and the summary report for quarter two of the trust's acuity and dependency audit, October 2013. This identified that some surgical wards and operating theatres were meeting establishment numbers, while other wards and operating theatres carried a number of staff vacancies. The trust surgical risk registers identified the nurse staffing levels on Ward 4 as a moderate risk, but no other surgical wards we visited were identified on the register. This meant that there was a risk that not all staffing deficiencies had been identified and taken into account when taking action to resolve staffing problems in the trust as a whole.

Staff told us that their wards were very busy and that, to meet patient needs, they often had to redeploy staff to different areas or try bringing in additional staff, (although this was difficult at short notice). Theatre staff reported that they also experienced being redeployed at short notice to other theatre areas. They told us of the difficulty in recruiting and said they were providing the best care they could. Ward managers and matrons often worked in the clinical areas to provide support on the wards and operating theatres. This meant that, at these times, they were unable to carry out their managerial responsibilities.

Junior doctors said they felt pressured and stretched to meet the demands of the service and the needs of the patients. This comment was supported by senior clinicians who confirmed that the workload for junior doctors was high.

We observed how busy the wards were, particularly Ward 4 (neurosurgery) and Ward 7 (vascular). These wards were untidy and we observed one patient's belongings on the floor next to their bed. Dirty linen was on the floor in one nursing bay without been placed in a linen bag and call bells rang for long periods of time in excess of five minutes before being answered. Patients said staff were extremely busy every day. One person reported, "They are run off their feet" and, "They never have a minute, I feel guilty ringing for them because I know how busy they are". Two patients told us they had waited so long for the call bell to be answered – between 20 and 25 minutes – which resulted in them being incontinent of urine, and this had been a very distressing experience for them.

Inspection January 2015: Nurse staffing

During the focused inspection we had concerns regarding nurse staffing on the acute surgical unit (ASU / ward H6). As part of the inspection we asked the trust to provide information on the planned and actual numbers of staff from November 2014 to January 2015.

- Between November 2014 - January 2015 we found on average there were 3 RNs per day on ward H6 on the late shift against a planned number of 4. In the 3 month period only 32% of late shifts met or exceeded the planned RN staffing levels. Staffing levels dropped to 2 RN's for the late shift on 6 occasions, 5 of these occasions happened in November.
- In the same time period we found on average there were 2 RNs staffing the ward on the night shift against a planned number of 3. In the 3 month period only 53% of night shifts met or exceeded the planned RN staffing levels. Staffing levels dropped to 1 RN for the late shift on 2 occasions, both were in December 2014.

On the 30 March 2015 we issued a section 64 letter to the trust requesting further information on nurse staffing numbers for February and March 2015. We found the actual numbers of registered nurses had improved in the months of February and March 2015.

- In February we saw information on the planned numbers of staff required for each shift was the actual number of nurses who worked during the month. We saw 88% of shifts had been at the planned numbers. At its lowest level staffing dropped to 2 RN's on the late shift of 1 February 2015.
- In March 2015 we saw information on the planned numbers of staff required for each shift was the actual number of nurses who worked during the month. We saw 82% of shifts met the planned numbers. At its lowest level staffing dropped to 2 RN's on the late shift of 12 March 2015.

Staffing information was available for the bed meetings which occurred between 8:00am to 20:00pm. There were four bed meetings per day. Any staffing issues after 20:00 were managed by the 1st and 2nd on call nursing staff.

Surgery

Following the inspection the trust told us staff were asked to move to areas that required support and when this has happened this would not necessarily be reflected in the staffing numbers on the off-duty.

Inspection January 2015: Initial assessment and treatment

During the focussed inspection we visited the ASU where concerns were raised regarding the lack of effective procedures to prioritise and manage patients who were admitted requiring bed. Staff told us they accepted admissions from the ED department and they also took direct admissions from GPs. Between 1 October 2014 and 25 January 2015 176 patients had been admitted directly onto the ASU. We requested further information on direct GP admissions to ASU for February and March 2015; there had been 82 admitted directly onto the ASU. The trust also provided information for ward 60,another surgical ward, and in the same time period 127 patients had been admitted directly onto the ward.

Staff said they tried to get all patients coming to the ward into a bed as soon as possible. However on occasions this meant patients were sat in the waiting room for a number of hours. When we asked staff if they recorded the number of hours patients waited for a bed or reported it they told us they did not routinely do this. Two doctors we spoke with told us it was difficult to assess and examine patients in the waiting room as they was no examination couch and it could be difficult to maintain privacy and dignity.

Following the inspection the trust provided us with the operational policy for the acute surgical units on Ward 6 and Ward 60 dated January 2012. We saw within the policy it stated that occasionally when there may be a short (i.e. no longer than 2 hours) delay in facilitating an admission, it may be appropriate for a patient who does need admission to a bed to wait in the assessment area. However we found there was no routine recording of the times patients waited to be admitted to a bed.

Inspection February 2014: Safeguarding

Nursing staff were able to explain how they would report any concerns and the percentage of staff that had completed training in safeguarding was over 80% in the areas we visited. We observed two examples where safeguarding concerns had been escalated appropriately in the operating theatres.

Inspection February 2014: Learning and improvement

Surgical specialty groups met on a monthly basis and considered mortality figures as part of their governance meetings. These figures were then taken to the mortality committee. We saw minutes from meetings on 15 November 2013, 20 December 2013 and 17 January 2014, which confirmed that issues had been discussed and action taken as result where this was required.

There was an effective process for the investigation of serious incidents. For example, - changes had been made to the consent process, which was then audited as a result of an incident. We attended a meeting of neuro-surgical consultants and observed how two critical incidents investigations had been discussed within the governance group internally and then externally reviewed. A root cause analysis had been completed, leading to changes to practice.

Although we found root cause analysis of incidents and learning from them did take place and was shared at ward or department level, learning from incidents from other health groups within the trust did not take place regularly to identify themes and trends. There was a risk to the trust by not routinely sharing lessons learnt and any improvements could not be implemented across the trust.

Inspection February 2014: Mandatory training

Some nursing staff told us that they had attended mandatory training, but developmental training was less likely to be approved due to staffing levels. However, not all staff were completing their mandatory training, with ranges between the four surgical divisions across the trust from 70.3% to 72.6%; only division 4 had met the 85% target. Junior doctors reported that other than their induction training there were no formal arrangements in place for them to receive training and the department was often too busy for more informal training to take place. This meant there was a potential risk that staff did not have up to date skills and experience to meet the needs of patients.

Inspection February 2014: Systems, processes and practices

In the operating theatres we observed safe surgical checks in place which included the use of the World Health Organisation (WHO) surgical safety checklist which is used to minimise the risk of avoidable errors to patients.

Surgery

We observed the implementation of all sections of the checklist and found that staff completed the checklist on all patients. Recent audits of the WHO checklist indicated that the trust scored 100% but this did not include auditing of all sections, which did not give the service information on how well the checklist had been embedded into daily practice.

We reviewed six patient records across four of the wards and noted that assessments had been completed accurately. For example, pressure ulcer risk assessment, venous thromboembolism (VTE or blood clots) and nutritional risk. We did note that, on Wards 4 and 7, some of the records had not been reassessed in a timely manner, which could compromise the safety of the patients.

The hospital used care bundles to ensure patients at risk received appropriate care (A care bundle is a collective use of care practices proven to improve care). We saw completed risk assessments for skin integrity, nutrition, and falls. Compliance with the completion of the care bundles were reported as poor as documented in the Quality, Effectiveness and Safety Committee report 13 December 2013. As a result the trust implemented intentional rounding and we saw evidence of this in practice where patients had been seen by a nurse on an hourly or two hourly bases dependent on need. This was documented in the patient's records. This meant that patients were reviewed regularly to ensure their needs were met.

Inspection February 2014: Cleanliness and infection control

The wards and operating theatres we visited were visibly clean and staff were observed wearing protective clothing. Hand-washing facilities and hand gel dispensers were available at the entrance to wards and staff were observed to adhere to the 'bare below the elbow' policy for better hygiene. Regular audits were undertaken of infection control practices and the outcomes discussed with staff. This meant that measures were taken to minimise the risk to patients.

The trust's infection rates for Clostridium difficile (C. difficile) and MRSA infection for the period August 2012 to July 2013 lie within a statistically acceptable range. Surgical site infection rates were within an acceptable range.

Inspection February 2014: Medications

We observed the safe storage of medicines in two of the wards we visited and in the operating theatres. Medication cupboards and trolleys were locked when unattended.

Inspection January 2015: Equipment and Environment

We found mobile x-ray machines were stored next to the lifts on floors 3, 6 and10. The x-ray machine on floor 10 was plugged in charging and there were mattresses, cages and other equipment in the foyer. We asked to speak with the head of radiography because we were concerned about the risk to patients and the public. We were told that the machines were stored in these areas all the time and that the machines could not be used because a key was required.

However. on floor 3 the x ray machine was plugged in and had the key insitu, with a label on which stated that it should not be taken out. We raised this with the Director of Governance. The head of radiography attended and told us that you needed a code to use the machine. We requested to see the risk assessment completed for storing the x ray machines in a public area. The director of Governance told us she would have the machine moved to a meeting room for safety immediately.

Following the inspection the trust provided a risk assessment for the storage of x-ray machines in public areas and we saw this was completed the day after our inspection. We saw the risk assessment identified potential hazards and control measures in place to mitigate any risk.

Inspection February 2014: Anticipation and planning

We talked to senior nurses who explained that meetings had been introduced a week in advance to discuss potential staff shortfalls for the following week. Where gaps were identified, steps were taken to offer overtime payment or redeploy staff to the areas of greatest need. This meant that measures were taken to minimise the risk to patients.

Are surgery services effective?

Good

Inspection February 2014: Using evidence-based guidance

Surgery

During 2012/13 the surgical services took part in all the clinical audits they were eligible to participate in – for example, Elective Surgery (National Patient Reported Outcome Measures Programme), Fractured Neck of Femur (College of Emergency Medicine) and Severe Trauma (Trauma and Audit Research Network). The trust was using national and best practice guidelines to care for and treat patients.

We found the surgical services were using best practice and national guidance and checking compliance with them. For instance neurosurgery was compliant with NICE IPG documents. In addition, innovative techniques were used, which had resulted in the cancer survival rates being the best in country for 21 months compared to national average of 14 months.

The trust introduced a new initiative, 'Pioneer Teams', in October 2012 and the hip fracture pioneer team focused on creating a more efficient service for patients and improving rates of recovery. The outcomes from this were the length of hospital stay had reduced from an average of 18 days in October 2012 to 14.3 days in January 2013. A 53% reduction in slips, trips and falls among this patient group and a 40% reduction in the number of pressure ulcers was reported.

Consultant surgeons were able to give a detailed account of the processes followed to obtain consent. Patients said that the procedures were explained to them, including the risks in detail, by the consultant before written consent was taken. Written information was available to patients. Operating theatre and ward staff were aware of the Mental Capacity Act 2005 and its implications in relation to consent, ensuring that treatment was in the patient's best interests. We reviewed three patients' medical records and written consent had been obtained prior to surgery.

Inspection February 2014: Multidisciplinary working and support

At ward level, and in the operating theatres, there was a real sense of effective team work in most areas. Multidisciplinary ward rounds were observed to take place and patients confirmed that they saw a doctor at least once a day on a ward round.

The critical care outreach team offered support to the surgical wards when requested, but it was observed that their workload was high so they were not able to respond to all requests. Physiotherapy services had begun to provide a seven-day service but this was outside the existing five-day establishment available.

Are surgery services caring?

Good

Inspection February 2014: Compassion, dignity and empathy

Patients told us that the staff were caring and compassionate. We observed that despite staff being busy they were polite to patients, explaining what they were going to do and why. Screen curtains were closed when attending to individuals' personal needs, and privacy and dignity were respected.

Each ward monitored the NHS Friends and Family Test. In addition, the Trusts own quality policy (setting the standard), ensured that Ward managers received feedback on their ward's progress against 12 standards. Ward 90 had improved significantly in the test results, moving from a red rating in December 2013 to an achievement of a silver ward in January 2014.

Operating theatre staff were observed to be kind and caring to patients, promoting their privacy and dignity throughout the theatre experience.

Inspection February 2014: Involvement in care and decision making

Patients said that staff explained to them what they were doing and gave them choices about the care that was delivered. One person said the surgeon had explained different treatment plans to follow for the particular condition they had and they had been able to express a choice as to which treatment plan to follow.

Inspection February 2014: Trust and communication

Patients and relatives said they generally felt well informed and were kept up to date by staff on the ward. They explained that although staff were busy they responded when asked to any concerns or information requests. We

saw a range of information available for patients on conditions and treatments. There was an interpreting service available for people whose first language was not English.

Are surgery services responsive?

Good

Inspection February 2014: Meeting people's needs

Two of the 11 patients we talked to had experiences of internal transfer while in hospital. One person told us they had been admitted to Hull Royal Infirmary then transferred to Castle Hill Hospital and transferred back to Hull Royal Infirmary. This person was unable to explain if this was for clinical reasons. Another person told us they were admitted to Ward 40, then following surgery and a four-day stay in critical care, were moved back to Ward 40, but then transferred to Ward 4 at 1.45am, upsetting their sleep. This was distressing for the patients and their relatives as it meant they had to develop new relationships with staff who were not familiar with their care needs.

Inspection February 2014: Vulnerable patients and capacity

We saw in care records that dementia screening assessments had been completed appropriately. The electronic boards at the nursing station used a butterfly symbol to identify those patients who were living with a dementia type illness and who may be vulnerable. This meant that staff were alerted to those patients who they may have concerns about prior to their operation.

Inspection February 2014: Access to services

The hospital was similar to other trusts for the proportion of patients whose operation was cancelled and the number of patients not treated within 28 days of last-minute cancellation due to non-clinical reasons, (identified through the Department of Health's Quarterly Monitoring of Cancelled Operations, January 2013-March 2013).

A number of initiatives were taking place to improve access for patients within some services. For example, changes had been made to extend the scope of senior physiotherapy practitioners to run a neurosurgical clinic. This had improved the New to Follow Up ratios, which meant patients, were getting seen quicker and followed up sooner following treatment. The service had received positive feedback from patients over the increased MDT arrangements. Advanced health practitioners had been introduced to run the cervical spine fracture clinics to increase access to appointments.

Steps were being taken to deal with the delays in accessing treatment and appointments. To reduce the amount of cancelled theatre time, some services such as spinal surgery were being moved to Castle Hill Hospital. This was to ensure that theatres were not tied up with trauma cases causing elective cases to be cancelled.

Inspection February 2014: Leaving hospital

Discharge planning was in place and the care records examined confirmed that discharge planning commenced well in advance of discharge. Patients were able to tell us what the plans were for their discharge and the expected date that they should be discharged. Overall patients told us they felt well informed. There had been new initiatives to improve the length of stay within different surgical services, for example, for neurosurgery the average length of stay had reduced to half a day in the last year.

Inspection February 2014: Learning from experiences, concerns and complaints

Staff explained that patient and relatives' feedback, particularly around concerns or complaints, was taken seriously and we saw evidence that this was documented. Complaints were standing agenda items and discussed as part of the clinical governance meetings and the minutes of the meeting for 15 November 2013, 20 December 2013 and 17 January 2014 confirmed this.

Inspection January 2015: Learning from experiences, concerns and complaints

We received information form the trust as part of the focussed inspection which showed that ASU had received seven complaints between October 2014 - February 2015. We saw the themes and trends had been identified and the largest number of complaints (two) related to condescending or dismissive behaviour.

Surgery

Are surgery services well-led?

Requires improvement

Inspection February 2014: Vision, strategy and risks

Information we obtained prior to the inspection identified that the trust had become more 'outward looking' and that managers were engaging and displaying the right characteristics of wanting to work in a whole systems approach. Initiatives had been introduced to engage more with staff and patients. However, we found that staff did not feel engaged or consulted on issues relating to the surgical service. Staff reported that within their own speciality they did not feel that they were appropriately consulted on potential changes and ways of working.

Leaders in the surgical areas were aware of the risks in their service and the risk register was reviewed regularly. Items on the surgical division's registers were not dated when they were added. This meant that it was not possible to identify when the issue was added to the register, and so if it was actioned in a timely manner.

Safety and risk was embedded and outcomes to investigations shared amongst surgical teams and wards. However, as there was limited shared learning across health groups and divisions, this did not promote a safety culture across the hospital, which meant the opportunity to reduce risk and improve patient safety was not at its most effective.

Inspection February 2014: Governance arrangements

There was a medical director who leads surgical services overall. Surgery at the trust was divided into four divisions and within each division there was a clinical lead for each surgical specialty. Each specialty held governance meetings and any concerns were escalated to the divisional governance meeting. The surgical divisions held regular governance meetings at various levels which meant there was a clear route for governance issues to be escalated and also cascaded to other teams. This meant that issues did not often reach staff working on the wards below manager level. However, staff reported that information passed up to the trust board, with limited information passed down to the wards. There was little information on good practice or shared learning taking place between the divisions and across the hospital sites.

Inspection January 2015: Governance arrangements

We found there was an operational policy for admission into the acute surgical units on ward 6 and 60. During our inspection staff we spoke with on the units were not able to describe the policy and were not aware the trust had a policy to manage admissions. We also found there was no routine monitoring of the policy to ensure compliance. The policy also described escalation procedures to ensure smooth running of the units however it was not clear if and when these actions were implemented. This meant that some patients waited a number of hours before being allocated a bed.

Inspection February 2014: Leadership and culture

Two surgeons stated that the leadership issued central directives with little contribution or involvement by the consultant workforce and the levels of staff below. Most staff in each surgical division worked well together. Nursing and junior medical staff told us they felt well supported by their immediate line managers and senior staff in their surgical teams. They showed commitment to providing good quality care to patients. However, this did not cut across the surgical divisions and staff were unaware of practices or initiatives taking place in other surgical divisions. One clinical lead said they had received no mentor prior to taking up the leadership post and felt that the leadership did not listen and was very target driven.

Staff at ward level were unaware of the members of trust board and told us they had never seen anyone from the board at ward level and did not receive communication from them.

Inspection February 2014: Patient experiences, staff involvement and engagement

Staff felt supported by their line managers but other than annual appraisal and team meetings there was little opportunity for supervision and reflection. Both medical and nursing staff told us that communication with senior management of the trust was poor and the senior team were not visible or engaging with staff working in the surgical areas.

Critical care

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

Information about the service

The trust's critical care services included intensive therapy and high dependency units on both Hull Royal Infirmary and Castle Hill Hospital sites. Hull Royal Infirmary had a total of 22 critical care beds situated in two units. Both units were generic meaning they cared for patients at both Level 2 and Level 3. We spoke with six family members and four patients, six members of nursing staff, senior and junior medical staff. We observed care and treatment and looked at the care records for six people. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

The hospital provided a comprehensive, consultant-led critical care service with 24-hour cover, seven days a week. There were good safety checklists in place for staff to deliver a safe and effective service. Infection prevention and control was well managed. Clinical audits were carried out regularly and feedback was shared with the teams during handover. Staff were aware of how to report incidents, but said they had received limited feedback.

The critical care team provided an outreach service to ward areas. The trust had recently introduced the national early warning score (NEWS) for acutely ill patients, which had led to an increase in referrals. At times the team experienced difficulties meeting demand as there was no back-up support available.

The staffing levels, experience and skills mix of the nursing team was sufficient, but did not meet the standard for having at least 50% of nurses with a post-registration qualification in critical care. There was enough medical staff but it was felt that the consultant on call rota was onerous.

Patients and families said care was good and they were very positive about their experience; they described staff as kind, caring and thoughtful. Patients' privacy and dignity were respected and patients and families were kept fully involved in all decisions about treatment and care.

Critical care

Critical care teams were well-led and staffed with a dedicated cohesive clinical team. Staff felt supported by the clinical team and line managers. However, staff reported that communication with Trust Board's executive management was poor.

Are critical care services safe?

Good

Safety and performance

The hospital provided a comprehensive, consultant-led critical care service with 24-hour cover, seven days a week. There was a formalised system in place for staff to provide a safe patient handover. The units had good safety checklists in place, including for equipment and cleaning, for staff to deliver a safe and effective service.

We looked at the care records for six patients. Appropriate assessments had been completed and there was ongoing monitoring of care bundles. Screening assessments had been completed and daily care planning was used. The records we reviewed were complete, legible and safe.

Learning and improvement

We spoke with all staff groups about incident reporting and they were able to explain the process to follow to report incidents and were confident in using the computerised system. We observed a patient safety meeting take place and the risks to patients faced that day were discussed. There was regular information sharing about incidents and information about patient safety at the handover and at ward meetings. Staff felt well informed on the unit and that learning from incidents was used to change and improve practice. Root cause analysis was used to investigate any incident and the findings were shared with staff in the unit.

Staff understood safeguarding processes and were able to describe how they would report and escalate concerns. Staff confirmed they had attended safeguarding training, which included the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.

Systems, processes and practices

Infection prevention and control was well managed overall, and infection rates were low. The critical care areas were visibly clean and staff were observed to wear protective clothing. Cleaning rotas were in use and daily records of fridge temperatures were recorded. Hand-wash facilities and hand gel dispensers were available at the entrance to

all the units, and staff were observed to adhere to the bare below the elbow policy for improved hygiene. Overall, the records of training we reviewed identified that most staff had completed infection control training.

Monitoring safety and responding to risk

The critical care unit allocated a risk rating to all the critical care standards and implemented an action plan for any standards that were not being met. Clinical audits were carried out regularly and any feedback from audits or incidents was cascaded to the teams during the handover.

Staffing

The staffing levels, experience and skills mix of the nursing team was sufficient and met the nurse staffing ratios determined by the national standards. There was enough medical staff but the consultant on call rota was felt by consultants to be onerous. If additional staff were required this was provided by staff working additional hours or by using bank (overtime) staff. The units did not meet the standard for having at least 50% of their nurses with a post-registration qualification in critical care. This had been identified as a risk and highlighted for action by the multidisciplinary team review of core standards.

The staffing establishment for critical care outreach team services was 14 whole time equivalent staff, which provided one nurse 24 hours a day. However, staff reported difficulties when there were further requests for support as there was no back-up provided. Staff told us they often missed break and meal times because of the demand on the service.

Are critical care services effective?

Good

Using evidence-based guidance

Patients received care in line with national standards. The units risk-rated themselves against the Intensive Care Society core standards for intensive care units, which was published in November 2013. Clinical audits were carried out regularly and results feedback to the teams during handover, for instance the lack of sufficient staff with post registration qualification in critical care and an absence of a dedicated pharmacist for critical care, were both escalated to the risk register. Where they were not meeting the standards, an action plan was implemented. Criteria was used to determine the suitability of the patient to be admitted to the critical care units using the national early warning score (NEWS) system for acutely ill patients.

Performance, monitoring and improvement of outcomes

Intensive Care National Audit & Research Centre (ICNARC) data from 2012 identified mortality rates to be similar to those in other trusts. A decision had been made to suspend data collection for a year due to the absence of the data clerk. The data collection had now resumed and the units were waiting for a new report, due in the near future.

We observed patient safety boards at the entrance to each unit, which displayed details of specific aspects of care. This included the number of pressure sores and infection rates for the previous month and the number of staff on duty that day. This provided information to patients and their relatives about the safety standards on the unit. On the day of our visit, the board displayed that there had been no infections or pressure sores in the unit in the preceding month.

The critical care team provided an outreach service to ward areas. The national early warning score (NEWS), which is a system for standardising the assessment of acute illness severity, had been introduced across the trust to replace a previously used tool. The new system had led to an increase of referrals to the team, which had increased the workload. There was no dedicated medical staff allocated to this team.

Staff, equipment and facilities

There were two critical care areas at Hull Royal Infirmary – one with 12 beds and the other with 10 beds. Both units cared for patients at care levels 2 and 3. The configuration of the dependency changed dependent on the patients' needs. The unit design was fit for purpose and there was adequate room between each bed. Storage facilities were tidy and clearly labelled, with all items stored off the floor.

The NHS Staff Survey 2012 identified that the number of staff receiving job-related training, learning or development was similar to that of other trusts. Staff confirmed this and said they had received appraisal and feedback on their performance.

Multidisciplinary working and support

Critical care

Staff told us they felt that they worked closely together and were a happy, cohesive clinical team. Our observations supported this view; there was a sense of effective team work. The critical care outreach team were supportive to the wards where possible, but this service was stretched to meet the demands of the wards because of the number of staff allocated to provide the service. Multidisciplinary rounds were observed taking place.

Are critical care services caring?

Good

Compassion, dignity and empathy

Without exception, all the patients and the families we spoke with said the care was exceptional. They described the staff as, "kind, caring and thoughtful". We observed staff speaking to patients and their family in a polite, considerate manner and observed them treating patients with dignity and respect. The facilities provided for family members were good.

Involvement in care and decision making

We were told by family members that staff had kept them fully informed regarding the progress of their family member. Patients who were able to speak to us said they had been involved in decisions about their care and treatment plans were discussed with them. We saw evidence in the care records that discussions between staff and the patient had been recorded. This meant that patients and their families were well informed.

Trust and communication

The critical care units monitored the outcomes of the NHS Friends and Family Test on a monthly basis and their score was consistently high in all areas. If any areas of concern were identified, this was discussed at the team meetings and an improvement action plan put in place.

Emotional support

Patients and their families reported that they were emotionally well supported by the critical care team, who ensured that they received information in a timely way, that they were able to discuss the treatments and ask questions. There was access to multi-faith spiritual services and the chaplaincy could offer support as needed.

Are critical care services responsive?

Good

Meeting people's needs

The critical care units were able to meet the needs of patients and the capacity of the units was sufficient to cater for the number of patients. The critical care bed occupancy was 71%, for the full year 2013/14. Staff told us that discharge was rarely delayed and operations were rarely cancelled because of availability of a critical care bed. The services were generic in that they cared for both patients at the dependency of Level 2 (those patients requiring more detailed observation or intervention, including support for single failing organ, system or post-operative care and those stepping down from higher levels of care) and Level 3 (those patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.)This meant that, as a patient's condition improved, they did not have to move units. The units introduced a system where staff moved to accommodate the patient's needs. Therefore, if one unit was busier than the other, it was the staff who moved units rather than the patient.

Information

There was a lack of specific information for patients about the critical care units. This had been identified and a nurse was leading on a project to produce specific information. Staff were knowledgeable about the anxiety and stress for visitors entering the unit, particularly with the extensive amount of equipment in use, and visitors were encouraged to speak with staff about their concerns.

Discharges

Staff were aware of the impact of patients and their families of moving from an intensive care environment and would take time to prepare them for the move to ward areas. There were no delays reported from the critical care units, and the process was managed as part of the patient's recovery.

Learning from experiences, concerns and complaints

There were regular meetings and handovers taking place daily, which included discussions about patients' and their

families' concerns and complaints. Staff told us that there were few complaints received, but they constantly strived to improve services and would discuss any concerns at the time they were made aware of them, which often allayed people's anxieties before a complaint was made.

Are critical care services well-led?

Good

Vision, strategy and risks

The critical care areas regularly monitored quality and safety issues and these were discussed at team meetings. The meetings were held in 'protected' time and gave the opportunity for staff to disseminate information and consider ways to improve practice. Staff told us they felt empowered to raise concerns.

Governance arrangements

There were governance arrangements in place and staff reported these worked well. There were regular team meetings to discuss issues that arose and report upwards when needed. Staff reported that they were involved in the decisions on the unit and that they were confident in local arrangements. Information was shared with staff.

Leadership and culture

Critical care areas were well-led and staffed with a dedicated cohesive clinical team. Staff said they felt supported by all levels in the clinical team, including their line managers. They showed commitment to delivering a high-quality service to their patients.

Communication with senior management of the trust was poor. Staff informed us that changes were made without consultation or explanation; for example, changes to the staffing structure. Staff did not know who members of the trust board were and had not seen them.

Maternity and gynaecology

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

Information about the service

The maternity service at Hull Royal Infirmary provided antenatal, intrapartum and postnatal care to women. The labour ward delivered approximately 6,000 babies each year.

We visited the antenatal clinic, antenatal and postnatal wards, obstetric theatres and the labour ward. We spoke with 15 women and 31 staff, including midwives, midwifery support assistants, doctors, consultants and senior managers. We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Summary of findings

Maternity services monitored and minimised risk effectively. Staff were aware of the process for reporting and there was learning from incidents. There were learning processes in place for effective professional clinical practice and the unit used the 'fresh eyes' approach, where two staff reviewed foetal heart tracings to reduce misinterpretation, improving patient safety. A national trigger tool and maternity dashboard were used to identify and report incidents specific to maternity care. The World Health Organisation's (WHO) surgical safety checklist was used to ensure patients were safe undergoing caesarean sections.

Figures showed midwifery staffing ratios were below nationally recommended. The service had recently recruited eight midwives and aimed to increase staffing to meet national requirements. There was a shortage of junior medical staff. The availability of consultants on the labour ward was below the national recommendations. However, there were effective systems in place to ensure sufficient cover to meet need. In addition, the trust planned to increase medical cover through the appointment of locum consultants and changes to rotas.

The service participated in national and local clinical audits. Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Risk assessment tools were used to ensure the timely referral of women developing critical illness during or after pregnancy.

Maternity and gynaecology

Women and their families spoke positively about their treatment and the standard of care. Privacy and dignity were respected. Women felt involved in developing their birth plan and had sufficient information to enable them to make choices. There were appropriate discharge arrangements. The service had introduced a dedicated baby clinic staffed by a children's doctor and midwives.

The service was well-led; staff were involved and engaged with service development. Staff were supported and could approach senior staff if they had concerns.

Are maternity and gynaecology services safe?

Requires improvement

Safety and performance

All areas of the unit were clean, safe and well maintained. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment. Infection rates showed healthcare associated infections in maternity services were low.

Staffing levels

Women said there were sufficient staff on the wards to meet their needs and they had received continuity of care and one-to-one support from a midwife during labour. There were systems in place to monitor and review staffing levels. The acuity of patients and staffing levels were discussed each day. Staff told us the wards were busy, however, they were able to prioritise and manage workloads. They told us they would work together and provide cover when staffing levels were short. Figures showed that the midwifery staffing ratios were below the recommended levels set by the Royal College of Obstetricians and Gynaecologists Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.

The head of midwifery told us the ratio of midwives to women was 1:35 against the recommended level of 1:28. This was because no recruitment to midwifery posts had taken place since 2010. The service had recently recruited eight midwives and the aim was to increase staffing to meet the national requirements.

There was also a shortage of junior medical staff to meet capacity and demand in the service. The medical director told us an action plan was in place to increase medical cover through the appointment of locum consultants and changes to the rota. Consultants were available on the labour ward for 98 hours a week, which was below the recommended target set by the Royal College. However, there were effective systems in place to ensure there was sufficient consultant cover to meet care needs.

Maternity and gynaecology

Care and treatment was planned and delivered in a way that was intended to ensure women's safety and welfare. We looked at five care records. The records contained a clear pathway of care, which described what women should expect at each stage of their pregnancy.

The records showed risks had been identified and explained to women. Staff told us they used a risk assessment tool. This ensured early recognition, treatment and referral of women who had, or were developing, a critical illness during or after pregnancy. The records showed risks had been monitored and action taken where required.

Ward areas had recently introduced 'intentional rounding'. This involved staff reviewing each patient's condition at set intervals to ensure that care was safe and reliable.

There were processes in place for safeguarding patients (protecting them from abuse). There was a named midwife for safeguarding; however, the post was funded for only 15 hours per week. The head of midwifery had identified this as a risk and a business case for a full-time post was being developed. Staff had a good understanding of their role and responsibilities with regard to safeguarding adults and children and said they had completed training in this area.

Learning and improvement

Maternity services monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to staff, patients and visitors to the unit. All incidents, accidents, near misses, never events (mistakes that are so serious they should never happen) and complaints were logged on the trust-wide electronic incident reporting system. Most staff were able to tell us what the unit's top five risks were. They said they received feedback about incidents that occurred within the service so that learning and improvements could take place.

There were learning processes in place for effective professional practice. The unit used the 'fresh eyes approach' – a system which required two members of staff to review foetal heart tracings. This reduced misinterpretation and supported midwives to improve patient safety.

Monitoring safety and responding to risk

There were systems in place to monitor safety and respond to risk. Each ward had a safety dashboard (performance reporting and tracking system) which measured and analysed patient harm and harm-free care. The results showed the service was compliant in areas such as pressure care, falls, and recording of clinical observations. Staff told us the information helped them to identify areas of good practice and enabled them to respond to concerns of clinical safety.

Are maternity and gynaecology services effective?

Good

Using evidence-based guidance

The service participated in national and local clinical audits. The trust's performance in the UK National Screening Committee's antenatal and new-born screening education audit was similar to what was expected. Staff told us they had been involved in audits relating to quality of care records and medicines management. This ensured there was a process to improve patient care and outcomes.

There was no evidence of risk for elective caesarean sections, emergency caesarean sections, puerperal sepsis other puerperal infections, maternal readmissions or neonatal readmissions (CQC Intelligent Monitoring Report October 2013).

Performance, monitoring and improvement of outcomes

The Royal College of Obstetricians and Gynaecologists assessment tool and maternity reporting and tracking dashboard were used to identify and report incidents specific to maternity care and highlight which incidents required immediate action or review. This ensured that appropriate measures were in place to minimise risks to patients.

As part of surgical checks and documentation for caesarean sections, the World Health Organisation (WHO) surgical safety checklist was used. We looked at a sample of records and found that the checks had been completed appropriately.

Staff, equipment and facilities

Staff had access to equipment they needed to meet patients' needs; they could also access the equipment they needed from other parts of the hospital. The equipment we

saw was clean, safe and well maintained. For example, we checked the adult and neonatal resuscitation equipment and found this was adequately stocked and fit for purpose. There were appropriate procedures in place for staff to check equipment each day and after each use. Staff had received training in the use of equipment.

The trust's medical physics department was responsible for maintaining equipment. Maintenance concerns were logged via an electronic system and prioritised based on risk. This ensured equipment was renewed and maintained in accordance with manufacturer's instructions.

The service had made appropriate adjustments on the wards to ensure women with a disability had appropriate access to facilities. This included adaptations to bathroom and toilet areas. There was equipment for women requiring bariatric care. Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity. These ensured women with a high body mass index were supported appropriately during labour and birth.

Multidisciplinary working and support

Staff told us there was good multidisciplinary team working. A multidisciplinary meeting was held each week to discuss any risks to the service and review management of severe maternal and foetal morbidity cases. There was 24-hour anaesthetic cover with access to advice from a designated consultant anaesthetist when required. There was also a rota to provide a theatre team for obstetrics 24 hours a day.

Staff worked closely with children's service to care for babies admitted to the transitional care unit. Staff said they received good support from the neonatal unit and could obtain advice at any time. There were arrangements in place for joint clinics with other care professionals, for example, sexual health, physiotherapy and medicine. The service did not have a high dependency unit facility. However where women required intensive care, staff worked with the critical care outreach team to ensure safe transfers.

Are maternity and gynaecology services caring?

Good

Compassion, dignity and empathy

Women and their relatives spoke positively about their treatment by clinical staff and the standard of care they received. They told us, "The care has been brilliant", "Staff have been kind and caring" and, "I can't fault the care, I've been treated very well". Staff interacted with women and their relatives in a polite, friendly and respectful manner.

There were arrangements in place to ensure privacy and dignity. Curtains were drawn around each bed and discussions with women were sufficiently confidential. There was also access to single room cubicles to allow for privacy. Most women said staff had treated them with dignity and respect. They said staff knocked on doors before entering. However, one woman who had been admitted to the gynaecology ward told us she had spent five hours on a trolley due to a shortage of beds. This meant privacy and dignity were not always promoted.

Involvement in care and decision making

Women said they felt involved in developing their birth plan and had sufficient information to enable them to make choices about giving birth. Women told us that staff kept them fully involved and clearly explained their care planning, treatment and discharge to them. The comments received included, "I've been told what's going to happen" and, "The staff have been honest with me but comforting which has reassured me".

Trust and communication

Staff meetings took place on a regular basis to ensure effective communication and knowledge sharing. Staff handover meetings occurred after each shift change and safety briefings had recently been introduced. The briefings took place twice a day to ensure all staff had up-to-date information about risks and concerns. Staff were aware of the process for escalating concerns such as increased staffing levels and bed capacity.

Emotional support

Maternity and gynaecology

There were facilities to ensure women and their families were emotionally supported following bereavement. There was a dedicated family room which was discreetly situated on the labour ward to ensure privacy. Although the unit did not have a named bereavement midwife, support was provided by midwives who were trained in the bereavement care pathway. The unit had a bereavement group which met monthly and included service user involvement. The unit worked closely with SANDS (a charity which supported families following the death of a baby) to enhance the service. This ensured care and support was provided in a dignified way.

Are maternity and gynaecology services responsive?

Good

Meeting people's needs

Maternity care records showed women's antenatal, labour and postnatal care had been assessed according to their individual, cultural and diverse needs. Patient information leaflets explained choices of birth at home or hospital which could be changed by the woman at any point in her pregnancy. Staff told us they discussed birthing options with women at the time of booking and would accommodate requests where possible, following risk assessments. A range of information leaflets about care and treatment were available in different formats and languages. Women were given information in a format they were able to understand and there was access to interpreting services if required. Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements, for example, menus included halal options.

The service supported women's choices in having a doula (or labour coach) present during birth. A doula is an experienced woman who supports women and their families during pregnancy and childbirth. This ensured that women's cultural preferences were being met.

Women said they had received good support and advice from midwives and peer support workers with breastfeeding so that babies were breastfed within 48 hours of birth. The service had achieved Level 2 UNICEF Baby Friendly accreditation and was working towards Level 3. The UNICEF Baby Friendly Initiative is a worldwide programme which encourages maternity hospitals to support women in breastfeeding.

There was other information available in all ward areas such as approximate waiting times and staffing levels.

Vulnerable patients and capacity

The service responded to the needs of vulnerable patients. There were a number of specialist midwives who provided support in areas such as teenage pregnancy and substance misuse. The service also had access to a learning disability link nurse. There were good working relationships with the community mental health team which included access to a psychiatrist, psychologist and mental health nurse. These ensured women were referred appropriately to receive specialist care. Staff told us they had received training in the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.

Access to services

There was good integrated working between the children's centre and midwifery team which had led to women accessing antenatal services earlier. The service had introduced an early booking protocol which had improved early intervention and prevention of healthcare risks to mothers and children.

Leaving hospital

There were appropriate discharge arrangements in place. The service had introduced a dedicated baby clinic staffed by a children's doctor and midwives. Allocated time slots were given to women so they knew when to take their baby for examination. This had reduced delays in discharge.

A discharge lounge was being introduced at the end of February 2014 to facilitate midwifery-led discharges before six hours and to enable women to return the next day for neonatal examination. Women received information and follow-up advice when they left the hospital. A community midwife saw women the day following their discharge to plan any further care from the midwifery service. Additional home visits were arranged, depending on clinical need.

Maternity support workers provided support in the community to women who were breastfeeding. Five midwives were also trained to support women and babies who had problems with fixing and lactation prior to

discharge and processes were in place for babies to return for follow-up appointments if required. These meant women were sufficiently supported after leaving the hospital.

Learning from experiences, concerns and complaints

There was learning from incidents and investigations, and changes were made to improve the service. Evidence showed learning was shared with staff, which enabled them to reflect and learn from incidents. We saw action had been taken following a serious incident to improve the assessment of women who were at risk of blood clots. These meant arrangements were in place to ensure lessons were learned.

There was a process to monitor and review complaints and suggestions for improving the service. Staff held debriefing and resolution meetings with women to discuss any concerns relating to their care and treatment. The head of midwifery told us service user engagement events had been held for women to discuss their experiences and identify what was important to them. The key themes from the events, included staff attitude, communication and waiting times for induction of labour. The service had responded to these concerns and developed an interactive learning programme to improve staff attitudes and communication. The head of midwifery said this had won a good practice award. A new pathway had also been introduced to improve induction of labour in low-risk women, which had improved waiting times.

Feedback from women during their hospital stay was used to improve the quality of the service. Each ward had a 'You said we did' communication board. This showed action had been taken in response to patient feedback in areas such as privacy, dignity and timeliness of discharge from hospital.

Are maternity and gynaecology services well-led?

Good

Vision, strategy and risks

Maternity services had a forward plan to 2017. The plan identified the key priorities and risks relating to the service. There were plans to transform maternity services which included the development of a midwifery-led unit at Hull Royal Infirmary. The service was aware of the risks to the service such as an ageing workforce, gaps in staffing skills mix and challenges relating to the recruitment of junior doctors. The service had escalated these areas to the trust risk register and was carrying out an external workforce review.

Local stakeholders reported that the trust was changing its culture and was more outward-facing. There was increased partnership working for instance, plus work undertaken on the integrated antenatal five-month pathway and the development of protocols and procedures.

Governance arrangements

We looked at the clinical governance arrangements on the wards to assess whether there was staff engagement at ward level and to determine if assurance processes were in place to monitor patient safety. The maternity risk management strategy set out clear guidance for the reporting and management of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality of care was reported and improved. There were processes in place for escalating risks to the Trust Board where required. Maternity services had their own governance meetings to discuss clinical quality, incidents and complaints. Staff told us the reporting of adverse events was encouraged so lessons could be learned and services improved.

Most staff told us members of the trust board were visible and receptive to concerns raised at ward level. For example, areas of risk relating to junior doctor staffing had been escalated to the trust board. The medical director told us the board had been supportive and were involved in discussions with the relevant organisations to improve junior doctor staffing levels.

Leadership and culture

The trust, in partnership with Hull and East Riding Clinical Commissioning Groups, took account of the views of women and their families through the Maternity Liaison Services Committee, a multidisciplinary forum where comments and experiences from women were used to improve standards of maternity care. Service user representatives also attended the labour ward forum and bereavement group.

There was good staff involvement and engagement in developing the service. The trust had set up a pioneer team

programme enabling staff to resolve issues or make improvements to their service. For example, a team of community midwives had established a series of community equipment stores which enabled them to save on travelling time and spent more one-to-one time with expectant women.

Learning, improvement, innovation and sustainability

The department led effectively to support staff with adequate training. Staff said there were opportunities for continuing professional development for them to enhance their skills. There were development days to enhance team working, facilitate new ways of working and to improve clinical effectiveness.

There was evidence of teaching sessions for junior doctors such as case note reviews, audit and attendance at perinatal mortality meetings. Some doctors felt that because of work pressures ward teaching was not as effective as it could be. However, they said they were well supported by the ward team and could approach their seniors if they had any concerns.

Local stakeholders reported that the trust was changing its culture and was more outward-facing. There was increased partnership working for instance, plus work undertaken on the integrated antenatal five-month pathway and the development of protocols and procedures.

Services for children and young people

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

Information about the service

The children's and young people's division was part of the trust's family and women's health group. The 54-bed service was based at Hull Royal Infirmary. The service provided a range of paediatric services including general surgery and medicine. In addition, sub-specialties were delivered as standalone or shared services with tertiary specialist paediatric centres located in Leeds and Sheffield. The division served a population of approximately 150,000 children living in the Hull and East Yorkshire geographical area. The trust had around 12,500 admissions (elective and non-elective) and around 53,000 outpatient attendances per year.

Children's services were split between the tower block, which accommodated Ward 130 (paediatric medicine), a paediatric assessment unit and a high dependency unit (HDU) with four Level 2 critical care beds. The surgical ward (Acorn Ward) had recently relocated to the adjacent Women and Children's Hospital where a dedicated children's outpatient department was based.

The neonatal unit provided a tertiary Level 3 critical care service with 16 special care, seven high dependency and five intensive care cots.

We visited Ward 130 (paediatric medicine), the paediatric assessment unit, the HDU in the tower block and Acorn Ward, the neonatal unit and the children's out-patient department in the Women and Children's Hospital. We talked with 39 children/parents/carers in all clinical areas and 35 members of staff, including consultant paediatricians, neonatologists, surgeons, trainee doctors, registered nurses, student nurses, clinical health care assistants, play specialists and the management team.

Services for children and young people

Summary of findings

Nurse staffing levels on the children's wards were identified as a major risk by the trust and we found they regularly fell below expected minimum levels, which placed staff under increased stress and pressure. We found there were some concerns relating to the physical environment and layout on Ward 130, the HDU and Acorn Ward.

Children's services were effective, with examples of evidence based care pathways kept under review and positive multi-disciplinary working within the departments and externally. Staff had been able to access mandatory training and the majority had received an appraisal.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. However, we found the service had a limited ability to provide holistic, family-centred care due to poor quality of facilities available for parents and families on Ward 130, the assessment unit and HDU in the tower block. Parents were not always able to sleep adjacent to their child or had been given inadequate sleeping facilities such as uncomfortable chairs. The trust did not meet basic environmental standards and facilities for families as recommended by the National Service Framework for Children – Standard for Hospital Services (2003).

We found the service responsive and accessible in the management and care of critically ill children.

The service was well-led with a clear leadership structure in place. A recent review of ward management showed the trust aimed to improve and develop leadership within the service. There were governance systems and processes in place. The trust did not have a board-level lead for children as recommended by the National Service Framework for Children – Standard for Hospital Services (2003). We found that, although there were initiatives in place, communication and engagement with staff groups could be improved.

Are services for children and young people safe?

Requires improvement

Safety and performance

We found that risks were identified, escalated and managed. Incidents were reported and monitored. We reviewed the trust risk register and found several areas of risk had been escalated, including staffing levels and the inability to locate all paediatric services together in the Women' and Children's Hospital. We reviewed two 'divisional monthly reports' from December 2013 and January 2014, which identified the same risks recorded in the trust level risk register and outlined the control measures in place.

Staff showed an awareness of the incident reporting system. Some staff gave examples of incidents they had reported via the Datix patient safety incidents healthcare software system, for example, around staffing issues. The management team thought members of staff were "good" at reporting incidents.

Nurse staffing was currently identified as a high-level risk within the paediatric wards and was not always achieving the Royal College of Nursing recommendations of one trained nurse to three children under two years, and one trained nurse to four children over two years of age. Staffing issues had arisen due to vacancy levels and increased maternity leave. We were told that cover had been arranged via existing staff working additional shifts, bank staff and clinical staff such as nurse specialists and managers working shifts on the ward.

The trust had approved additional funding for nine posts above the establishment level to assist with staff shortages. An initial recruitment drive during 2013 had been unsuccessful because the division had not been able to attract suitably qualified nurses. The most recent recruitment drive had been more successful, although there was no visible sign of this having made an impact at the time of the inspection. Priority had been given to ensuring adequate staffing on Acorn Ward (paediatric surgery) which was understaffed at times, and was located away from other children's wards in the Women' and Children's Hospital.

Services for children and young people

We reviewed staffing levels on Ward 130 (medicine) to gain a clearer insight into current staffing levels within the division. Bed numbers had been reduced on Ward 130 from 24 to 20 beds to assist with staff shortages. Management told us, and the policy document "Management of paediatric bed and patient placement issues" stated the minimum staffing levels for Ward 130 should be four registered nurses and one clinical health care assistant (HCA) during the day. Staff explained that day-time staffing was regularly at three registered nurses plus one HCA and that bed numbers had been raised above the limit of 20 beds at times to accommodate busy periods without increased staffing.

Other staff members told us that morale was very low and gave examples of how it had led to colleagues feeling stressed. Staff told us they found it difficult to meet patients' care needs at times. We observed caring staff who appeared very busy due to a mixture of staffing levels and workload. We reviewed reported incidents statistics for the period November 2013 to January 2014, which showed a number were related to, "organisational issues including staffing" (42 of the 162 incidents reported).

It was reported that staffing levels on the neonatal unit had improved recently and staff did not raise concerns about staffing levels. There were currently three paediatric surgeon's employed by the division. Their on call rota was currently set at one full week in every three weeks. We were told by a number of medical staff this was not sustainable. We talked with the divisional operations manager who explained the trust was aware of this matter and it was hoped that an additional consultant could be recruited soon due to the ongoing discussions with other local providers about developing paediatric surgical services.

Various infection prevention and control measures were in place. For example, we saw hand-washing sinks and alcohol gels at the entrances of the ward areas. We found the Acorn Ward and the neonatal unit in the Women's and Children's Hospital to be clean, tidy and reasonably free of clutter. On Ward 130 some areas needed improvement. Two large bins (one household, one clinical) were located directly on the ward within a small open side area, which was not a suitable or safe location for a children's ward. There was an odour when near these bins and we found the clinical waste bin had been left unlocked for a short period, which posed a safety risk. The clinical treatment room had a paper shredder located on the floor adjacent near to the patient treatment couch. This was a clinical room and should not have non-clinical equipment in use within the area as it posed a safety and infection control risk.

Learning and improvement

We saw evidence which demonstrated incidents were discussed and reviewed via various meetings including the Datix incident meeting, Paediatric governance meeting and the Health group governance committee within the Family and Women's Health Group. The divisional nurse manager provided an example, which showed how learning and change to practice had occurred following a recent incident.

Systems, processes and practices

The trust had a dedicated safeguarding and child protection service which was located within the Anlaby suite (Craven building). The service offered support and advice to any member of staff in relation to safeguarding children. The service also supported other agencies such as the police and social services who may require health support. The service had a named nurse and named midwife although the provider level risk register noted the named doctor role was vacant. We were told that funding for a new named doctor post had been secured for eight sessions per week and would shortly be advertised. It was not immediately clear from the risk register what interim cover arrangements had been put in place. The divisional operations director explained there was some sessional cover provided by one of the consultant paediatricians and one of the emergency department consultants. Safeguarding training was provided but not all staff had completed the appropriate levels for their role. For example, only 71.96% had undergone safeguarding children and young people Level 3 requirements.

Monitoring safety and responding to risk

The children's HDU had recently moved from a purpose built unit on the second floor (Ward 200) to floor 13 as a phased interim measure until all children's services were located together within the Women' and Children's Hospital. The general environment was cluttered and poorly set out for a critical care area. For example, the four-bed bay had inadequate space around each bed and was not directly observable from the nurse station area. The nurse station was located within another open side bay, which was also used as the drugs and general storage

area. The HDU environment was warm and stuffy with no noticeable air flow. An incident form had been submitted before out inspection because of the warm environment and the potential impact this may have had on a child's temperature regulation.

On the Acorn Ward, we saw one corridor with several single rooms which were not observable from the nurse station area, which posed a potential safety risk. One consultant paediatric surgeon voiced concerns over how isolated this corridor and rooms were from the rest of the ward. Parents had also voiced concerns. We talked with a parent who was staying in one of the rooms on this corridor and they said they felt, "isolated". We spoke with the divisional operations director who told us they were aware of this issue and that one parent had suggested closed circuit monitoring. We were informed that the division this reviewing this suggestion.

Are services for children and young people effective?

Good

Using evidence-based guidance

We found the children's and young people's division had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. There was a guidelines committee, which reported to the monthly paediatric governance meeting and was attended by the multidisciplinary team. The divisional nurse manager gave several examples of guidelines and clinical care pathways which had been reviewed over the last 12 months for example; neonatal guidance was reviewed following some incidents relating to an intravenous antibiotic.

We reviewed in more detail the 'Paediatric department integrated care pathway exacerbation of asthma in children 2 years and over', which had been reviewed and updated during 2013. The governance meeting minutes from 14 October 2013 confirmed that the pathway had been reviewed noted the changes introduced and that there were plans to audit the effectiveness of the amended pathway. We talked with the asthma clinical nurse specialist who talked through the management of children with asthma. This demonstrated that patients were receiving evidenced-based care.

Performance, monitoring and improvement of outcomes

We found the children's services worked with other partnership bodies to provide effective care for children and families, for example, with the clinical commissioning group's children and maternity monthly programme board, the local authority safeguarding assurance board, the disabilities board for children with special needs and the Yorkshire critical care network.

Staff, equipment and facilities

We found staff of all grades were receiving training and appraisals within the division. Information forwarded by the trust showed that, by 31 December 2013, 81.5% of staff had received an annual appraisal and 77.8% were up to date with mandatory training. Staff confirmed they had attended mandatory training sessions covering various subject areas and had received an appraisal from their respective line manager. The division's nurse teacher practitioner talked through training and support plans for the next 12 months. These included plans to facilitate a clinical skills day in March 2014 and additional training utilising the educational facilities available at the Hull site.

One recently recruited registered children's nurse explained they had received an induction and had a named, experienced colleague who had provided good support. Staff views differed on how they felt supported by the management team. Some staff said they felt well supported and others gave negative views for example, one person said, "Staff were frightened to talk to managers" about staffing concerns because they might get into trouble.

We talked with a number of consultant paediatricians, surgeons and neonatologists, along with other grades of doctors working within the children's division. Medical staff felt well supported by each other and support packages were available for trainee doctors. For example, we found there was a strong induction package for doctors (and other staff) on the neonatal unit.

We found that the facilities did not promote effective care in some areas. In the HDU a consultant explained that there

Services for children and young people

were no dedicated spotlights over each bed space, which meant the main lights had to be turned on at night disturbing other children. We talked with the chair-person of the family involvement group who raised environmental concerns about the current HDU. Another consultant was concerned about the lack of available equipment since the move, stating they had made, "seven trips to intensive care unit [adults] to get equipment one night".

Multidisciplinary working and support

We talked with a number of consultant paediatricians, a consultant neonatologist and a paediatric surgeon along with consultants from the emergency department and the adult intensive care unit. We found there were very positive interdepartmental working relationships in place to facilitate the effective care of children and young people. The ward manager for the neonatal unit explained (and gave examples of) how they had close working relationships with maternity services, the children's wards, and other services.

Are services for children and young people caring?

Good

Compassion, dignity and empathy

The NHS Friends and Family Test questionnaires and completed responses were available on noticeboards in each of the division's clinical areas. These results showed families' experiences had been usually positive. Comments had been captured and recorded so that other people accessing the service could read them. We found other children's and parent's views had been sought via specific questionnaires developed by teams within the division for example, a recently completed 'adolescent asthma clinic' questionnaire.

Over the two day period of inspection we talked with 39 young people, parents and carers whose children were staying on Ward 130 (medical), HDU, Acorn Ward (surgical), the neonatal unit and attending the children's out-patient department. Parents' views about the care from medical, surgical and neonatal teams were, overall, positive. For example, some comments included: "Fabulous staff, brilliant no issues with care level" (Ward 130): "Very happy with nursing and medical care" (HDU): "Very happy, good communication and very clean" (Acorn Ward): "Good …waiting times are okay and the environment is okay" (Out-patients Department): and, "Amazing …staff excellent …always informed and kept up-to-date" (Neonatal Unit).

Involvement in care and decision making

One young person who was a patient said both the medical and surgical wards were, "very good" but the medical ward did not have any buzzers to get help. However, they finished by stating there was, "good staff and stuff to do". We received some negative comments about aspects of care, for example: "Staff are inconsistent…some are interested and some are not" (Ward 130), "[My] appointment was before 1pm but still waiting after 2pm, but no one has been over to say what the delay is" (out-patients department) and, "I've received conflicting information …Need to keep asking questions" (Ward 130).

We reviewed a sample of eight care records on the Acorn Ward and the HDU. We found records had been completed with appropriate details of the child's medical history, needs relating to their activities of daily living and consent to treatment forms for surgical procedures. Individualised risk assessments had been completed using tools such as a children's skin assessment. We were told that nursing documentation had been reviewed and updated and was currently being prepared for printing. We reviewed a draft version of the documentation and saw that it had been streamlined and documented a negotiated and agreed care plan with the child and parent.

Trust and communication

The children's and young people's division facilitated a parent-led "family involvement group" known as FIG. This had been set up around 11 years ago originally for the families who were users of the paediatric HDU. Meetings were held every two months and a sample of meeting minutes and other documents showed the group were able to influence care and assist in raising funds for equipment. The group had produced their first newsletter during October 2013 and a decision had been taken to gain new members to capture all of the trust's children's services. We talked with the chairperson of the group who told us how valued the HDU service was because it helped to care for many children locally and reduce transfers to paediatric critical care services in Leeds and Sheffield.

Emotional support

Services for children and young people

Parents reported that they were emotionally supported by the nursing team, who would answer their questions and talk to them about treatment, which lessoned anxiety. However, due to the lack of family centred facilities, parents were feeling stressed at not being able to be with their child when they felt they needed to.

Are services for children and young people responsive?

Requires improvement 

Meeting people's needs

We reviewed evidence of how the division worked with external agencies and organisations to plan services to meet the needs of children and families. For example, regular meetings were attended with the clinical commissioning group's children and maternity monthly programme board, the local authority safeguarding assurance board, the disabilities board for children with special needs and the Yorkshire critical care network. The neonatal ward manager explained how the unit worked closely with the Yorkshire and Humber operational delivery network. We reviewed previous meeting minutes of the Hull /York paediatric surgery meeting, which showed how the division worked with other NHS providers to progress plans which would develop paediatric surgical services within the regional area.

Vulnerable patients and capacity

There were policies and processes in place to cover capacity, consent and safeguarding of children and young people, Staff had received training were confident in how to manage issues over capacity and had received safeguarding training, although not all staff had received training in safeguarding Level 3 where appropriate. There were concerns raised by staff, particularly in the A&E and AAU, about the care of young people with mental health issues and where they were placed within the hospital, as well as delays in access to assessment (see note in A&E section on the children's mental health service provision). Some staff felt that placing young adolescent people on adult wards was not always in their best interest.

Access to services

The range of children's services available at the Hull Royal Infirmary could be accessed via a range of routes. The trust had recently commissioned separate children's accident and emergency (A & E) department. The department currently closed at 11pm and during the night children were treated within the adult department. There was a paediatric assessment unit on floor 13 adjacent to Ward 130 (medical) and the paediatric HDU. The unit accepted referrals from the A&E department, local general practitioners and other healthcare professionals so that children received an initial assessment and treatment prior to full admission or discharge home. We were told this unit had reduced the number of children admitted and increased the proportion of children discharged in under four hours. The service had three paediatric consultant surgeons along with a surgical ward, which meant they could offer treatment procedures locally that would normally be performed at a tertiary centre such as Leeds.

The division had a dedicated, four-bed HDU, currently located on floor 13 of the tower block. The HDU service offered Level 2 critical care services such as non-invasive ventilation. This meant some children could be treated locally and did not require transfer to a Level 3 paediatric critical care facility at Leeds or Sheffield. The neonatal unit operated as one of four tertiary units within the Yorkshire region which offered full Level 3 critical care facilities for poorly neonatal babies. The children's wards and neonatal unit utilised an early warning system developed regionally in Leeds to detect a sick child or infant who may require urgent /critical care. The system, known as the paediatric advanced warning score (PAWS) allowed the paediatrician and children's nursing team to promptly identify when a child's clinical observations may be lying outside the normal range. The colour codes on the charts then assisted the decision-making processes regarding the stabilisation and transfer of critically ill children to a regional paediatric intensive care unit using a range of clinical guidelines. The service had introduced the chart during 2013 and planned to review the effectiveness of the PAWS system to identify any local changes that needed to be made to suit the nature of available services at Hull.

The hospital was part of the Embrace transport network, a specialist transport service for critically ill children in Yorkshire and the Humber region. The management team told us that access to this service usually worked very well. The processes we saw demonstrated that the hospital had

safe and effective systems in place to ensure a critically ill child could be promptly identified and transferred to their own HDU or a regional specialist paediatric/neonatal critical care centre.

Facilities for parents

At the time of the inspection, the paediatric service was undergoing a period of service transformation. As a result, whilst access to parental accommodation was available, it was not yet at optimum levels and parents were not always able to sleep next to their child or had been given inadequate sleeping facilities such as uncomfortable chairs. We therefore found a limited ability to provide holistic, family centred care.

We found the division currently had a limited ability to provide holistic, family-centred care due to the poor quality of facilities available for parents and families on Ward 130, the assessment unit and HDU. Of the 39 parents we talked with, we received a number of negative comments about the lack of facilities available for parents and the lack of sleeping facilities adjacent to their child. For example, on the HDU, one parent told us they were concerned that the bed area was, "cramped with a lack of space". This parent explained that when their child became acutely ill, the medical team had struggled for space and there was no privacy as the curtain could not be closed. Another parent on the HDU told us, "accommodation is non-existent … I've tried to sleep in a chair for four nights". A parent on Ward 130 told us they were offered a bed in the playroom as there was no space next to their child. In addition there was only one designated parent toilet cubicle (next to two patient toilets). These toilets were located in the same room as the only patient shower area. A room had been designated as a parent's room and this had a kettle and a microwave oven available. However, on two occasions we saw this room being used by healthcare professionals as a meeting room with parents, which meant it was not accessible for other parents to rest and make a hot drink. We spoke with one family who told us that staff hadn't informed them of the availability of the parent's room for the first three days of admission. Other parents had not been offered a bed, and one parent told us they'd had to sleep on a small plastic visitor's chair one night.

The recently opened Acorn Ward had better facilities for parents overall because there were some single rooms with en-suite facilities and a number of shower rooms and toilet facilities available. Parents on the Acorn Ward did not raise any significant issues about sleeping arrangements. The ward had a large, informative and well-designed parent information board.

We talked in detail with the children's and young people's management team about the current facilities and the trust's future plans for the service. We also reviewed strategy documents such as Clinical Strategy – General Paediatrics and the Children and Young People's Service Transformation: Update Paper (January 2014). The trust was planning to move the current in-patient services located on floor 13 to new facilities within the Women and Children's Hospital. This would include a newly built HDU, a combined medical/surgical ward, assessment/short stay unit and a new building adjacent to the hospital, which would include resident parent facilities. The medical director for the family and women's health group told us the plans had been approved and it was hoped the building works would commence during the summer of 2014.

In the outpatients department, the environment was reasonable, although we found that the television was not working, the range of toys could be improved, along with better sensory play facilities for children with special needs. We did not find any areas of concern regarding the available parent facilities for the neonatal unit.

Leaving hospital

Discharge planning

The divisional nurse manager and matron told us that the pager holder for the nursing team in the division attended a daily meeting with the paediatricians each morning to identify and plan for those children identified for discharge. The acute community nursing team attended this meeting at least twice weekly so they could be involved and informed on discharge planning arrangements for children under their care.

We reviewed discharge planning on the Acorn Ward (surgery) to see how responsive discharge planning was to meeting children's needs. Care records showed that discharge planning for children and their families began on admission and arrangements had been made where required with other services such as the community nursing team for example, for wound checks. Children and parents were given suitable information when discharged, such as the immediate discharge letter, which highlighted

follow-up appointments, drug treatment and other information. We were told there were sometimes delays to a child's discharge from the Acorn Ward at certain times of the week. Children who were reviewed in the morning by some adult surgical specialties such as orthopaedics were often waiting until the evening before the doctor returned to complete discharge documentation.

Information

The division had information leaflets available relating to specific conditions and treatments - for example, nasogastric tube feeding, asthma management plans (age related), paediatric oncology shared care and pressure ulcers and sores – and other information for carers. We talked with a play specialist who explained how a child friendly information booklet had been written and developed for siblings of babies who may be born with a certain gastro-intestinal problem which required surgery. The booklet was developed as the result of a parent asking for information for their other children. This example demonstrated that staff were responsive to families' needs.

Learning from experiences, concerns and complaints

The trust had a complaints process in place and parents showed awareness of how to make a complaint. We reviewed a range of documents which demonstrated that the trust effectively managed complaints and learned lessons arising out of investigations. A document from the family and women's health group summarising lessons learned from complaints for the period January 2013 to November 2013 noted several areas where actions had been taken to address issues identified for improvement. For example, the care pathway for children with complex needs had been reviewed as a result of a complaint. Governance records such as meeting minutes and divisional monthly reports showed complaints were logged and reviewed. This meant the trust had a responsive complaints process in place.

Are services for children and young people well-led?

Good

Governance arrangements

We found effective systems to ensure the quality and safety of care was monitored and maintained. Using the Acorn Ward as an example at ward level we found a range of local audit checks were undertaken regularly, including weekly record keeping audits, bed space and mattress audits, tissue viability monitoring along with various safety thermometer measurements which fed into the trust's thermometer measurements. We found similar checks had been undertaken in the division's other clinical areas such as Ward 130.

The divisional nurse manager explained that there were various governance and other management meetings held within the division, for example, the neonates (new born infants) meeting. We reviewed a sample of the paediatric governance meeting minutes which showed the meeting discussed and actions taken on a range of health, safety and quality areas.

Leadership and culture

We found the children's and young people's division had a clear leadership structure. A recent skill's review for band 7 nursing at ward level had led to changes in ward managers and the current structure of one ward management for the neonatal unit, Acorn Ward, Ward 130, HDU and the assessment unit. These ward managers reported to the matron for the division who in turn reported to the divisional nurse manager. Discussions with these managers showed that they had a clear understanding of their roles and responsibilities. We were informed that a skills review for band 6 (deputy ward manager) was yet to be undertaken on the children's wards. The neonatal clinical consultant lead and the clinical lead for paediatrics were responsible for medical leadership and they reported to the family and women's health group's clinical lead.

Learning, improvement, innovation and sustainability

We heard from the management team and clinical leads that morale was currently low within the division due to a combination of reasons, including the skills mix review. One reason given was the phase one separation of the surgical ward from other children's wards in the tower block and the movement of the HDU from a dedicated facility on floor 2 to floor 13. We were told that one paediatric clinical lead had resigned during these changes.

We found, through discussions with paediatricians, that some consultants had not always felt involved about some of the recent changes which had occurred although other

senior manager's offered a different view. Two consultants said they had not been adequately involved and they had only been informed of the date of the HDU move "a couple of weeks before", which meant they had little time to prepare. None of the management team we talked with had any awareness of the current timeframe for the commencement of the phase two movement of the remaining children's clinical areas to the Women's and Children's Hospital. However, the clinical lead for the family and women's health group was aware of when the phase two work would commence. These examples showed that communication within the group and division was not always satisfactory and could be improved.

There was no formal board level children's lead to promote their rights and views as required by the National Service Framework for Children - Standard for Hospital Services (2003). We talked with a non-executive trust board member who told us they were not aware of any nominated children's lead at board level.

The division had produced a monthly report which captured incidents, medication errors, complaints, the risk register, safeguarding children, audit, infection and other business areas such as 'delivery against priorities.' These meeting minutes and reports showed the division monitored and took actions to address areas identified for improvement.

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 services were provided by a palliative care team based at the Queens Centre for Oncology and Haematology at Castle Hill Hospital, but provided a service across Castle Hill Hospital and Hull Royal Infirmary and the local hospice. The team included specialist palliative care consultants, specialist nurses and an end of life care facilitator. The team was available Monday to Friday with helpline services out-of-hours during evenings and weekends. Individual wards had dedicated end of life care champions.

In accordance with national guidance, the trust had ceased the Liverpool Care Pathway for delivering end of life care on 20 January 2014. They had replaced this with three guidance documents: Guidance for Development of a Personalised Management Plan for the dying patient, Guidance for Symptom Management for the Dying Patient and Palliative Rapid Discharge Pathway.

We visited four inpatient wards at Hull Royal Infirmary and the bereavement centre located with the mortuary and the neonatal unit. We spoke with the end of life care facilitator, nursing staff and their managers, two chaplains and a pathologist. We reviewed information we received via our listening event and bereavement surveys carried out by the trust. We reviewed the records of people who were receiving or had received end of life care.

Summary of findings

End of life services support was provided to patient areas across the trust by a dedicated palliative care team. The team consisted of palliative care consultants, specialist nurses and an end of life care facilitator. The team was available Monday to Friday with a helpline service during evenings and weekends. Individual wards had end of life care champions.

Patients received safe and effective end of life care, which involved patients and relatives/carers. Care was flexible and responsive to individual needs and there were good systems to facilitate preferred place of care.

The hospital gathered patients and family views to improve care and treatment. An example was the introduction of 'Heather Hospitality,' which provided essential emergency items for families spending long periods with their relative during the end of their life.

There was a retrospective end of life case review group, which met regularly to review care practice and identify areas for learning using anonymised patient journey notes. Membership included health and social care organisations, hospital staff and the palliative care team. Bereavement services were supportive and staff who worked in the bereavement centre had received specialist training and were supported by CRUSE.

The service was well-led and staff felt supported. The service was working towards national gold standards of best practice.

End of life care

Are end of life care services safe?

Good

Safety and performance

In all areas where people received end of life care, we saw infection control guidance displayed. We observed hand washing facilities and alcohol hand gel was available in several places on each of the wards we visited. We observed staff and visitors following guidance on hand hygiene. Wards were clean and there were ample supplies of personal protective equipment such as gloves and aprons. Staff told us there were facilities to nurse people in isolation if they were at risk from infection.

Staff were able to demonstrate an understanding of safeguarding issues and how to escalate if they had concerns. They were also able to demonstrate an understanding of the Mental Capacity Act 2005 and best interest's decisions. Staff were able to give examples of when best interest decisions had taken place to support patients assessed as lacking capacity.

Learning and improvement

We looked at the terms of reference for the retrospective end of life case review group. The group met every eight weeks to review care practice and identify areas for learning using anonymised patient journey notes. Membership included health and social care organisations, hospital staff and palliative care team members. The clinical medical director told us how valuable the group was and the impact it had on improving patients' experience of care, such as being able to provide the preferred place of care.

All wards we visited had access to specialist pressure relieving mattresses, syringe drivers and hoisting equipment. The mortuary had the necessary capacity to meet the hospital's needs.

Systems, processes and practices

The hospital had safe systems in place to ensure that patients were identified accurately following death. The bereavement office ensured that documentation, including issuing death and cremation certificates was completed in a timely way. The office also provided supportive and practical information for relatives following the death of a loved one.

Monitoring safety and responding to risk.

We looked at the end of life care records for five patients and saw that the guidance for end of life had been followed; this included daily review, pain relief and check on preferred place of care. The records showed that regular discussion about patients' wishes and preferences had taken place and been agreed with them. We looked at 10 do not attempt cardio-pulmonary resuscitation orders (DNA CPR) for a cross-section of wards (these orders record if a person has stated that they do not wish to be revived if they stop breathing or their heart stops beating, or if the responsible clinician has discussed with the patient or relative that it would be inappropriate, unsuccessful or not in the patient's best interest to do this). Nine orders were completed fully.

Appropriate risk assessments had been carried out for the prevention of pressure sores and these had been reviewed regularly. Where patients needed to be turned in their beds records were completed appropriately.

Anticipation and planning

We spoke with staff about patients preferred place of care and were told that the risks associated would be discussed with patients and their careers as part of planning.

The palliative care team was created five years ago and had its initial provision in oncology services. However, the team now provides consultant and specialist nurse services for patients at the end of life across all specialties and has strong links with community and local hospice services. Staff providing end of life support reported to us that the team were accessible and responsive to their requests for support in providing end of life care for patients.

The trust was aiming to ensure each ward had a link end of life nurse, who received additional training and developed closer links with the palliative care team. In accordance with national recommendations, the trust had developed new guidance to replace the Liverpool Care Pathway for the delivery of end of life care and this was being implemented across all services. The new guidance was being presented to ward-based staff by specialist palliative care consultants and the end of life facilitator. This was to ensure staff had a

End of life care

better understanding of the guidance with the aim to improve end of life care for patients. The use of new guidance was audited to identify effectiveness and areas to improve practice.

Are end of life care services effective?

Good

National guidance

In accordance with national guidance, the trust had ceased the Liverpool Care Pathway for delivering end of life care on 20 January 2014. They had replaced this with three guidance documents: Guidance for Development of a Personalised Management Plan for the dying patient, Guidance for Symptom Management for the Dying Patient and Palliative Rapid Discharge Pathway.

Performance, monitoring and improvement of outcomes

We looked at five patient records and saw in all cases, saw that the new guidance had been followed. We saw that care records showed pain relief plans; nutrition and hydration were provided according to patients' needs. Risk assessments for pressure ulcers, falls and nutrition were documented in care plans and patient's wishes for preferred place of care was clearly documented. Staff told us that the availability of drugs, which could be anticipated as needed, was effective and this meant patients' pain relief was controlled more effectively.

Staff, equipment and facilities

Staff working in areas where end of life was more frequent received specialist training, for example on elderly wards and in oncology services. For others training was provided by the end of life facilitator and palliative care team. Most wards identified an end of life champion who attended specialist training and was responsible for supporting other staff on the ward and linking with the palliative care team. We spoke to an end of life champion who informed us that the additional training they had received had impacted positively on the support they could provide. The end of life facilitator had held two lunch time-drop in events for champions focussing on patients' preferred place of care, and staff reported how valuable the sessions had been. As a result of feedback from the Cancer Patient Experience Survey 2012/13, staff were receiving advanced communication skills training in order to improve skills in having 'difficult' conversations.

Staff said the support provided by the palliative care team was good and staff valued their 'lead by example.' Staff confirmed they had received safeguarding and Mental Capacity Act 2005 training and gave examples of instances where they had facilitated best interest meetings to decide on care and treatment where the patient lacked capacity.

Multidisciplinary working and support

End of life care was provided by the clinical team originally looking after the patient with support from the palliative care team, which meant patients were cared for by people they were familiar with. The palliative care team told us they attended multidisciplinary team meetings and took responsibility for daily monitoring of patients approaching the end of life. This helped ensure that patients were consulted about treatment, pain relief, spiritual and emotional needs. Staff confirmed that this support had improved their confidence in delivering good quality end of life care and that the palliative care team responded to referrals swiftly.

Staff told us that where ever possible people would be supported with their preferred place of care. They said the introduction of the palliative rapid discharge pathway meant if a patient wished to go home or to the local hospice then the mechanisms were in place to facilitate this quickly. The hospital had an arrangement with the local ambulance service to provide transport for rapid discharge and staff confirmed this was effective within two hours in most cases. The palliative care team had good links with community services such as district and Macmillan cancer support nurses, and for supply of equipment.

Are end of life care services caring?

Good

Compassion, dignity and empathy

Staff were caring and compassionate. We heard from a range of people at our listening event and also from people who contacted us to describe their experiences of end of

End of life care

life care. A minority of people felt their experience could have been improved thorough better communication between staff and relatives; this has been acknowledged by the trust and additional training provided. However, most people were very complimentary about their experience.

The palliative care team were committed to improving end of life care and had recently pioneered a scheme called 'Heather Hospitality' to support families who were attending hospital to be with their relative at their end of life. It included practical support with reserved parking close to the hospital entrance, unlimited visiting and a supply of toiletries and essential items, which families may not have had time to organise before arriving at the hospital.

Involvement in care and decision making

Staff told us that wherever possible people were moved to side rooms towards their end of life. Staff were able to give us examples of how they ensured care was very personal to the patient and accommodated the need to be both flexible and innovative with regard to patients' wishes. For example we saw in one patient's notes that they had not wanted their relatives present when they were told their diagnosis but wanted time to absorb the information and consider options.

Staff talked to us about the respect and dignity they gave to the patient following death and the support provided to families of the deceased. We were present on a ward where a patient had recently died; we observed staff dealing with this in a sensitive manner which respected all patients on the ward. The bereavement centre instigated the trust's feedback survey to give relatives an opportunity to comment on the service provided.

Trust and communication

The trust had a 24-hour chaplaincy service which offered support for patients and staff. They worked closely with the end of life care facilitator to monitor people receiving end of life care. Chaplains supported and trained volunteers who visited patients on wards to offer spiritual support. The hospital chaplaincy had developed local networks to support patients to access support from different faiths and cultures.

Emotional support

Staff talked to us about the respect and dignity they gave to the patient following death and the support provided to families of the deceased. The bereavement centre, as well as offering practical support also offered emotional support and links to services such as the Cruse Bereavement Care charity.

Are end of life care services responsive?

Good

Responding to patients

In the National Bereavement Survey (Voices) 2011, the Primary Care Trust cluster, (which was the commissioning structure at that time) performed in the bottom 20% in eight of the 26 questions, three of which were in the 'Patient Preferences and Support of the Bereaved'. In response, the trust had developed the palliative care team to include consultant and nurse specialist support accessible across the trust. This had resulted in increased referrals for support with end of life care for patients dying of non-malignant illness demonstrated by 39% of referrals for end of life coming from non-cancer patients in 2012/13.

End of life care was supported by auditing and governance groups, which included other agency representatives. Their aim was to improve end of life care support to patients and their families and best practice through learning. The retrospective end of life case review group was an example of this.

Vulnerable patients and capacity

We reviewed two patient records where patients had lacked capacity to make decisions. In both cases a mental capacity assessment had been completed followed by a multi-disciplinary meeting to discuss and agree treatment in the best interest of the patient. We spoke to staff on an oncology ward and an elderly ward. They all said that where possible relatives were included in the meeting to determine best interests. All staff confirmed they had received Mental Capacity Act 2005 and safeguarding adults training.

Access to services

The palliative care team told us they promoted referrals through visiting wards and attending multi-disciplinary

meeting and holding awareness raising events. Every ward we visited had information visible at nurses' stations with contact details for referrals. Staff said the response from the palliative care team was supportive and swift to requests.

Facilities

The main bereavement centre was based at the Hull Royal Infirmary site. The systems in place for bereaved relatives were supportive and ensured as far as possible the process for obtaining, and registering death was straightforward. Staff employed at the bereavement centre had received specialist training and were also supported by members of the charity Cruse. There were private facilities where people could talk to staff about any issues. The bereavement centre had an appropriate viewing room, which was nicely and sensitively decorated. There was information available for relatives about the procedures following bereavement.

Leaving hospital

The trust had responded to patients' wishes to have a preferred place of care and had worked collaboratively with other partner agencies to develop a rapid discharge pathway. The pathway included the availability of anticipatory supplies and 'just in case' drugs, specialist equipment and transport provision. The audit results into the effectiveness of the pathway indicated that, in the quarter October to December 2013, 100% of patients achieved their preferred place of care. Staff gave us examples of instances where they had been able to assist patients in this and how effectively they collaborated with other agencies.

The bereavement centre facilitates an end of life survey; the results of which were collated and any action either addressed at ward or trust level, depending on the nature of the feedback.

Learning from experiences, concerns and complaints

We saw evidence via the bereaved carer action plan that complaints had been responded to and learning developed into improved practice. For example, where a patient did not achieve preferred place of care, further training was planned for ward staff to focus on the pathway for this area of care.

Are end of life care services well-led?

Good

Vision, strategy and risks

The service was well-led. The trust was committed to providing high quality end of life care and had completed surveys and audits to identify where it needed to make improvements. The palliative care team had a clear vision to improve and develop high quality end of life care across all specialisms. The increase in consultants and their specialist experienced supported this vision particularly in the area of non-malignant end of life.

Governance arrangements

The trust had systems in place to audit the quality of end of life. This included audits of preferred place of care; DNA CPR order completion; a review of those patients who died under the previously used Liverpool Care Pathway; and the new end of life care pathway guidance. When issuing death certificates, the bereavement centre gave relatives an End of life bereaved carer experience survey; the results were collated and developed into an action plan via the bereaved carer focus group.

Leadership and culture

We heard from staff that the palliative care team was well supported by the clinical support medical director and clinical support nurse director. The service was working to ensure national gold standards of best practice were embedded throughout the hospital and coordinated with patient care in the community or at home.

Patient experiences, staff involvement and engagement

Patient's experiences were gathered via the bereaved carer survey, and through the complaints process.

At ward level staff told us they were supported by their managers and the palliative care team; their physical presence and 'on the spot' ad hoc training was particularly valued. Each ward was encouraged to identify link palliative care nurses who received additional training and provide a link to the palliative care team and end of life facilitator.

Learning, improvement, innovation and sustainability

End of life care

The bereavement service took part in the trust's 'pioneer teams' programme as a way of encouraging staff to find solutions to problems and improve the overall care experience for patients. The pioneer team reviewed the service offered and implemented a 'one point of contact' for bereaved relatives so they could collect belongings and death certificates, and receive help and advice in arranging to register the death at the same time. There was also an improved environment and viewing facilities.

The pioneer team had also implemented the Heather Hospitality scheme to support relatives who attended hospital urgently without the time to pack essential personal items.

Representatives from the palliative care team, end of life facilitator, staff and managers all expressed a desire to develop an end of life network across all disciplines and community services.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Inadequate
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Hull Royal Infirmary provides outpatient services for a number of specialists including children's, surgical and medical, orthopaedics, chest and fracture clinics and ophthalmology. Appointments usually originate from GP referrals through a paper system or NHS Choose and Book, which is a national electronic web-based appointment system that offers patients a choice of where to receive health care.

We visited audiology, medical, orthopaedic, ophthalmology and children's outpatients and the chest clinic. We spoke with nine patients and four members of staff including the divisional manager for ophthalmology. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

There were systems in place to assess risk and escalate concerns. Staff were aware of how to report incidents and met regularly to discuss learning from incidents. The outpatient areas were clean, with access to hand gel with prompts to use. Staff were using good infection prevention practices and had sufficient supplies of personal protective equipment. Staff understood safeguarding processes and how to raise alerts if they identified concerns.

Clinics visited were very busy and hot. There was a shortage of space in some clinical areas, which resulted in patients being weighed and having urine tests in the same area, which compromised patients' privacy and dignity.

Staff received patient records in a timely manner, which allowed them to review information and plan for patients' visits. A local initiative had been introduced using a strip of card with two stars on it for patients' files to identify if a patient had a special need such as a learning disability or dementia. This was to ensure the patient did not have to wait too long or they could arrange an alternative location to wait.

Analysis of trust data showed that clinics were regularly cancelled by the trust, for example, of 45,678 appointments scheduled for December 2013, 11,097 had been cancelled. Delays in meeting outpatient appointments were recorded on the trust's risk register, which stated that actions should have been taken to

address this by October 2013. We were told there were insufficient slots on the NHS Choose and Book electronic appointment system, causing delay and failure to meet referral-to-treatment time targets. Most patients had to wait up to an hour for their appointments, although they felt they were given enough time once they were seen. The department had taken account of increased frailty of patients and had introduced outpatient clinics in the community. Routine information was given over the telephone, which reduced the need for patients to travel long distances. There were leaflets and posters displaying information about interpreting services.

Patients felt involved in their care and treatment and staff explained processes. Patient reported that staff had a good knowledge of the specialty which reassured them. However, patients commented on poor parking facilities, which could be crowded, particularly around visiting times and could be costly when clinics overran.

Are outpatient and diagnostic imaging services safe?

Good

Safety and performance

The senior staff nurse in charge of general outpatients had a good awareness of the systems to report incidents. They told us they met with staff regularly and discussed around learning from incidents.

Learning and Improvement

Staff reported that they discussed the outcome to incident reports at team meetings and learning was shared throughout the department. Staff told us where changes were needed action plans were put in place. A root cause analysis was undertaken as part of incident investigations and the outcomes to these were shared. There was a good learning environment within the clinics as staff felt well informed and were keen to improve practices from lessons learned.

Systems, processes and practices

The outpatient areas were clean, with access to antiseptic hand gel and prompts for use. There was sufficient seating and access to drinking water. We observed staff using good infection control practices and they told us there were sufficient supplies of personal protective equipment.

There was easy access to emergency resuscitation equipment in all outpatient areas. These were checked every day to ensure they were in good working order.

Staff understood safeguarding processes and what to do if they needed to raise an alert. They said they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. This meant that any suspicions of abuse would be reported appropriately so that children and vulnerable adults would be protected from harm.

Staff in all outpatient areas we visited confirmed that they received patient records in a timely manner which allowed them to review information and plan for the patient's visit. For example, staff insert a card with two stars on it into a patient's file where there was an identified special need,

such as a learning disability or dementia. Staff told us this helped them to ensure that the patient's needs were met including appropriate waiting time and location. This scheme was a local initiative and not a trust-wide scheme.

We did observe some unattended patient records located outside treatment rooms which we considered to compromise patient confidentiality.

Monitoring safety and responding to risk

Staff were aware of how to identify risk and reported incidents at the time using the hospital's electronic reporting system. There were local risk registers in place and risk was discussed at team meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff, equipment and facilities

Patients we spoke with across all outpatient clinics we attended said although staff were busy they thought there were sufficient personnel with the appropriate knowledge and skills. Senior staff said they had staff vacancies which took a long time to recruit to. They said that they just 'managed' with staffing they had. One senior member of staff had recently taken on responsibility for another clinic due to long-term sickness absence. Staff told us that they received regular clinical supervision and appraisal. We reviewed the training records for staff and saw they had received appropriate and up-to-date mandatory training with regard to health and safety matters.

The clinics we visited were very busy and appeared cramped. Clinics were very hot and a number of patients commented about this to us. There was a shortage of space in some clinical areas and on some clinics people were weighed and had urine tests in the same area, which did not respect their privacy and dignity. We saw leaflets and posters displaying information about medical conditions.

Are outpatient and diagnostic imaging services caring?

Good

Compassion, dignity and empathy

We spoke to patients waiting for appointments and people who attended our listening events. We heard positive comments about staff attitude; that privacy and dignity were upheld and staff were caring towards them. Comments we received from patients included "excellent staff, they can't do enough for you."; "caring staff, always very kind" and "it's been very good this morning".

During our observations in the clinics we saw that staff were kind, friendly and caring in their interactions with patients. They spoke with people in a clear way and explained to them what the process would be with regard to their appointment. We reviewed information held by the trust about complaints received about outpatients. Out of 36 complaints, six related to the attitude and type of care patients felt they received from staff.

Involvement in care and decision making

Patients told us they felt involved in their care and treatment; that options were provided and time given to consider treatment plans.

We also saw posters providing information about interpreting services.

Trust and communication

Staff told us that interpreters were available for people whose first language was not English and for people who were deaf and used sign language. Leaflets and posters were seen to provide this information for patients.

Emotional support

We observed staff taking time to explain processes and reassure patients. Patients told us staff seemed to have good knowledge of their specialty, which was reassuring for them.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Inadequate

Meeting people's needs

Vulnerable patients and capacity

Staff told us they reviewed patients' records in order to screen for more vulnerable patients - for example, people with learning disabilities, dementia or more frail patients. Staff told us about the Butterfly Scheme which helped identify people with dementia and the local initiative of the 'star card' on patients' records to alert staff to special needs. All staff had received training with regard to safeguarding adults and the Mental Capacity Act 2005; they said they felt confident in raising issues with consultants or appropriate professionals.

Access to services

Analysis of trust data showed that clinics were regularly cancelled by the trust, for example, of 45,678 appointments scheduled for December 2013, 11,097 had been cancelled. Delays in meeting outpatient appointments were recorded on the trust's risk register. Most patients told us they had had to wait for up to an hour for their appointments, they told us they accepted this as the norm. However, everyone we spoke with said that felt they were allocated sufficient time for their consultation; appointments were unhurried and patients were given time for treatment and explanation about diagnosis and next steps.

The department had taken into account the increased frailty of patients attending outpatients, and had introduced outpatient clinics in the community. If patients were receiving routine information this could be completed as a telephone consultation, which reduced the need for patients to travel long distances.

Parking

We spoke with patients about parking facilities at the hospital. We were told that availability of parking was poor and always more difficult during visiting hours. We were also told that cost was an issue particularly as there was lack of confidence in allotted times for appointments being met, which resulted in people paying for more parking.

People at the listening event told us they struggled to locate wheelchairs to transport relatives to their appointments.

Learning from experiences, concerns and complaints

Waiting times

Patients told us about whether their appointment took place at their allocated time. For the ophthalmology clinic people said that in the main clinics ran on time. For other outpatients departments, however, patients told us that clinics were almost always late with regular waits from between 45 minutes to an hour. Patients said that staff were apologetic and kept them informed of the approximate delay time.

Booking appointments

We spoke with patients about the booking system in outpatient clinics and at our listening event. We heard mixed responses; some people said the system was efficient and others had experienced delays and difficulties securing an appointment.

We spoke with the divisional general manager and they confirmed that currently there were insufficient slots for people in the NHS Choose and Book electronic appointment system, which was causing delays and a failure to meet national referral-to-treatment time targets. They said they felt there was not sufficient focus on follow-up appointments and there was concern that this would impact negatively on patient health. They were unable to clarify why clinics were cancelled, other than due to a lack of available consultants. We were unable to locate any monitoring of delay in follow-up appointments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Vision, strategy and risks

The trust had systems in place to manage risk through its risk management strategy. Meeting referral to treatment times appeared on the trust's corporate risk register for cancer screening, ophthalmology, dermatology and radiology due to increased demand, staffing and lack of equipment. We found it difficult to identify robust action

planning other than reviewing the risk regularly and making attempts to risk assess individual patients and increase clinics where possible. We were unable to source any evidence to measure effectiveness of action taken.

Governance arrangements

Although we were able to track some audits and performance data, there did not appear to be any clear system for overall governance of the outpatients clinics. We saw recorded in the outpatients transformation steering group meeting held on 11 December 2013 the need to develop a set of principles for outpatient clinics from which a baseline audit could be undertaken and improvements monitored and measured.

Leadership and culture

Staff reported good support and leadership and all departments we visited reported that their manager was approachable and they experienced good team work. From our discussions with staff we found there was a commitment to providing well-run clinics and staff had made improvements where they could within their scope of responsibility. However, staff reported that there was little cohesion between managers and clinic-level staff.

Patient experiences, staff involvement and engagement

We reviewed complaints about outpatients services and found, of the 36 complaints made, six were upheld and 12 were partially upheld. Complaints issues included: delays in receiving appointments and cancelled clinics (both impacting on delayed diagnosis and treatment); attitude of staff; lack of information; and disregard for patient privacy and dignity. We were unable to find evidence of shared learning from complaints or compliments.

Learning, improvement, innovation and sustainability

The trust had identified where it was not meeting national targets and where there were weaknesses. Where action plans were in place, these were either at an early stage or had not yet reached targets for completion. We noted that a report had been prepared following an audit on outpatient cancellations but this was in draft form.

At department level, staff were committed to providing a good service and looked at ways to improve. For example, with the introduction of systems such as the 'star card' on patients' records to easily identify those who were vulnerable or had special needs.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified and skilled staff and experienced people across all health groups including medical and nursing staff, particularly A&E, AAU, and medical wards.
- Ensure that staff are suitably supported and receive appropriate training, including safeguarding Level 3 where appropriate, and post registration qualifications in critical care.
- Ensure all staff have completed their mandatory training.
- Ensure that junior doctors are appropriately supervised and not taking on roles and responsibilities for which they have yet to complete competencies in.
- Ensure that there are suitable arrangements for on-call, and that junior doctors are not responsible for multiple pagers across different areas.
- Review why staff feel that they are experiencing bullying and feel pressure to undertake additional hours, and put meeting targets above patient care.
- Ensure that staff who are involved in caring for patients living with dementia are suitably trained, for example portering staff.
- Ensure that only staff employed for caring duties, including dealing with patients exhibiting challenging behaviour due to mental health illness or dementia, support patients.
- Review incident reporting to ensure that staff report incidents appropriately and in a timely manner.
- Ensure that staff receive feedback from incidents reported, including never events and complaints.
- Ensure lessons learned are disseminated across divisions.
- Ensure that children are assessed and treated in an appropriate environment, in line with national guidance.
- Ensure that patients have access to hospital appointments and cancellation of outpatient clinics is kept to a minimum.
- Review the patient flow within and across hospital sites to ensure that patients are not experiencing multiple moves, including through the night.
- Ensure that patients' assessment and treatment is based on best practice guidelines and delivered in a timely manner.
- Ensure patients receive appropriate fluid and nutrition to meet their needs. We found patients particularly in A&E and AAU were going without drinks and food for several hours.
- Ensure that there are suitable arrangements in place for pharmacy provision across all areas to provide clinical overview and reconciliation of patient medications.
- Ensure that patient records are appropriately maintained.
- Provide family friendly facilities for parents on Ward 130 and the high dependency unit to enable parents to support their children.
- Ensure that the environment is safe within the children's and young people's services by ensuring that clinical rooms have only appropriate equipment and that waste bins are appropriately stored.

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- Ensure there is an effective system in place so that patients attending Accident and Emergency have an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival of the patient at the Accident and Emergency Department in such a manner as to comply with the Guidance issued by the College of Emergency Medicine and others in their "Triage Position Statement" dated April 2011 or such other recognised professional processes or mechanisms as the trust commits itself to.
- Review the patient pathway into the hospital, particularly the A&E department, to ensure that patients are assessed and treated appropriately to meet their needs.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Consider reviewing the criteria for ambulance attendance at A&E, to ensure that patients are admitted to the most appropriate place to meet their needs.

Outstanding practice and areas for improvement

- Review the cleaning arrangements in A&E to ensure that there are sufficient staff at all times to keep areas clean following patient treatment.
- Review the mental health support available for children and young people in the A&E.
- Review and improve the communication among clinicians, including handover arrangements in A&E.
- Review arrangements in A&E to ensure that there is a senior clinician with an overall overview of the A&E department and the interface with AAU.
- Review GP referrals into the AAU and develop performance and assurance measures to ensure that failings can be addressed.
- Review the Clarity self-check in system in the A&E Minors department to ensure that patients' symptoms are appropriately recorded and there are no barriers to communication such as the need for an interpreter.
- Review the use of patient passports as these were not consistently being completed.
- Develop the auditing of the WHO checklist to include the completion of all sections.
- Review the information captured on the risk registers so that dates of inclusion are included.
- Provide more sensory play equipment for children with special needs in children's outpatients.
- Identify a board level lead for the outpatients department.
- Ensure that the privacy and dignity of patients is safeguarded and promoted in the A&E and the AAU. Patients were waiting on trolleys in corridors for significant periods, often without easy access to toilet facilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii)** **Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety.** **Patients experienced multiple moves around the hospital and across sites putting them at risk of delayed assessment and inconsistent treatment.** **Delayed access to diagnosis and treatment was experienced in the A&E and the AAU.** **Patients were waiting significant lengths of time on trolleys in corridors, causing delays in assessment and treatment putting their welfare and safety at risk.** **Patients on A&E and the AAU were not always having their needs met with regard to ongoing care such as, observations of medical condition, assistance with going to the toilet in a timely manner, the need for drink and nutrition during long waits to be seen.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b)**

This section is primarily information for the provider

Requirement notices

Service users were not protected from risks relating to their health, welfare and safety as the provider's systems designed to assess, monitor the quality of the services and identify, assess and manage risks were ineffective.

Not all incidents were reported and learning from incidents was not widely shared across the hospital.

Junior doctors were covering multiple patient groups, without appropriate supervision and working outside their competencies putting patients at risk.

Staff reported pressure to meet national targets as priority over patient care putting patients at risk.

Appointments were cancelled leading to delayed diagnosis and treatments.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 Health & social Care Act 2008 (Regulated Activities) Regulations 2010 'Medication'.** **There were not suitable arrangements in place for the oversight and reconciliation of patients' medicines by a pharmacist in some areas.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1) (a) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Safety and suitability of premises'.**

This section is primarily information for the provider

Requirement notices

The facilities on Ward 130 and the high dependency unit did not provide suitable facilities for family and promote family centred care.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Staffing'. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There were significant shortage of junior doctors, who working across multiple patient groups, without appropriate supervision, sometimes outside their competency. There was a significant shortage of nursing staff across acute elderly medical wards and surgical specialities, including theatres. There were insufficient medical staff in maternity services. There were shortages of appropriately qualified medical and nursing staff in children's services, including the children's A&E.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Regulation 23 (1) (a) & (b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Supporting workers'.

Suitable arrangements were not in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard.

Not all staff had completed their mandatory training or had the opportunity to obtain further qualifications appropriate to the work they perform.