Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust

Hull Royal Infirmary

Quality Report

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Date of inspection visit: 19 – 21 May 2015
Date of publication: 13/10/2015

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	Inadequate
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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. In total, the trust had approximately 1,300 beds and 7,400 staff. The HRI site has over 700 beds.

This was a focussed inspection of the Hull Royal Infirmary (HRI) as concerns had been identified both during a previous comprehensive inspection of Hull and East Yorkshire NHS Trust in February 2014 and concerns had also been highlighted through other information routes such as the public and staff which required following up. The follow up inspection of HRI was on 19 – 21 May 2015.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect the core services critical care or end of life services at the follow up inspection. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At the inspection in February 2014 we found the trust was in breach of regulations relating to patient care and welfare, medicines management, staffing, premises, staff support and governance.

Overall, at the May 2015 inspection we rated the HRI as 'requires improvement'. We rated it 'good' for caring, but it requires improvement in providing safe, effective and well-led care. We rated it inadequate for responsive.

We rated surgery as 'inadequate'; the urgent and emergency service, medical care, and children & young people, as 'requires improvement'; with maternity services and outpatient and diagnostic services as 'good'.

Our key findings were as follows:

- There was continuous and persistent deterioration of the Emergency Department's performance against the four hour target to see and treat people.
- Staff within ED were unable to locate the major incident plan and they subsequently told us that the plan was unavailable as it was under review. Staff were not aware where the major incident store was located and major incident training was out of date. There was a lack of general maintenance and cleanliness issues within the theatre environment. There were also concerns about response to infection control audits within the Emergency Department.
- The trust had responded to previous staffing concerns and was actively recruiting to fill posts however there were areas in medicine where nurse staffing levels were impacting on patient care and treatment particularly on the elderly care wards. There were also staffing pressures in the electrocardiography department at Castle Hill Hospital which meant staff were struggling to carry out cardiac diagnostic tests for patients. The hospital faced significant challenges in recruiting senior emergency medical staff and there was a shortage of consultant paediatric surgeons, occupational therapists and dieticians. There were also concerns about staffing levels within histopathology, emergency department, nursing and surgery.
- Systems and processes on some wards for the management of medicines and the checking of resuscitation equipment did not comply with trust policy and guidance.
- Most patients across the medicine health group received a good standard of care. However, on the elderly care wards patients were waiting for staff to assist them with their basic needs. Call bells were not in reach of patients in some areas. There was inconsistent use of the red top water jug system to identify patients that required assistance with nutrition and hydration. Care was not always being actively recorded in the patient's records.

Summary of findings

- There had been changes to medical pathways of care to improve access and flow however this had not yet resulted in a significant improvement; as there continued to be delays in discharge, patient bed moves out of hours and, patients were being cared for on non-specialty or other specialty wards due to inpatient capacity issues.
- There was an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014.
- The environment and facilities on the 13th Floor required improvement to protect children and young people from the risk of self-harm and/or injury. Following the inspection the Trust told us it was working with the local Child and Adolescent Mental Health Service (CAMHS) to provide staff training and introduce an accepted anti-ligature risk assessment as part of its health and safety audits.
- At the time of our inspection, some procedures such as flexible hysteroscopy, were undertaken without written consent or the use of the safer steps to safer surgery. The trust was informed and action was taken.
- Most staff had received safeguarding training and could demonstrate an understanding of their role and what action to take if they were concerned about a person.
- There was a backlog of incidents that had not been investigated in a timely manner and therefore lessons learnt and duty of candour requirements were not being effectively applied.
- There was a lack of long-term clinical strategy.

We saw several areas of outstanding practice including:

- The plastics trauma team, based in outpatients, had developed a one stop service for patients to attend the department and be immediately listed for theatre when appropriate.
- In relation to Radiology discrepancies we saw that the peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- address the breaches to the national targets for A & E and referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard to eye services and longest waits.
- ensure there is a sustainable action plan to improve the reporting performance of the histopathologist service.
- ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the elderly care wards, consultant and nursing cover within A & E; histopathologists, and surgical wards.
- ensure that all incidents are investigated in a timely manner, that lessons are learnt and that duty of candour requirements are effectively acted upon and audited.
- ensure that there is a policy and procedures in place to ensure that there is effective transition for young people to adult services.
- ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.
- ensure appropriate arrangements are in place to respond to major trauma and incidents within ED.
- ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.
- take further steps to improve the facilities for children, young people and parents on the 13th floor.
- take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, and that there is an appropriate "safe room" for the use of children and young people with mental health problems. Following the inspection the Trust told us it was introducing an anti-ligature risk assessment.

Summary of findings

- ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.
- ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the hospital must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.
- ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014).
- ensure that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance.
- review its patient pathways and patient flow through services to ensure:

1. the plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management
2. the seating area on the elderly assessment unit is not used for beds
3. plans for dealing with extra capacity are reviewed including the "reverse boarding" policy.
4. internal patient transfers take place in accordance with trust policy and reduce the number of patient bed moves 'out of hours' unless for clinical reasons
5. more timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.

- ensure use of best practice guidance, such as the "Safer steps to surgery" checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients.
- review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres.

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 	The department's performance against the four hour target had continued to deteriorate. Performance information since the opening of the new department indicated a marginal improvement: the four hour target was 71.4% in April 2015 and 72.7% in May 2015 and the Trust remained a national outlier. Access to beds in the hospital did not always follow an agreed pathway and identifying accessible beds presented a constant challenge with 761 breaches of patients waiting in A & E in April 2015 whilst awaiting medical beds. The department faced significant challenges in recruiting senior emergency medical staff. The shortage of consultants had an impact on assessment of patients, access and flow and major trauma preparedness. Nursing staff had increased although staffing remained an issue. The governance structures had recently changed and the revised arrangements were still to become embedded. The department's risk register identified most high risks the department currently faced and was reviewed at governance meetings. There was a backlog of 340 incident reports awaited further review although the incidents had been reviewed to identify significant risks. Staff within ED were unable to locate the major incident plan and they subsequently told us that the plan was unavailable as it was under review. Staff were not aware where the major incident store was located and major incident training was out of date. Equipment was outdated and checks were not being carried out. In paediatric resuscitation a medicines storage cupboard was left unlocked and controlled drugs were not checked appropriately, but the department took prompt action to address our concerns. There were some partial omissions in the records of the controlled drugs registers. Appraisal rates had declined significantly in the previous 12 months but plans were in place to

address this. Medical staff appraisals were up to date. Mandatory training was not up to date for all staff but 83% of staff overall had completed their mandatory training.
The opening of the new department had a positive impact on the privacy and dignity of patients. Nursing and support staff were caring and compassionate in their interaction with patients. Monitoring of meals and hydration had improved. Training and awareness of dementia had increased. The hospital identified themes and trends from the investigation of complaints and the department had implemented changes following complaint investigations.
The department used nationally recognised clinical guidelines. Multidisciplinary working was effective within teams. Consent was discussed and obtained appropriately. The medium to long term vision required further development. The trust was actively addressing the bullying concerns. A survey undertaken in the department indicated that staff no longer felt bullied.

Medical care

Requires improvement

All domains were rated as requiring improvement for medical care.
Staff understood their responsibilities to raise concerns and report patient safety incidents however policies for reporting incidents were not being consistently followed. There were delays in completing serious incident investigation reports which the trust was monitoring with its commissioners.
The trust had responded to staffing concerns and was actively recruiting to fill posts however there were areas in medicine where nurse staffing levels were impacting on patient care and treatment, particularly on the elderly care wards. There were also staffing pressures in the electrocardiography department at Castle Hill Hospital which meant staff were struggling to carry out cardiac diagnostic tests for patients. Performance against mandatory training had shown some improvement compared to 2014. Safeguarding systems were in place and staff were aware of the processes to report concerns. Infection prevention and control was managed appropriately.

Summary of findings

Systems and processes on some wards for the management of medicines and the checking of resuscitation equipment did not comply with trust policy and guidance.
Most patients across the medicine health group received a good standard of care. However, on the elderly care wards patients were waiting for staff to assist them with their basic needs. Call bells were not in reach of patients in some areas. There was inconsistent use of the red top water jug system to identify patients that required assistance with nutrition and hydration. Care was not always being actively recorded in the patient's records.
There had been changes to medical pathways of care to improve access and flow, however this had not yet resulted in a significant improvement as there continued to be delays in discharge, patient bed moves out of hours and, patients being cared for on non-specialty or other specialty wards due to inpatient capacity issues.
There was a new leadership structure and senior managers were aware of the challenges in the health group. The health group was involved in a number of initiatives to improve staff engagement, develop staff and embed trust values and behaviours. There was some progress in these areas.
Information showed that the majority of intended outcomes for patients were being achieved.

Surgery **Inadequate**

There had been three Never Events reported for the surgical health group between April 2014 and March 2015; two in relation to wrong site spinal surgery on the Hull Royal Infirmary site (between December 14 and March 2015) and one on the Castle Hill hospital site involving a retained foreign object. Within the surgical health group 21 serious incidents reported for surgery in the last twelve months. Incidents were investigated however external support was being put in place as there were delays in investigating incidents and securing clinical staff for panel members to investigate incidents. The rate of incidents reported in this trust was lower than the England average.
A number of concerns in relation to infection prevention and control were identified. This included potential risks of contamination caused by

Summary of findings

inappropriate storage and ineffective cleaning protocols. Hand washing facilities for clinical procedures were poor on ward 6; inappropriate access to store rooms and temporary repairs to flooring in wards and clinical areas which hindered effective cleaning processes.

There was a lack of assurance of the governance systems in place to maintain safety. There was a risk register and an integrated governance group , however the group had not been quorate for two of three meetings we reviewed and the risks had not been addressed in a timely manner. The reports we saw identified issues such as “rotten plant” and the presence of dirt and rust within the ventilation systems that served the theatres.

There was a backlog of complaints requiring investigation across the Health group. Matrons were unable to attend the monthly Patient Experience Committee due to their clinical workloads.

The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. National data indicated that the number of cancelled operations had been increasing and were above the national average. A number of issues affecting patient flow through the hospital had been identified.

Nurse staffing levels varied from a 67% to 98% fill rate against the planned establishment which was confirmed on review of rotas for the two weeks in the previous month to the inspection.

There was no clinical strategy for the health group. Members of staff were able to articulate the health group’s values and short term operational plan, although they were not aware of the plans to manage winter pressures. Senior managers told us the health group’s objectives was to make decisions affecting the present and medium-term and not about the longer-term. Staff said health group managers were available and approachable and leadership of the service was good. Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.

During meetings with staff a history of a poor culture between qualified and non-qualified staff

Summary of findings

was mentioned. We were told that senior managers were aware of this and had addressed it. Staff told us that an open and honest culture had been developed and significant change in the culture of the service had been achieved.

Maternity and gynaecology

Good

This inspection was to follow up the outstanding requirement relating to insufficient staffing within the midwifery services. We therefore only inspected the safe domain which we rated as good. The trust had a full time named midwife for safeguarding and staff confirmed they had received safeguarding training and supervision relevant to their role. There were systems in place to manage and review risks to vulnerable adults, young people and children; safeguarding policies and procedures were in place and available to staff.

Staff reported an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014. Consultant cover on the labour ward had remained at similar levels to the previous inspection at 101 hours per week. We were told that the recent recruitment of three WTE consultant obstetricians increased the hours up to 147 hours a week. The skill mix of the junior medical staff at the unit was similar to the England average. Patients told us they received 1:1 care from a midwife during labour and consultant and medical care which met their needs.

Services for children and young people

Requires improvement

The majority of the care records we reviewed were incomplete and generic care plans were in place, with little specific information recorded which related to the individual's needs. We saw that some children's records were also incomplete and were being stored in areas accessible to the public. The wastage of controlled drugs was not recorded in the records we viewed. Staff we spoke with told us they were concerned about the lack of CAMHS support and had not received an appropriate level of training to help them care for children with mental health needs.

At the time of the inspection, concern was raised that the windows in Ward 130 did not all appear to have effective window restrictors in place and whether risk assessments had been completed. We made the trust aware of this at the time of the

Summary of findings

inspection and following the inspection the trust provided written assurance that they had checked all the windows in the building and they met the appropriate standards. We noted that children and young people with mental health needs on Ward 130 did not have appropriate risk assessments in place. We found that children and young people with mental health needs were nursed regularly on this ward. There was a 'Green Room' for children who required a "safe bed space" where they could be closely and continuously observed. Staff told us this was not fit for purpose. We reviewed the space and noted that it would be difficult to observe children if the room was in use. We saw a number of ligature and anchor points on the ward. This meant children and young people could be at risk of self-harm and/or injury. Following the inspection the Trust told us it was working with the local Child and Adolescent Mental Health Service (CAMHS) to provide staff training and to introduce an accepted anti-ligature risk assessment as part of its health and safety audits.

The trust had made progress in ensuring that nurse staffing levels were safe and we saw evidence that appropriate nurse staffing was available across the service on most occasions. There was no improvement on the number of surgeons available and they were still working to a 1:3 rota.

Outpatients and diagnostic imaging

Good

The outpatients and diagnostic imaging service was judged as good overall. The service was rated as good for safety, caring and being well-led. Responsiveness was rated as requires improvement and the effective domain was inspected but not rated. Throughout our inspection we witnessed good care being given. Most patients were happy with the care they received.

Incidents were reported and managed appropriately. Patient areas were clean and infection prevention and control procedures were adhered to. Records were almost always available for clinics. Staff knew their responsibilities within adult and children safeguarding. There were a small number of concerns noted regarding audit of records and vacant consultant histopathologist posts.

Summary of findings

Staff had access to evidence based protocols and pathways. Internal and external audits of radiation regulations showed good compliance. Systems and processes were in place to monitor report and address any issues with patient outcomes. However there was little audit of waiting times within departments. Access to information was generally good for staff but patients reported some issues regarding accessing and timeliness of results. Turnaround for results times was acknowledged as an issue and there were some mitigating actions in place to improve this situation. During our visit to the gynaecology outpatient department, it was observed that women were undergoing flexible hysteroscopy without being asked for written consent. This was raised as an urgent issue with the Trust and assurances were received that this was addressed.

The trust had performed worse than the England average for the three waiting time measures for "all cancers" since April 2013. There were four reported breaches of 52 weeks before completion of pathway during January 2015. Improvements had been made to waiting times but there were still significant improvements needed, particularly with reviewing follow up patients. For cancer waiting times and diagnostic waiting times the trust was better than the England average.

Both staff and managers were clear about the vision and strategies for both the Trust and their own departments. Priorities, challenges and risks were well understood; there were clear governance structures and good progress was being made to improve services for patients and reduce waiting lists for both new and follow up patients. We found evidence of good local leadership and a positive culture of support, teamwork and innovation.

Hull Royal Infirmary

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Hull Royal Infirmary

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

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

The trust serves a population of around 600,000. Life expectancy for those in East Riding of Yorkshire is better than average, but worse than average for those in Hull. Kingston Upon Hull performs significantly worse than average for most measures on the local health profile. East Riding of Yorkshire performs similar to or better than the England average. Hull is one of the most deprived local authorities in the country. East Riding of Yorkshire is in the 2nd IMD quintile (where 1 is the least deprived).

The trust has not yet achieved foundation trust status. The trust's management structure is based on health groups: these are surgery, medicine, family and women's health and clinical support along with the corporate functions.

Hull Royal Infirmary was inspected in June 2012 and October 2013 and found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulation 13 (medication) 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.

At the comprehensive inspection in February 2014 the HRI site was found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: 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. Compliance actions had been set for all these breaches and the trust had action plans in place to become compliant by March 2015.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Michael Wilson, CEO, Surrey & Sussex Healthcare NHS Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical, A&E and surgical consultants, junior doctors, senior managers, nurses, midwives, allied health professionals, children's nurses and experts by experience who had experience of using services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

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

However, as this was a focused inspection we did not look across the whole service provision; we focussed on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

The team inspected the following core services at HRI:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity
- Services for children and young people
- Outpatient and diagnostic services

We did not inspect the core services critical care or end of life services at this inspection.

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisations.

We held a listening event in Hull on the 18 May 2015, where 52 people attended and shared their views and experiences of the Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 19 and 21 May 2015. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Hull Royal Infirmary

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

Detailed findings

operates acute services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at Beverley Community Hospital and some outpatient services in other locations.

Hull Royal Infirmary has over 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 2013/14. 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. There is also an ophthalmology (eye) hospital on site.

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

Overall the trust has:

Beds approximately 1,300 including:

- General and acute 992
- Maternity 72
- Critical care 44

Staff (whole time equivalent establishment): 7,361.65

- Medical 1,024.38
- Nursing 3,004.73
- Other 3,332.54

Revenue (2014-15 projection): £522,330

Activity summary (Acute) – 2013/14

- Inpatient admissions 185,676
- Outpatient (total attendances) 617,971
- Accident & Emergency (attendances) 131,308

Our ratings for this hospital

Our ratings for this hospital are:

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

Detailed findings

Notes

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

2. As this was a follow up inspection to the comprehensive inspection in February 2014 not all services or domains were inspected.

Urgent and emergency services

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

Information about the service

Hull Royal Infirmary emergency department received 130,239 attendances in 2014-15, which represented in excess of approximately 350 patients per day attending the department. Of the total number of patients attending, 29.1% of these resulted in an admission to hospital, which was above the England average of 21.9%.

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

The adults' emergency department included a major's area which included 8 initial assessment bays and 24 enclosed cubicles. Two of these cubicles had en-suite facilities. The resuscitation area had 10 cubicles. The children's emergency department consisted of eight main cubicles, two triage or initial assessment rooms, one paediatric resuscitation area and a waiting area for children. The minor's area consisted of a rapid self-check-in for patients to use, supported by a staffed reception area. A waiting area behind the nurse's station was used for vulnerable patients.

A further phase of building work for the department, still to be completed, included facilities for mental health patients, a relatives room, and a wet room to store and clean equipment returned from ward areas.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was requires improvement. Four domains; safe, caring, responsive and well-led were rated as required improvement. The effective domain was inspected but not rated during the February 2014 and January 2015 inspections.

In May 2015 we spoke with 30 patients and their relatives, and 40 members of staff of different disciplines which included visiting healthcare professionals, for example ambulance staff. We observed the practice of care and treatment in the department. We reviewed electronic records and documentation and reviewed information provided prior to our inspection.

Urgent and emergency services

Summary of findings

There had been a continuous and persistent deterioration of the department's performance against the four hour target to see and treat people within. Performance information since the opening of the new department indicated a marginal improvement: the four hour target was 71.4% in April 2015 and 72.7% in May 2015 and the Trust remained a national outlier. Access to beds in the hospital did not always follow an agreed pathway and identifying accessible beds presented a constant challenge with 761 breaches of patients waiting A & E in April 2015 whilst awaiting medical beds.

The department faced significant challenges in recruiting senior emergency medical staff. The shortage of consultants had an impact on assessment of patients, access and flow and major trauma preparedness. Nursing staff had increased although staffing remained an issue.

The governance structures had recently changed and the revised arrangements were still to become embedded. The department's risk register identified most high risks the department currently faced and was reviewed at governance meetings. There was a backlog of 340 incident reports awaited further review although the incidents had been reviewed to identify significant risks. Staff were unable to locate the major incident plan within the department and we subsequently found the plan was unavailable as it was under review. Staff training in responding to a major incident was out of date. Equipment was outdated and checks were not being carried out. In paediatric resuscitation a medicines storage cupboard was left unlocked and controlled drugs were not checked appropriately, but the department took prompt action to address our concerns. There were some partial omissions in the records of the controlled drugs registers.

Appraisal rates had declined significantly in the previous 12 months but plans were in place to address this. Medical staff appraisals were up to date. Mandatory training was not up to date for all staff but 83% of staff overall had completed their mandatory training.

The opening of the new department had a positive impact on the privacy and dignity of patients. Nursing and support staff were caring and compassionate in their interaction with patients. Monitoring of meals and hydration had improved. Training and awareness of dementia had increased. The hospital identified themes and trends from the investigation of complaints and the department had implemented changes following complaint investigations.

The department used nationally recognised clinical guidelines. Multidisciplinary working was effective within teams. Consent was discussed and obtained appropriately. The medium to long term vision required further development. The trust was actively addressing the bullying concerns. A survey undertaken in the department indicated that staff no longer felt bullied.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

There was a shortage of medical staff which the Trust was aiming to address with a three-year recruitment programme including overseas recruitment. There was not the required level of consultants as stipulated for a major trauma centre. The shortage of consultants had an impact on assessing patients and access to senior medical decision-makers. The department had increased the level of nursing staff, however at the time of inspection it was still below the required numbers.

Staff were unable to locate the major incident plan within the department and subsequently told us the plan was unavailable as it was under review. Staff training in responding to a major incident was out of date. Staff in the department were not aware where the major incident store was located. Equipment was outdated and checks were not being carried out.

There was a backlog of 340 incidents which required further review. We received assurance that the incidents had been reviewed to identify significant risks. Serious incidents were investigated and practice was changed as a result of these incidents. Staff were aware of their responsibilities under the duty of candour requirements.

Some patient trolleys and commodes were not clean. We observed instances of staff not hand washing. Hygiene audits had recently commenced which identified that some items of equipment required cleaning.

The resuscitation area was fitted out with new equipment and an equipment checklist was used. Equipment was appropriately maintained. In majors, a mattress was faulty which presented a risk of cross-infection. In minors, the panic alarm was faulty, although a weekly check was undertaken of these devices. Equipment checks were reported through an on-line system and the medical physics department undertook the maintenance of medical devices.

There were some partial omissions in the records of the controlled drugs registers. The temperature of medicines fridges in the majors and resuscitation area were not monitored accurately. In paediatric resuscitation a medicines storage cupboard was left unlocked.

There was a nurse led approach for initial clinical and risk assessment. There remained some concerns as to the minors self-check-in system being able to identify the severity of the patient's condition. Systems were in place to safeguard vulnerable adults and children. However, the A&E department had not achieved the required compliance for level 3 child safeguarding training. Mandatory training was not up to date for all staff but 83% of staff overall had completed their mandatory training.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. There had been no never events reported between February 2014 and January 2015.
- For the period February 2014 and January 2015, 15 Serious Incidents were reported, including one unexpected death of an inpatient. No pressure ulcers, falls or catheter-associated urinary tract infections were reported as part of the patient safety thermometer data, for this service.
- For the period February 2014 to March 2015, the emergency department reported 643 incidents. This reflected an increase in the reporting of incidents. We reviewed the reported incidents which were awaiting review, and found there were a number of open, pending and unallocated incident reports. Of these, 340 were within the system's holding area, 322 overdue; 53 were under review, and 43 were overdue. The oldest of these, submitted in November 2014, was a pressure care concern which was still to be allocated to an investigator. The department identified 18 members of staff who investigated incidents. We discussed the backlog of incident reports with the department's clinical governance lead and received assurance that the incidents had been reviewed to identify significant risks, for example, potential serious incidents and deteriorating patients.
- Our January 2015 inspection had found that between October 2014 and January 2015, there were 327 pressure ulcers which had been reported in the emergency department. We found these reports were not checked to see whether the patient had been in hospital in the previous 30 days. The department provided an update which indicated that five hospital acquired pressure ulcers occurred during this period. Following review, three of the five incidents had been

investigated and re-categorised as they were not hospital acquired pressure ulcers. This meant that two of the incidents were hospital acquired in the emergency department.

- We reviewed the investigation reports for two serious incidents. The investigation reports included recommendations, an action plan and arrangements for shared learning. The investigation report was shared with clinical teams through their governance arrangements, including presentation at the emergency department governance meeting, each health group and the executive team. We saw evidence that practice in the department was changed as a result of these incidents.
- We reviewed actions taken since our 2014 and 2015 inspections, when we asked the department to review incident reporting to ensure that staff reported incidents appropriately and in a timely manner. The department reported that it had upgraded the incident reporting system and reviewed its incident policy. Incident reporting had been given more prominence on the trust intranet. We had also asked the department to ensure staff received feedback from incidents reported. The department reported some progress but also acknowledged that further work was required to communicate lessons learned across the trust. Our January 2015 inspection had found that learning from incidents was not being effectively communicated to staff.
- We asked eight members of staff in the department as to how incident reporting had changed since our previous inspection. Most staff were familiar with reporting incidents but a common theme was they felt they received little feedback. However, one member of staff received feedback after reporting faulty equipment. Reported incidents that required sharing with the team were included on the daily briefing sheet which was shared with the team on duty and emailed to all staff in the department. Incident reporting was included in staff induction training.

Duty of candour

- The trust had in place a policy relating to these new requirements. Information to be reported under the duty of candour requirements was not yet included in the electronic incident reporting system.
- Our January 2015 inspection had found that the Safety Experience and Effectiveness meeting reviewed incidents which met the requirements of Duty of Candour. Of six incidents which related to the emergency department, only three of these had evidence indicating the date of a verbal apology given to the patient or relative. The back log of incidents meant assurance of duty of candour requirements could not be ascertained.
- At our May 2015 inspection we saw from the minutes of the department's clinical governance meeting held in December 2014 that the duty of candour requirements were discussed. We saw that information about duty of candour was displayed on the staff intranet. Staff we spoke with were aware of their responsibilities under the duty of candour requirements.

Cleanliness, infection control and hygiene

- We reviewed actions taken since our 2014 and 2015 inspections, when we asked the department to review the cleaning arrangements in the department to ensure that there were sufficient staff to keep areas clean following patient treatment. The department reported that it had competed actions to review arrangements with its cleaning contractors. Our January 2015 inspection had found that some areas of the department were not cleaned to the required standards. In the evening the resuscitation area was not cleaned before the next patient was admitted, which meant that there was a risk to patients of cross-contamination.
- At this inspection we observed that the recently opened resuscitation area used a colour co-ordinated lighting system which was green if the bay was clean and ready to use, and red if it required cleaning. Equipment, including trolleys that were ready to use were labelled with an "I am clean" sticker. Water checks were completed. Support staff undertook cleaning checks and we saw evidence that these were recorded.
- The patient-led assessments of the care environment (PLACE) undertaken for 2014 included the emergency department. We reviewed the emergency department cleaning audit against national cleaning standards undertaken in January 2015 which identified action required, and action taken for each area of the department.
- Some patient trolleys were not clean. Portering staff told us they cleaned trolley mattresses after each patient's use, but currently there was no designated area in the department to do this. In the majors utility area we found two commodes which were dirty and stained. We

were informed that domestic staff visited the department in the morning and evening, and could be contacted at other times (24/7) if required. When we asked senior staff about hygiene audits we found these had only recently commenced; the audit identified that trolley beds and some other items of equipment required cleaning. When we visited unannounced in the evening we did not observe staff hand washing. In the paediatric emergency area, we were informed that toys were cleaned but staff did not know how often this was done and no record was kept. We were informed that the Saving Lives audit tool of infection control standards was completed monthly, although we did not review this.

Environment and equipment

- A newly extended and refurbished emergency department opened in April 2015. The majors area consisted of 24 enclosed cubicles (previously there were eleven majors cubicles), with doors and the area visible through the use of extensive glazed panels with curtains for privacy. Two of these cubicles had en suite facilities. The monitoring and observation area in majors was located centrally in the line of sight for staff, with 12 cubicles on each side. For cubicles at the extremity, observation was more limited although two of these were used for training. The resuscitation area comprised of 10 cubicles (previously there were five resuscitation cubicles) with beds and co-ordinated lighting to indicate the status of each cubicle. Staff and patients we spoke with expressed appreciation of the new facilities which provided a better and suitable environment for emergency care.
- A separate children's emergency department had been refurbished within the last two years. This separate but linked area consisted of eight main cubicles, two triage or initial assessment rooms, one paediatric resuscitation area and a waiting area for children. The television was not working in the children's waiting area.
- The minors area consisted of a rapid self-check-in for patients to use, supported by a staffed reception area. A waiting area behind the nurses station was used for vulnerable patients and this was also used for children when the paediatric emergency department was closed. We observed the area being used by a family and an elderly patient who had suffered a stroke. This mix of vulnerable patients potentially presented some risk to the safety of patients.
- We were informed that a further phase of building work for the department, still to be completed included facilities for mental health patients, a relatives room, and a wet room to store and clean equipment returned from ward areas.
- We reviewed actions taken since our 2014 inspection. At the inspection in January 2015, which confirmed that previous concerns identified as to the availability and maintenance of equipment in the resuscitation area had been met. In the resuscitation area, we found the area was fitted out with new equipment and an equipment checklist was used. In the paediatric resuscitation area, a resuscitation checklist was used for neonates. We checked equipment labels, which were in date.
- We inspected equipment in other areas of the department. In majors, for one trolley we found a hole in the mattress, which presented a risk of cross-infection. In minors, the information screen was faulty, but was reported after the inspector pointed it out to staff. We found the panic alarm was faulty. Staff confirmed that a weekly check was undertaken of these devices. Staff also confirmed that the medical physics department undertook the maintenance of medical devices. We were informed that equipment checks were reported through an on-line system.

Medicines

- At our 2014 inspection we asked the trust to ensure that there were suitable arrangements in place for pharmacy provision across all areas of the service and to provide clinical overview and reconciliation of patient medications. The trust executive confirmed that additional staff resources were being put in place to support the reconciliation of medicines within 24 hours in 80% of instances by August 2015. The emergency department was not identified as an area of concern.
- In a review of information prior to the inspection we found that one serious incident reported in the last 12 months was related to the management of medicines. At the inspection we reviewed arrangements for the safe storage and administration of medicines in the emergency department.
- The temperature of the medicines fridge in the resuscitation area was not monitored accurately. In majors, we found that medicines fridge temperatures were not checked daily. However, we did not find evidence that the fridge was operated with temperatures out of range.

- We checked the stocks of controlled drugs in majors and in the resuscitation area. Controlled drugs were stored and administered safely and stock balances were correct. We reviewed the checks undertaken of controlled drugs. These were checked twice daily and a member of senior staff undertook a weekly check. However, there were some partial omissions in the records of the controlled drugs registers.
- In the paediatric resuscitation area, we found medicines storage cupboard was left unlocked and controlled drugs were not being checked appropriately. When we returned the following day we found the department had taken action to address the risk we had identified. In the resuscitation area we found 10 omissions in the recording of quantities administered and in checking and signing of controlled drugs. However, we found that stock balances were correct.

Records

- The emergency department used an electronic patient record system widely used in the NHS. Nursing and medical documentation was electronic within the trust. The trust had revised the format of its patient records since our previous inspection. We were informed that revised nursing documentation was due to be used from June 2015.
- We reviewed the recording of information including the nursing assessment documentation used in the emergency department. The assessment document included a record of assessment tools used, for example, the pressure area assessment tool and skin care bundle. We found records were completed accurately and comprehensively.
- The department completed a matron ward round record by selecting six charts to check record keeping for each aspect of care recorded. Any immediate action taken was noted.

Safeguarding

- We reviewed actions taken since our previous inspection, when we asked the department to ensure that staff were supported to complete Safeguarding Children Level 3 training where appropriate. At the time of the inspection it was reported in the “Named nurse and named midwife report” dated May 2015 that level 3 child safeguarding training was non-compliant across the trust at 66.6% with the majority of non-compliance within the A&E department.
- The department reported its progress in increased training rates overall which meant that 400 staff out of 604 staff requiring this training had completed it prior to our inspection. This represented 66.2% of eligible staff. The trust informed us it aimed to achieve 80% compliance by March 2016, which reflected national requirements.
- Registered nurses completed safeguarding level two training. Staff we spoke with had competed this training, or arrangements were made for them to attend. The A&E department had not achieved the required compliance for level 3 child safeguarding training.
- We reviewed actions taken since our previous inspection, when we asked the A&E department to ensure that staff were supported to complete Safeguarding Children Level 3 training where appropriate. At the time of the inspection it was reported in the “Named nurse and named midwife report” dated May 2015 that level 3 child safeguarding training was non-compliant across the trust at 66.6% with the majority of non-compliance within the A&E department.
- The department had systems in place to safeguard vulnerable adults. Staff we spoke with were aware of their responsibilities and of the appropriate safeguarding pathways to use. We reviewed evidence of appropriate risk assessments being undertaken, including escalation to the safeguarding team when safeguarding concerns were suspected.
- We noted that information was not always recorded in A&E about children in the same households as adults with risk taking behaviours or other vulnerabilities so that they could be brought to the attention of paediatric liaison services. The trust had acknowledged as a gap and actions were being put in place to address this.
- Information on children who attended the A&E department was routinely reviewed by the safeguarding team and if required information was sent to health visitors, school nurses and the child’s GP.
- For the paediatric emergency department, the child protection team was available to provide support and we found this was used on a daily basis. For children or young people presenting with emotional, behavioural or substance use issues, the department liaised with the Child and Adolescent Mental Health Service (CAMHS). However, we were told there was no formal process in place to access CAMHS out of hours.

Urgent and emergency services

Mandatory training

- In relation to mandatory training, we reviewed actions taken since our 2014 inspection, when we asked the trust to ensure that staff were supported to complete mandatory training. The trust reported some progress in compliance with mandatory training. At our inspection 83% of staff overall had completed their mandatory training, as against 79% in April 2014.
- Each Health Group had improved its overall compliance with mandatory training during 2014-15; for Medicine, which included ED, the level of compliance was 80%. Two of the six elements of mandatory training achieved below this level; fire training was 71.5% and manual handling 74.5%.
- We spoke with emergency department managers and staff about their mandatory training. Managers explained that completing the fire training module involved time off site. Some training had been cancelled during the recent pressures experienced by the department. The opening of the new department had provided the opportunity to bring more training into the department; two bays in majors were being used for this purpose.
- Protected time was being allocated to members of staff who required training and we were given examples of this. The teaching practitioner / clinical educator reminded staff by email when aspects of their training were due. Some, but not all, staff we spoke with confirmed that their mandatory training was up to date. Staff were able to view the status of their training on the trust intranet.

Assessing and responding to patient risk

- At our January 2015 inspection we observed ambulance handovers to staff within the department. We found that some patients admitted by ambulance did not always have prompt initial clinical assessments to identify their individual needs. We formally requested the trust to ensure there was an effective system for patients to receive an initial assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of their arrival in the department. We requested the trust to comply with the guidance issued by the College of Emergency Medicine and others in its "Triage Position Statement" dated April 2011 or other recognised professional guidance. We requested the trust to review the patient pathway into the hospital, particularly the emergency department, to ensure that patients were assessed and treated appropriately to meet their needs.
- Our January 2015 inspection reported on a trial of a rapid assessment and treatment (RAT) system which for patients who arrived by ambulance, provided an early assessment by medical staff. This system had been operated for six months during 2014 and a comparison with majors undertaken which demonstrated improved times to triage to be seen by a doctor and the decision to admit. However, the use of RAT was discontinued because the department did not have sufficient senior medical staff to operate the RAT system effectively. The divisional risk register identified that some high risk patients could be discharged from the department without senior input. The risk was elevated to high due to RAT not being in place, linked to the reduction in availability of senior medical staff. Consultant medical staff we spoke with confirmed that the RAT system had started to work well, but that without more consultants, it was not currently possible to operate it.
- In the minors area a self-check-in system for patients was used supported by nursing staff based at reception. The check in system prioritised how quickly a patient was seen, based on the information they submitted. Following the 2014 inspection the department undertook a review of the appropriateness of the system in identifying when a patient who arrived carried significant risks. The department had also identified the need to review the response to patients who submitted inaccurate or exaggerated data, because a higher proportion of patients than expected were being allocated for medical rather than nursing review. Our January 2015 inspection reported that a number of staff of various disciplines told us that they had concerns about the system and how well it was able to identify the severity of the patient's condition.
- Escalation criteria guidance was used for deteriorating patients. An observation chart for the National Early Warning Score was completed, supplemented by an initial assessment investigation matrix developed locally with input from medical and nursing staff. A standard operating procedure (SOP) for escalation within the emergency department was in place. This specified escalation triggers and set out escalation actions for medical and nursing staff to follow. At our May 2015 inspection senior nursing staff told us that during busy

periods escalation could become somewhat hit and miss; some managers responding to escalation visited the department, whereas others chose only to speak on the telephone.

- For patients at risk of pressure ulcers, the department assessed risk using a recognised pressure area assessment tool which was included in the initial nursing assessment.
- For patients at risk of falls, a summary falls risk assessment was included in the initial nursing assessment. Patients at risk of falls wore a yellow wristband during their stay in the department.
- At the May 2015 inspection, we observed the arrival of patients in the minors, majors and paediatric areas of the department and spoke with 12 patients who were waiting to be seen by a doctor. Staff said their objective was to stream the patient to the appropriate area of the department, based on the initial assessment and we observed that triage and streaming took place. We found that staff responded appropriately to the risks patients presented in each area.
- In majors we observed that the initial assessment was nurse led and followed a see and treat model. The newly arrived patient was met and greeted by a band seven nurse. We observed that a detailed handover was undertaken with ambulance staff. Risks discussed included, for example, the patient's history, allergies, medicines and pain management and nursing staff then undertook a comprehensive initial assessment, including neurological observations, skin care and arrangements for x-ray.
- Our January 2015 inspection found that ambulance crews frequently waited in excess of 15 minutes to handover patients to emergency department staff. In December 2014 1330 out of 2148 ambulance handovers (62%) were triaged in less than 15 minutes. In January 2015 we found 1329 out of 2211 ambulance handovers (60%) were triaged in less than 15 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.
- An analysis of hand-overs delayed by over 30 minutes in the period from November 2014 to March 2015 showed 928 ambulances were delayed by over 30 minutes.
- Between September 2014 and March 2015 there were 1,842 black breaches at the trust of which there had been 308 black breaches in February and 423 during March 2015. Black breaches are defined as the time between an ambulance arriving at the hospital to the patient being formally handed over to the emergency department which is longer than 60 minutes.
- Performance information for ambulance turnaround times for the week of our visit in May 2015 indicated that 52% of patients were seen within 15 minutes.
- Data provided by the trust indicated that for April 2015 the arrival to initial clinical assessment/triage was, on average, 10.9 minutes and from arrival to be seen by a doctor was 108.7 minutes.
- In paediatrics, two of three patients we observed arrived at the department after first attempting to go to their GP. We observed that each patient was triaged after 15 minutes. For children who arrived between midnight and 8am when the department was closed and arrived in majors, we were unable to ascertain how triage arrangements were prioritised for them.
- In minors, patients were encouraged to use the self-check-in system. The system either triaged the patient or issued a flag for nursing staff to undertake the triage. Reception staff were available 24 hours to provide support for patients. However, staff also expressed some reservations as to the effectiveness of self-check-in. A member of staff told us they felt the self-check-in system removed an opportunity for staff involvement when they may notice if the patient appeared acutely unwell and has "under-triaged" themselves; more generally, patients knew to "over-triage" to be seen more quickly. For example, they could answer "yes" to the question about whether they were experiencing serious bleeding. We observed five patients, two of whom used the self-check-in which they found was easy to use and worked well. However, at another time we observed a patient who was in pain and who encountered some difficulty when they attempted to use the system as it was very slow.
- For patients in the department, intentional rounding was undertaken every one to two hours and included in the nursing assessment documentation.
- For patients who presented with mental health needs, we found no pro forma was in place for rapid mental health assessment.

Nursing staffing

- National comparative information showed the staffing skill mix in the emergency department was generally similar to the England average.

Urgent and emergency services

- At our January 2015 inspection we had identified concerns with the insufficient numbers of nursing staff in the emergency department. Information provided by the trust indicated that the department required 12 registered nurses and three support workers for each shift. The actual numbers of registered nurses had improved in the months of February and March 2015. The department had prepared a business case to increase the numbers of nursing staff to required levels. In March 2015 the planned numbers of registered nurses for day shifts had increased to 14 and for a night shift it had had increased to 13 registered nurses. The actual numbers of nurses who worked during March 2015 meant 74% of shifts met the required numbers of staff.
- The department had reviewed its requirement for nursing staff based on draft NICE national guidance and had used acuity and dependency data. This was confirmed by a review of the trust's safe staffing return for April 2015 and of nursing staff rotas for the emergency department in May 2015. The department employed 68 WTE nursing staff and had recruited 18 additional qualified nursing staff who were due to commence in June 2015. The department had undertaken recruitment of nurse practitioners, five of whom were due to commence work in September 2015. We were informed the department's staff retention rate was 93% and its sickness rate was 4.8%. When we spoke with senior nursing staff they told us staffing remained an issue, but the availability of staff was improving.
- We reviewed actions taken since our 2014 inspection, when we asked the department to review and improve the communication among clinicians, including handover arrangements in the department and in particularly from night shift to day. The department reported that a designated room has been identified to hold the evening handover. Our January 2015 inspection had found that staffing information was available for the bed meetings which occurred between 8am and 8pm. There were four bed meetings per day. After 8pm any staffing issues were managed by the first and second on call staff.
- At our May 2015 inspection we confirmed that staffing deployment in the department and a safety briefing were discussed during daily operational meetings. We were informed the department only rarely used agency staff. When an internal bank of staff was used, staff received induction and training which was specific to working in the emergency department.

Medical staffing

- In our February 2014 inspection report we referred to the Royal College of Emergency medicine (CEM) 2011 operational handbook which stated that every emergency department that had over 100,000 attendances per year should have a minimum of 16 consultants.
- At our January 2015 inspection the actual number of consultants was nine WTE plus two part-time consultants one of which was on leave and due to return to work within two months. There was usually only one consultant working in the department at any given time. The consultants were covering gaps in the registrar rotas. 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 and July 2015. We were informed that the planned number of registrar level doctors within the emergency 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 was 4.8 WTE.
- At our May 2015 inspection the trust shared with us its plans to recruit more emergency medical staff. The department faced significant challenges in recruiting emergency medical staff, particularly consultants and registrars, and a three-year recruitment programme was being put in place to address this, which included overseas recruitment. The trust had reflected the risks the recruitment of consultant and registrar posts presented in its risk register. We confirmed that one consultant had returned from leave in February 2015. To cover the shortfall in registrars, consultants acted down to cover a registrar post.
- As we found at our previous inspection, there was no paediatric consultant in the children's emergency department and at peak times, the paediatric area could encounter some difficulty in obtaining medical help. This meant that children were not routinely appropriately reviewed by a senior clinician as outlined in the RCPCH Standards for Children and Young People in Emergency Care Settings 2012.
- A member of consultant staff worked in the department until midnight, and was then available on call. We reviewed the medical staff rota, which confirmed these

arrangements. We spoke with a number of consultants and other medical staff in the department. The shortage of consultants impacted on patient flow and access to senior decision making which on occasion fell to junior medical staff and senior nurses.

- The hospital was designated as a major trauma centre. There was not a consultant trauma team leader always available within five minutes, 24 hours per day which was the national requirement for co-ordinating care to trauma patients. The Trust were undertaking a prospective audit of trauma calls that take place between midnight and 8AM to determine the number of calls during this period.

Major incident awareness and training

- We reviewed the document the trust had prepared in response to crowding issues in the emergency department. The document identified the role of the hospital major incident plan in the escalation pathway in the event of a major incident. The respective roles of the incident planning team and the trust board were also identified. However, the member of nursing staff in charge was unable to locate the major incident plan within the department. We subsequently found the major incident plan was unavailable as it was under review.
- Senior managers we spoke with informed us that staff attended major incident training. For the emergency department, this included simulation exercises. We were informed that the major incident training was undertaken once only and no refresher training was in place. A member of consultant medical staff had been identified to lead on major incident training.
- When we spoke with staff in the department we found they were not aware where the major incident store was located. In the major incident equipment store, we found equipment was outdated and checks were not being carried out. We reviewed 24 items of equipment and found that each was out of date, with expiry dates ranging from February 2009 to August 2014. We did not find an equipment contents list for the store which would have assisted in undertaking checks of equipment.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The department used National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) and other recognised clinical guidelines. The department measured and benchmarked its performance against other trusts through participation in national audits. The initial nursing assessment included pain control. Staff usually responded promptly to requests for pain relief. Steps had been taken to ensure that patients' needs for nutrition and hydration were addressed.

Appraisal rates had declined significantly in the previous 12 months. Plans were in place to address appraisals for nursing staff. Medical staff appraisals were up to date. A clinical educator provided training and practitioner support for nursing skill development. Study days were planned but they could be cancelled due to staffing shortages in the department.

There was effective multidisciplinary working within teams. Information and guidance for staff including policies and procedures was available through the trust intranet.

Consent was discussed and obtained appropriately. Staff mainly demonstrated a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards although not all staff we spoke with had experience of using the procedures.

Evidence-based care and treatment

- The department used National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) and other recognised clinical guidelines and patient group directions to support the treatment provided for patients. For example, for treatment of head, ankle and knee injuries, the emergency department assessment card included checks using the clinical guidance.
- Medical staff accessed a clinical data bank through the trust intranet. It was the responsibility of the clinical lead for the department to ensure guidance information was kept up to date. Guidance we reviewed was up to date and revised clinical based protocol guidance and new pathways for care were discussed at clinical excellence meetings.

- The department undertook a programme of local and national audit. The department's programme of local audit was based on the Safer Care audit which was reported at health group level: checks was undertaken during clinical rounds; six patient charts were selected for each aspect of care and immediate action taken was noted.

Pain relief

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts in patients' responses to questions as to the administration of pain relief.
- The initial nursing assessment included a question about the patient's need for pain control. The assessment record included checks undertaken and medication administered to provide pain relief for the patient.
- In the major's area, we spoke with a patient who had not been administered pain relief; however, after they were seen by a doctor, pain relief medication was given to the patient. We observed that when the relative of a patient asked for pain relief, staff responded immediately.
- In the paediatric emergency area, staff told us that following an audit of the use of the children's pain score three weeks before our inspection, the department had found the score was not being completed consistently which had been fed back to staff.
- In the minor's area, patients using the self-check-in system were asked to complete a pain score, to answer whether they required pain relief, and to identify the area the pain was located. A patient identified as in moderate pain was allocated an "amber" score by the system which alerted staff to check the patient's need for pain relief.
- A previous patient had also told us they had poor provision of pain control when they had attended the department and had not received pain relief for five hours.

Nutrition and hydration

- We reviewed actions taken since our 2014 inspection, when we asked the department to ensure patients received appropriate fluid and nutrition to meet their needs. The department reported some progress against this action. Food and drink was being offered to patients in the department if clinically appropriate.
- At our May 2015 inspection we saw that steps had been taken in the department to ensure that patients' needs for nutrition and hydration were being addressed. As well as meals being provided three times a day, sandwiches and drinks and cultural and special diets were available on request throughout the day and monitored using the fluid balance chart.
- Checks included in the initial assessment included the patient's needs for food and drink, including their needs for assistance if required, and the need for intravenous fluids. These checks were supported by intentional rounding.
- For majors, the department had introduced an audit of nutrition and hydration coinciding with the opening of the new department in April 2015.
- For minors, we observed that water was not available in the waiting area. We found patients could request a drink from the receptionist, who checked first that it was appropriate for the patient.

Patient outcomes

- Unplanned re-attendances to the emergency department within seven days of discharge were analysed for the period from January 2013 to September 2014. The unplanned re-attendance rate varied between 7% and 8% and the England average was around 7.5% for this period.
- Proportionately fewer patients were leaving the department before being seen, compared to the England average, although the proportion was increasing over time.
- The CQC 2014 national survey of patient experience in the emergency department indicated that the trust scored the same compared to other trusts for questions about arrival at the department, tests undertaken, hospital environment and facilities and leaving the department. However the trust scored worse when compared to other trusts for waiting times, doctors and nurses, care and treatment and overall experience.
- The emergency department contributed to the CEM clinical audit programme and measured and benchmarked its performance against other trusts through participation in these audits.
- Our February 2014 inspection reported on the department's participation in national clinical audits. This included the asthma, the feverish child, the vital signs and the consultant sign-off audits. 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. There were no changes to these audits for the May 2015 inspection.
- We reviewed the CEM 2013 audit on severe sepsis and septic shock at the May 2015 inspection and it had mixed performance outcomes. For example, it showed red flags for fluids, blood glucose measurement and antibiotics being administered within one hour.

Competent staff

- The proportion of nursing staff in the emergency department who received an appraisal between April 2014 and February 2015 was 52%, compared to 83% in 2012/13 and 61% in 2013/14. For health care assistants and other support staff, the proportion who received an appraisal between April 2014 and February 2015 was 42%, compared to 87% in 2012/13 and 68% in 2013/14.
- At our May 2015 inspection we spoke with senior managers about the recent declining trend in appraisal rates, which appeared to be the converse of other staff groups in the trust. Managers explained that appraisals had been difficult to maintain during the operational problems encountered in the department in the previous 12 months. We found plans were in place to address appraisals. Staff were being allocated protected time to attend and appraisal and training rates were being monitored monthly. Most staff we spoke with had undertaken an appraisal in the previous 12 months, or arrangements were in place for this. Staff told us they felt the appraisal was a worthwhile process, and not just a tick box exercise. For some staff, this was their first appraisal in two years.
- The General Medical Council (GMC) reported that doctors in training and their educational and clinical supervisors described the workload in the emergency department as being extremely high. This could affect the level of supervision available to doctors in training and, in some circumstances it may be possible for a very sick patient to be seen and discharged by foundation year two doctors without further referral to a more senior colleague. An action plan was prepared which was being taken forward by the department as part of the GMC's enhanced monitoring process. A further assessment by the GMC in April 2015 concluded that doctors in training received a good level of supervision. The medical staff rota was being reviewed to identify gaps, which the trust reported was to be actioned by August 2015.
- A report from October 2014 indicated that the delivery of education for foundation doctors in the A&E department was extremely limited.
- Medical staff appraisals we found were up to date. Doctors provided peer support within their teams and we found evidence of positive feedback for this. Support from occupational health was available for members of staff who felt the need of additional support.
- A member of nursing staff (band seven) worked in the department as a clinical educator. The role supported training and practitioner support for nursing skill development. Plans were in place for new staff to receive induction training in the department. Supervised practice was supported by senior medical and nursing staff, Preceptorships were used for new staff. No formal induction was available for bank staff.
- Study days were planned but they could be cancelled due to staffing shortages in the department. Nursing and support staff received competency based training and mentoring was used. In addition to mandatory training, an advanced trauma course was available for some senior nursing staff, although places were limited. Nursing staff working in the paediatrics area told us that nurses on rotation to the paediatric department had not always received training for the care of paediatric patients.
- Healthcare support staff received training appropriate for their role and worked within their competencies.
- Not all nurses within the trauma team had been trained in the Advanced Trauma Nurse Course (ATNC) or equivalent therefore there was not an appropriately trained trauma nurse on every shift. However, training had been put in place which would have sufficient nurses trained by September 2015.

Multidisciplinary working

- We found there was effective multidisciplinary working within teams. We observed good working relationships between nursing and medical staff within the department.
- We found the paediatric emergency team were proactive in developing and maintaining close working relationships with the paediatric ward. Regular meetings were held with the senior nursing staff on the ward. The

paediatric ward provided medical and nursing support for the emergency team; for example, after the paediatric emergency area closed at midnight, the ward provided assistance as required.
- The emergency mental health liaison team based at the hospital provided support for patients of all ages who arrived with symptoms of mental illness or with emotional distress. The emergency department liaised closely with this team in providing support for patients.
- The paediatric emergency team maintained established links with the child and adolescent mental health services team. Staff in the department spoke positively of the support they received form this service.
- Consultant medical staff worked effectively with colleagues elsewhere in the hospital and with commissioners to support multidisciplinary team working.
- The department worked with primary care in assessing the needs of patients arriving in the department. A GP worked in the department to provide support for a primary care stream.
- The department engaged with charity organisations that supported homeless people and that provided substance use support services to support patients.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week.
- The paediatric emergency area opened at 8.30am and closed at midnight. The children's waiting area remained open and patients who arrived after midnight were seen in the main emergency department.
- Support for patients with symptoms of mental illness were available 24 hours a day.
- Diagnostic tests such as X-rays, blood tests, CT scans were available 24hours a day.

Access to information

- Medical and nursing staff could access current information for each patient in the department. The information was displayed clearly on screens in each of the areas of the department. Information screens were sited to support the confidentiality of the information displayed.
- The computer information system used in the department was widely used in the NHS. An electronic patient record patient flow manager provided patient information throughout the patient pathway and included the patient's medical and social history. Enhancements to the system were due to be implemented during 2015.
- Information and guidance for staff was available through the trust intranet site. Information available included policies and procedures related to the department. We also observed that information for staff was displayed on notice boards within the department.
- All staff had access to email and a high volume of communications were sent by this medium. However, some staff we spoke with felt email had limitations for some types of communications and gave examples of it being misused.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was discussed and obtained appropriately. Patients were requested for their consent. For most patients who arrived in the department, interventions required informal or verbal consent.
- Understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included in mandatory training which staff attended on a three-yearly basis.
- Staff we spoke with mainly demonstrated a clear understanding of the MCA, of their responsibilities and of DoLs procedures, although not all staff we spoke with had experience of using the procedures.

Are urgent and emergency services caring?

Good

The trust had achieved good progress in promoting the privacy and dignity of patients which had been greatly improved with the opening of the new emergency department. Patients were cared for with empathy and with respect to their dignity. Conversations demonstrated an empathetic and caring attitude by staff. In the minors area confidentiality of patient information was not always supported.

Patients and relatives felt involved by staff in their care and treatment. Staff mainly listened to patients and had informed them of what was happening and most patients

were happy with staff explanations and said that staff made them feel comfortable. Intentional rounding provided an additional opportunity for interaction with patients and their relatives and supported their involvement. Patients and relatives told us that staff had provided emotional support during their time in the department.

Compassionate care

- There was no patient survey information available about the new department. The patient surveys results relate to comments by patients prior to the move to the new department.
- In the Care Quality Commission (CQC) A&E survey 2014 the trust performed about the same as other trusts for four questions related to caring, but it performed worse than other trusts for the remaining four questions. The trust performed about the same for questions related to arrival at A&E, tests (answered by those who had tests only), hospital environment and facilities, and leaving A&E. The trust performed worse than other trusts for questions related to waiting times, doctors and nurses (answered by all those who saw a doctor or nurse), care and treatment, and experience overall.
- Of the 24 questions relating to caring in the emergency department survey, the trust scored worse than others for 11 of these. For the remaining questions, patients' responses were similar to other trusts.
- Since April 2014, the proportion of patients who recommended the trust in the NHS Friends and Family Test had declined. In November 2014 it was approximately 65% against a national average of 88%. In May 2015, from a response rate of only 5.6% the percentage of people who would recommend had increased to 71% with a national average of 88.3%. In April it was a 5.9% response rate with 66% of respondents recommending the department.
- We reviewed actions taken since our 2014 and January 2015 inspections, when we asked the department to ensure that the privacy and dignity of patients was promoted in the emergency department. Patients had been waiting on trolleys in corridors for significant periods, often without easy access to toilet facilities. This had not significantly improved at our January 2015 inspection; when the refurbishment of the department was still in progress.
- At our May 2015 inspection we observed care and treatment being administered in the minors, majors and paediatric areas of the department and spoke with about 30 patients who were in each area of the department. We found patients were cared for with empathy and with respect to their dignity. We observed that nursing and support staff were very caring and compassionate in their interaction with patients. Conversations demonstrated an empathetic and caring attitude by staff.
- However, one patient we spoke with on a ward in the hospital who had been admitted from the emergency department told us they had waited in the department for five hours in the evening with only a chair to use whist they were being unwell. We spoke with staff about the care provided for this patient. Another patient who had arrived in the minors area and used the self-check-in facility related his positive experiences and told us, "Care was spot on."
- In the minors area, however, we found that confidentiality of patient information was not always supported. Information on the self-check in screens was visible to the next patient standing immediately behind the patient in front who was using the screen.

Understanding and involvement of patients and those close to them

- Our 2014 inspection found that patients' care and treatment was mostly discussed with them. Patients in majors were not always clear what was happening to them or whether they were able to make choices about the treatment they received.
- At our May 2015 inspection we observed that staff demonstrated a good level of rapport in their interactions with patients and relatives. We saw that relatives were included in discussions. We found patients and relatives felt involved by staff in their care and treatment. Most patients told us that staff listened to them and had informed them of what was happening; they were happy with staff explanations and said that staff made them feel comfortable.
- In the minors area we observed one patient who was requested to take a seat and wait for a doctor but was given little other explanation. Another patient who had arrived at the department for the third visit in a few days told us he felt that nursing staff were not listening to them.
- In the majors area we observed a member of support staff as they introduced themselves to the patient and explained about the arrangements for their x-ray.

However, another patient who had arrived in the department from a ward area and was waiting for an x-ray and scan was unclear as to how long they would need to wait.

- In the paediatric area we spoke with the relatives of one patient who needed to return to the department the next day, and had requested written instructions to support the further visit. Staff provided these written instructions.
- We spoke with staff as to the operation of intentional rounding which had recently been introduced in the department. Staff felt this provided an additional opportunity for interaction with patients and their relatives and supported their involvement.

Emotional support

- Our 2014 inspection reported that staff attempted to provide emotional support for patients and their relatives even although they were very busy. Patients and relatives told us that staff were helpful if they were approached.
- At our May 2015 inspection we observed that staff provided emotional support to patients and to their relatives. Patients and relatives we spoke with told us that staff had provided support during their time in the department.
- Bereavement support and relatives rooms were provided.

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

Inadequate

There had been a continuous and persistent deterioration of the department's performance against the four hour target to see and treat people within. Since May 2014, the trust has only met the four hour waiting time standard once and according to national data was the worst performing trust in April 2015. Black breaches had occurred in significant numbers over the previous 18 months. Between September 2013 and March 2015 there were 1,842 black breaches at the trust. Performance information since the opening of the new department indicated a marginal improvement was achieved in most performance data: the four hour target was 71.4% in April 2015 and 72.7% in May 2015 and the Trust remained a national outlier.

Access to beds in the hospital did not follow an agreed pathway and identifying accessible beds presented a significant and constant challenge for the department: in April 2015 there were 761 breaches whilst waiting for a medical bed.

The new emergency department was planned and designed in consultation with patients and staff. The hospital had commenced a transformation programme and was engaging with external partners to reconfigure services to enhance emergency pathways of care.

Dementia leads had undertaken work to improve awareness of dementia. The use of patient passports to support patients with a learning disability was well established. The department was equipped with trolleys capable of carrying bariatric patients and there were bariatric chairs and aids available for the support of bariatric patients.

The hospital identified themes and trends from the investigation of complaints. Action plans were prepared following complaint investigations and there were several examples of actions the department had taken in response to complaints.

Service planning and delivery to meet the needs of local people

- The newly extended and refurbished emergency department which opened in April 2015 was planned and designed in consultation with patients and staff following feedback received from patients and their relatives about their experiences in the department. A separate children's emergency department had been refurbished within the last two years, also following feedback received from patients and their relatives. Staff and patients we spoke with expressed appreciation of the new facilities which provided a better and suitable environment for emergency care.
- The trust executive informed us they were aware that the A&E and acute medical service pathways in their present form did not fully meet the needs of patients in the trust's catchment area for urgent and emergency care. The service model was being refined in consultation with commissioners and neighbouring

providers of care. The trust had commenced a transformation programme and was engaging with external partners to reconfigure services to enhance emergency pathways of care. The trust's objective was to improve the experience of patients by reducing extended waiting times in the department.

- Opening of the newly reconfigured and expanded emergency department supported the trust in achieving compliance with its major trauma centre accreditation requirements in connection with NHS England.
- Bereavement and relatives rooms were provided although plans were in place to refurbish these facilities. The newly refurbished area was to include four waiting rooms for relatives, with viewing rooms and separate waiting rooms and an exit door onto an external corridor to provide privacy. The new facilities were being built in response to feedback received from relatives. We were assured that the new build area would support privacy and dignity and provide excellent facilities for relatives visiting the department.

Meeting people's individual needs

- We reviewed actions taken since our 2014 inspection, when we asked the trust to ensure that staff who were involved in caring for patients living with dementia were suitably trained; to review the mental health support available for children and young people in the emergency department; to review the operation of the self-check in system in the minors area to ensure that patients' symptoms were appropriately recorded and there were no barriers to communication such as the need for an interpreter, and to review the use of patient passports as these were not being completed consistently.
- The trust reported that dementia leads had undertaken work to improve awareness of dementia, training uptake and to provide dementia friendly environments. The number of staff trained had increased from 342 in 2013/14 to 1900 in 2014/15, so that 2242 staff were trained in dementia. Dementia awareness sessions had been held.
- The hospital also reported it had reviewed mental health provision in the department. We were informed that all emergency department staff now understood the procedures in place for reviewing a patient's mental health needs. Two pilots had been undertaken at a weekend with mental health teams to ensure rapid access to support was in place and a business case has been developed to increase provision. A significant number of waiting time breaches (40 in April 2015) were attributable to waiting for the mental health crisis team to assess the patient. We found there were a relatively high number of mental health support referrals; there were three patients who required this service during the evening we visited the department.
- The trust had also completed a review of the use of patient passports. Patient passports were completed by other care providers prior to admission. The learning disabilities nurse received details of patients with a learning disability which were discussed at twice daily safety briefings and patients were also highlighted on the ward information board. During patient assessments the learning disability nurse assessed their needs and checked these were met.
- The trust had completed a review of the operation of the self-check-in system and an audit had confirmed that symptoms were correctly recorded. Positive patient feedback had been received.
- Whilst we found no evidence of direct barriers to communication which involved the need for an interpreter, staff did express some reservations as to the effectiveness of self-check-in. We observed five patients, two of whom used the self-check-in which they found was easy to use and worked well. Another patient required assistance as they were struggling to use the system. We were not able to confirm how well the system worked where there were language or literacy issues for the patient. However, interpreter services were available, including an on-line service.
- In the resuscitation area, we observed that the department was equipped with trolleys capable of carrying bariatric patients. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity). We also observed there were bariatric chairs available for patients' use in the department, including the paediatric area and a range of manual handling aids for the support of bariatric patients was available.

Access and flow

- We reviewed national comparative information which showed that the median time to initial assessment for the emergency department had been around, or slightly shorter than the England average since January 2013.

Urgent and emergency services

- The standard for median time to treatment is 60 minutes. National comparative information showed that the time to treatment has been longer than the England average, and the standard of 60 minutes since March 2013.
- Between November 2014 and December 2014 there was a 57% increase in the number of four hour breaches. Since May 2014, the trust has only met the four hour waiting time standard once, and there had been a clearly declining trend. April 2015 performance data indicated performance against the four hour target of 71.4% and three twelve hour trolley waits. In May 2015 it was 72.7% and the Trust remained a national outlier. Data from NHS England indicated that in June 2015 performance was at 73%. For much of this time the Trust was the worst performing trust in the country for this target.
- The total number of breaches occurring in June 2015 was 3027. The top three breach reasons were recorded as follows: Long Wait to be Seen – 1748 and awaiting a bed – 713.
- Proportionately more patients were waiting between four and 12 hours from the decision to admit, compared to the England average, and this proportion was increasing. Between 23 December and 23 January 2015 there were six patients who had waited longer than 12 hours on a trolley in the emergency department.
- The total time patients spent in the emergency department was longer than the England average, and had increased between January 2013 and September 2014.
- We reviewed actions taken since our 2014 inspection, when we asked the trust to review the patient pathway into hospital, particularly the emergency department, to ensure that patients were assessed and treated appropriately to meet their needs; to consider reviewing the criteria for ambulance attendance at the emergency department to ensure that patients were admitted to the most appropriate place to meet their needs; and to review the patient flow within and across hospital sites to ensure that patients were not experiencing multiple moves, including through the night.
- The new emergency majors department had opened on 22 April 2015. An analysis prepared by the trust of performance data before and after the opening of the department indicated a marginal improvement was achieved in most performance data. Overall, the number of trolley waits exceeding four hours had reduced from 39 per day to 18 per day. However, an average of 88 patients per day breached the four hour target in the period to 30 April 2015.
- To address the failure to achieve the four hour target, the trust held a trust wide meeting to agree actions for the trust and for the emergency department specifically, to take and an action plan for the acute pathway was prepared which the trust shared with us. The trust prepared a response to national recommendations on crowding in the emergency department, which included a recommendation to introduce the rapid assessment and treatment model of care for the majors area. On 14 May 2015 the trust held an internal summit meeting chaired by the acting chief operating officer to consider what urgent actions to take to facilitate patient flow through the hospital and to co-ordinate actions with the emergency department.
- The trust informed us that operational issues had affected the trust's ability to move patients through the emergency care pathway in a timely manner, leading to crowding in the emergency department. This affected the trust's ability to take a timely handover of patients from the ambulance service, leading to black breaches. Staff presented a range of views as to how this was to be addressed. For example, at times of peak demand the trust had accommodated significant numbers of medical patients in surgical and other beds throughout the hospital.
- We spoke with senior nursing staff about the breaches that occurred during an evening of our visit. Staff had identified patients who were likely to exceed the four hour wait after three hours, but actions required to support the patient's care and treatment frequently involved liaison with other departments, including the identification of a bed for the patient to be admitted, or tests to be completed prior to discharge. Arrangements were followed to escalate long waits to on call managers and to include the bed manager. In excess of 50 breaches of the four hour target occurred during one evening of our visit.
- We spoke with senior nursing staff as to the time recording for four hour or 12 hour breach information. We received assurances that the recorded information was accurate. Reception staff informed us that during busy times the patient could wait in the corridor for long periods before booking in; however the clock was counting the waiting time as the ambulance crew

booked in the patient on entering the building. When ambulances were queueing, we found there was some uncertainty as to whether the crew should book the patient in while still in the ambulance. The effect was to extend the four hour wait time during periods of the highest activity.

- The evening bed state capacity meeting was attended by the operation support manager and the on call managers. The meeting did not follow a set agenda or other formal structure and did not include any direct liaison with staff from the emergency department. Live bed state and available bed data were reviewed on the electronic display board which indicated various beds throughout the hospital but not all of these were available for use by patients admitted from the emergency department. It was not apparent how this linked with the number of patients in the emergency department awaiting in-patient team review or a bed. We were informed that there were several meetings of this kind throughout the day but it was unclear how the meeting assisted bed allocation to patients in the emergency department.
- Emergency department medical staff did not have admitting rights except for the acute medical unit. Senior managers acknowledged that arrangements for the discharge of patients from the department remained a significant issue. A patient flow support function had been introduced to facilitate the flow of patients through the department.

Learning from complaints and concerns

- At our 2014 inspection we found staff were not regularly informed as to the outcomes of complaints and lessons learned were not discussed at team meetings. Nor were staff aware how the trust disseminated learning from complaints investigations.
- At our January 2015 inspection we found the trust identified themes and trends from the investigation of complaints it received. Most complaints related to waiting times for procedures or investigations and waiting on a trolley in the department.
- At our May 2015 inspection we asked staff about learning from complaints and the preparation and follow up of action plans from complaint investigations. We found several examples of actions the department had taken in response to complaints. The introduction of meeting and greeting by a senior nurse of patients who arrived in the majors area, of intentional rounding, and of the serving of regular meals for patients waiting, were examples of steps the department had taken in response to complaints received from patients.
- The Patient Experience Team responded to complainants and progressed the investigation of complaints. Responses to complainants following an investigation were signed off by a director. Actions in response to complaints were taken forward by senior nursing staff in the department and we found a system was in place to follow up to ensure actions were completed and learning shared in team meetings and disseminated through the department's governance arrangements.

Are urgent and emergency services well-led?

Requires improvement

The leadership of the trust had persistently been unable to deliver the national four hour target for patients to be seen and treated since the last inspection and the percentage achievement had deteriorated considerably.

There were objectives for 2015-16 and quality and safety goals for 2015-16. The emergency medicine division's planning priorities described a vision for the health group which included the emergency department. The focus had been on identifying the immediate changes required and developing an operational plan for the next one to two years. The medium to long term vision required further development and the recently revised vision and strategy had still to become embedded. Staff were consulted as to the design of the new emergency department which opened in April 2015.

The department's risk register identified most high risks the department currently faced. The risk register was reviewed at health group governance meetings and at a recently established meeting held specifically to review risk. The governance structures had recently changed and the revised arrangements were still to become embedded. The effective sharing of key information with operational staff required further development and not all staff were aware of the governance structures. The department lacked a focus on its clinical governance arrangements and required further clinical leadership.

Allegations of bullying had been followed up in the department and action taken. A survey undertaken in the department indicated that staff no longer felt bullied. In the emergency department a stress survey was undertaken in 2014 and this had been repeated in 2015 which indicated marginal improvements had been achieved.

Vision and strategy for this service

- The trust had prepared revised objectives for 2015-16 which the executive informed us was reflected in three newly stated values which it identified as care, honesty and accountability. The trust's quality and safety goals for 2015-16 were safer care, better outcomes and improved experience. The executive informed us that this recently revised vision and strategy had still to become fully embedded throughout the trust.
- The emergency medicine division's planning priorities for 2015-16 and 2016-17 described a vision for the health group and priority objectives and outcomes which included the emergency department. For example, the delivery of targets for the emergency department was a stated outcome for the trust.
- The operational plan for the medicine health group for 2015-16 and 2016-17 included the emergency department within the emergency medicine division. The plan included overall five year goals supported by an action plan which specified measureable outcomes. For example, the steps being taken to address the shortage of medical consultant staff were included.
- The department's focus had been on identifying the immediate changes required and developing an operational plan for the next one to two years. We concluded the medium to long term vision required further development.
- We found the trust's vision and strategy had been cascaded to the senior nursing staff (Band 8) in the department who were actioned to cascade this to other staff in the department. We observed posters reflecting the strategy and vision displayed in staff areas. The involvement of all staff in this vision was work in progress for the department.

Governance, risk management and quality measurement

- Our 2014 inspection found that staff were unaware of governance structures in place in the department and we reported we found a disconnect between staff in the department and staff involved in governance of the medicine health group. No identified senior clinician maintained an overview of the department on a shift by shift basis.
- We reviewed actions taken since our 2014 inspections, when we asked the department to review management arrangements to ensure that there was a senior clinician with an overall overview of the department; and to review information captured on the risk registers so that dates were included. The department reported that the senior clinicians roles were agreed and recruitment was in progress. Dates had been added to the risk register and included in risk reports.
- Our January 2015 inspection found there was no system to share learning across different departments. The department's risk register had not identified the nursing staffing risks in the department. We were informed by the Trust post-inspection that nurse staffing had been added to the register on the 14 May 2015.
- At our May 2015 inspection we reviewed the department's risk register. We found that it identified the high risks the department currently faced included the recruitment of senior medical staff and the delivery of the 95% waiting time target. Each risk was identified with a named risk handler. The risk register was reviewed and risks were discussed at health group governance meetings which were held monthly. The risk register was previously discussed at the department's clinical governance meeting but the minutes of the meeting held in December 2014 indicated that the risk register was to be reviewed at a separate meeting held specifically to review risk. We confirmed that this meeting now took place on a monthly basis.
- We spoke with the clinical governance lead and the clinical lead for the department about the arrangements for governance meetings. We reviewed the minutes of the clinical governance meeting for the department which was held in December 2014. The last meeting was held in April 2015 but the minutes were not available at the time of our inspection. A further meeting had been arranged for June 2015. Clinical governance for the department was overseen by the quarterly governance committee for acute medicine and an integrated governance committee for the medicine health group which linked in to the medicine health group board. The minutes of the integrated governance committee for the medicine health group showed that emergency department representatives, for example the clinical

lead, attended this meeting. We saw that issues affecting the operation of the emergency department, such as achieving the four hour waiting time target, were discussed.

- A speciality clinical governance meeting was held monthly which was attended by the quality and safety manager and consultant medical staff. The meetings were not minuted although we were informed this was due to start. A clinical excellence meeting was also held monthly and meetings were minuted. A senior staff executive forum was held weekly and attended by senior medical and nursing staff; standing items including recruitment and staffing issues were discussed and the meeting was minuted. A consultants' meeting was held weekly and attended by HR at which the weekly performance dashboard and the consultants' rota was reviewed. An emergency department nursing staff meeting was held monthly and minuted. We reviewed the minutes of the meetings held in February, March and April 2015. We saw that operational issues including incidents, complaints, risks and performance trends were discussed at this meeting.
- We spoke with the clinical lead consultant for the department and other consultant medical staff as to the functioning of the governance arrangements. Staff expressed the view that the governance structures were recently changed and the revised arrangements were still to become embedded. The effective sharing of key information with operational staff was considered to be a weakness which required further development.

Leadership of service

- Our 2014 inspection found staff felt there was effective team working in the department, however staff could feel bullied on occasions which added to the pressure on them when the department was busy. The trust had subsequently commissioned an external review with recommendations and actions to investigate the allegations of bullying.
- At the May 2015 we noted that actions it had taken which included: the appointment an anti-bullying Tsar; behaviour training and empowering staff. We saw evidence that allegations of bullying had been followed up in the department and action taken. A survey undertaken in the department indicated that staff no longer felt bullied.
- We found staff we spoke with recognised changes were being made to the leadership team, although they expressed some mixed views about these changes. Positive changes were acknowledged but staff felt it was too early to judge the effect they had had. A number of staff we spoke with confirmed they had completed leadership training and development. One member of staff made allegations of bullying but said they felt it was now a minority of senior staff that this applied to. However, some staff felt well supported by their managers.
- Most staff we spoke with said they felt the chief executive was visible and the arrival of the new chief nurse was seen as positive and staff comments on executive team visits to the department were mainly positive. Staff appreciated the chief executive's visits to the department and felt he was approachable. However, during and following our visit we also received information expressing a lack of confidence in the executive leadership of the trust and allegations of poor leadership of the department. When we raised this senior staff acknowledged that there was more to do in developing the leadership arrangements. Some changes were still to be implemented in the management structure which included the emergency medicine division.

Culture within the service

- Our 2014 inspection reported on the culture of the emergency department. We found staff felt under pressure to meet targets and were made to feel as though they had failed to do their job correctly by senior managers if targets were not met, which was perceived as more important than making sure patients received the correct treatment. In the paediatric emergency area, we found that morale was low because staff felt under pressure. A stress audit was to be undertaken in the emergency department to investigate the reasons for staff stress.
- At the May 2015 inspection the executive reported on steps it had taken to bring about changes to the culture, which included undertaking a cultural survey. In the emergency department we found that a stress survey was undertaken in 2014 and this had been repeated in 2015. The results of the survey showed that mostly marginal improvements had been achieved, but this was in most areas of the survey. This was confirmed by staff we spoke with who said that the culture in the department had improved.

- Several staff we spoke with said they were enthusiastic about their jobs and they enjoyed their role in the department. However, during and following our visit we received information expressing concerns as to low morale in the department and alleging that staff did not feel respected.

Public engagement

- The trust engaged with patients and the public through the NHS Friends and Family Test. From April 2014, the proportion of patients recommending the trust in the Friends and Family Test had fallen, but the most recent results at the time of our inspection showed an increase in the proportion of patients recommending the hospital from November 2014 onwards. In April 2015, 65.6 % of patients recommended the hospital.
- Comments and suggestions from patients and the public were also received through the PALs service and through Healthwatch.
- In the emergency department, we spoke with a member of staff in the patient flow support office whose role included contact with patients and relatives about their experience of visiting the department.

Staff engagement

- Results from the NHS staff survey 2014 showed that overall, the indicator of staff engagement for the trust's score of 3.53 was in the lowest (worst) 20% when compared with trusts of a similar type. The national 2014 average score for 2014 was 3.74. The trust's result was very similar to the score (3.56) it achieved in 2013. This meant there was no change in the overall level of staff engagement since the previous year.
- Our 2014 inspection reported on the trust-wide initiatives in place to engage with staff. We found staff in the emergency department did not feel engaged outside of the department and demonstrated little awareness of the various initiatives taking place across the trust.
- A Survey of staff undertaken in the department by commissioners had indicated some improvement but also identified areas where further changes were required.
- Staff were consulted as to the design of the new emergency department which opened in April 2015. Consultations with staff included on-line surveys.

Innovation, improvement and sustainability

- The opening of the new emergency department represented a substantial improvement in the facilities for the hospital so that emergency care and treatment was provided in a suitable environment. The newly extended department opened in April 2015 and further phases of work were planned.

Medical care (including older people's care)

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

Information about the service

Acute medical services were provided at Hull Royal Infirmary. In April 2015 following a reconfiguration of services and transformation of the acute medical care pathway wards 19, 21 and 22 had moved from Castle Hill Hospital to Hull Royal Infirmary. Two new medical elderly wards 12 and 120 had been created and a respiratory ward (ward 500) on the Hull site along with a new elderly assessment unit which was based in the acute assessment unit and an ambulatory care facility.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was requires improvement. Caring was good; however the safe domain was rated as inadequate with effective, responsive and well led rated at required improvement.

We visited all the medical elderly wards, the hyper acute stroke unit (HASU), wards H5 respiratory, H10 diabetes, H11 neurology, H200 winter surge ward, the short stay ward (H1), acute assessment unit (AAU), elderly assessment unit (EAU), ambulatory care unit and the patient discharge lounge.

We spoke with 31 patients, 10 relatives and 63 staff. We attended a number of focus groups and we observed care being delivered on the wards. We looked at 29 sets of patient notes, and also reviewed the trust's performance data.

Summary of findings

All domains were rated as requiring improvement for medical care.

Staff understood their responsibilities to raise concerns and report patient safety incidents however policies for reporting incidents were not being consistently followed. There were delays in completing serious incident investigation reports which the trust was monitoring with its commissioners.

The trust had responded to staffing concerns and was actively recruiting to fill posts however there were areas in medicine where nurse staffing levels were impacting on patient care and treatment particularly on the elderly care wards. Performance against mandatory training had shown some improvement compared to 2014. Safeguarding systems were in place and staff were aware of the processes to report concerns. Infection prevention and control was managed appropriately.

Systems and processes on some wards for the management of medicines and the checking of resuscitation equipment did not comply with trust policy and guidance.

Most patients across the medicine health group received a good standard of care. However, on the elderly care wards patients were waiting for staff to assist them with their basic needs. Call bells were not in reach of patients in some areas. There was inconsistent

Medical care (including older people's care)

use of the red top water jug system to identify patients that required assistance with nutrition and hydration. Care was not always being actively recorded in the patient's records.

There had been changes to medical pathways of care to improve access and flow however this had not yet resulted in a significant improvement as there continued to be delays in discharge, patient bed moves out of hours and, patients were being cared for on non-specialty or other specialty wards due to inpatient capacity issues.

There was a new leadership structure and senior managers were aware of the challenges in the health group. The health group was involved in a number of initiatives to improve staff engagement, develop staff and embed trust values and behaviours. There was some progress in these areas.

Information showed that the majority of intended outcomes for patients were being achieved.

Are medical care services safe?

Requires improvement

There were improvements in staff reporting incidents however some reportable incidents were not consistently being completed in line with trust policy. There were delays in completing serious incident investigation reports which the trust was monitoring with its commissioners.

The trust had responded to staffing concerns and was actively recruiting to fill posts however there were areas in medicine where the levels of nurse staffing was having an impact on the ability to provide patient care and treatment. There were also staffing issues in the electrocardiography unit based at Castle Hill Hospital and staff felt under pressure to carry out cardiac diagnostic tests for patients to comply with national recommendations. Since the last inspection medical rotas have been reviewed and time had freed up for junior doctors by increasing the resources in the Hospital at Night team.

The management of deteriorating patients was provided in a timely manner however this was not always actively recorded in the patient's records. Systems and processes on some wards for the storage, security and administration of medicines and the checking of resuscitation equipment did not comply with trust policy and guidance.

Performance against mandatory training had shown some improvement compared to 2014. Safeguarding systems were in place and staff were aware of the processes to report concerns. Infection prevention and control was managed appropriately.

Incidents

- There were some improvements in systems for incident reporting and most staff said they were aware of the type of incidents to report. The rate of incident reporting showed the trust was in the middle 50% of reporters. However, we found that incident reports were not being consistently completed in accordance with trust policy. For example, the trust restraint policy indicated that when patient watch by a security guard was initiated an incident report should be completed. Evidence from the Safeguarding and Vulnerable Adults Restraint Update

Report 18 May 2015 showed there had been 296 episodes of patient watch between April 2014 and March 2015, 21 incident reports had been completed for these.

- For the period December 2014 and March 2015 the medicine health group reported 2,510 incidents, the majority of which had caused no harm. The main themes related to falls, hospital acquired pressure sores patient transfer, omissions of care and staffing resource.
- Data relating to serious incidents and Never Events for the medicine health group showed there were 42 incidents of this type in 2014/15 compared to 19 in 2013/14.
- Staff reported delays in the completion of investigations into serious incidents due to staffing shortages on the wards. The serious incident report for April 2015 showed eight investigations in medicine had been delayed between one and 14 weeks.
- We reviewed a root cause analysis report relating to a never event which was reported in 2014/15 relating to a misplaced naso-gastric (NG) tube. The report included the care and service delivery problems, root causes, contributory factors, good practice points and lessons learnt. Actions had included the introduction of a NG care bundle, escalation of patients who were suspected of acute aspiration for immediate senior medical review and review of guidelines.
- Since the last inspection the trust informed us that they had upgraded the electronic incident reporting system and the serious incident reporting policy had been reviewed. Trust data showed staff had reported approximately 850 more incidents in 2014/15 compared to the previous year.

Safety thermometer

- The trust used the NHS Safety Thermometer which is a local implementation tool for measuring, monitoring and analysing harm to patients and 'harm free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots).
- There were 42 pressure ulcers reported between December 2013 and December 2014. The rate had increased since October 2014.
- There were 28 falls reported between December 2013 and December 2014, the prevalence rate had reduced in recent months. The falls risk assessment had been revised to become a "falls multifactorial assessment" as recommended by NICE. This was being used on the eighth floor elderly wards and in the new elderly assessment unit.
- There were 50 urinary tract infections for people with catheters between December 2013 and December 2014.
- There were two tissue viability nurses for the trust who provided advice to wards regarding the management of pressure care. A system of pressure care link nurses had been developed in medicine. One link nurse told us they had two protected study days a year for this role. Other staff had received tissue viability training in response to the increase in the number of pressure ulcer incidents.

Cleanliness, infection control and hygiene

- Ward areas appeared clean and we saw that staff regularly washed their hands between patient interventions. Staff were bare below the elbows, in line with trust policy and national guidelines for best hygiene practice.
- There were no methicillin-resistant staphylococcus aureus (MRSA) Bacteraemia infections within medicine over the last 12 months. Nine acute acquired cases of Clostridium difficile had been reported by the trust year to date as at 15 May 2015.
- We observed staff in medical areas following guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).
- Sluice facilities on one of the wards we visited were cluttered. There was a lack of consistent use of labelling of clean equipment on two wards.
- Infection control information was visible in all ward areas. This information included how many days a ward had been free from c. difficile.
- Infection control and environmental audits were carried out in clinical areas. Overall results were compliant with trust targets on most wards.

Environment and equipment

- The ambulatory care unit was a new build, the trolley bays were visible to staff who were able to adequately observe any deterioration in a patient's health. However, staff told us there was a lack of equipment for dependent patients which they had to borrow from the Acute Assessment Unit (AAU).
- Ward 200 had 21 bed spaces, there were flow meter ports at every bed space but at the time of the

inspection there was one suction meter and six oxygen flow meters. The ward had three oxygen cylinders and the resuscitation trolley had suction and oxygen. There was no portable suction on the ward. The charge nurse told us they prioritised the higher acuity patients for beds with oxygen. The ward was only supposed to admit low acuity patients however we were told that there were occasions when unwell patients were admitted. We checked the incident reports to look for inappropriate admissions to ward 200; one incident was reported specifically around inappropriate admission to the ward as the patient was unwell.

- We checked 12 sets of resuscitation equipment on 12 wards, three wards had a robust system in place for checking the equipment. Across the other 9 wards out of 1023 days the equipment should have been checked there was no evidence it had been on 231 occasions which was 23% of the time.
- Adapted equipment such as specialised baths was available for patients on the acute stroke ward.

Medicines

- A number of patients had been waiting between one and five hours in the discharge lounge for take home medicines. For example, one patient had been waiting for over 90 minutes yet their discharge had been planned at 10am the previous day. Three patients had been waiting between three and five hours. One medication had been dispensed in a different dose to that prescribed, this was noticed by a nurse in the discharge lounge and was rectified. Another patient was waiting for medication which included a controlled drug.
- On ward 8 a member of our inspection team was able to enter the treatment room containing medications as it was unlocked. In the same treatment room the drugs fridge had been reported as not working on 18th May 2015, there was no evidence on 21st May 2015 that any action had been taken to rectify this.
- Records showed medicine fridges on some wards were not being consistently monitored in line with trust policy to ensure appropriate temperatures were maintained for the safe storage of medicines. For example, on one ward a minimum temperature of one degree centigrade was recorded on five days in April 2015 and five days in May 2015 which was outside of the recommended range, however, no action had been taken.
- Records showed medication doses were not consistently signed to indicate that the medicine had been given and where medication was not given the reason for doing so was not always recorded using the numeric codes for "omitted or delayed doses" on the drug chart.
- On two wards we observed that tablets had been left in a medicine pot on the patient's bedside and nursing staff had not stayed to ensure that the medication had been taken by the appropriate route of administration which was not in line with the trust's medicines policy.
- Take home medicines were dispensed on EAU, removing the need to send the prescription to pharmacy which had improved patient discharge times.
- Patients who required follow up were identified by the pharmacy team on admission through the medicines reconciliation process.
- Patients who were discharged to a care home were followed up after seven days to identify and address any medicine issues.
- Records showed controlled drugs were stored and recorded safely.

Records

- A number of records were not appropriately maintained; for example, we reviewed 27 risk assessments for nutrition, falls, and moving and handling, 59% of which were fully completed. 69% of the 16 intentional rounding records that we reviewed were fully completed.
- The trust submitted examples of local documentation audits which showed a 40 to 60% compliance rate.
- On AAU there was confidential clinical patient identifiable data visible to the public in the area before the entrance to the ward. We discussed this with the Matron who told us she would address this immediately.
- Staff told us that completing documentation took them away from the bedside: the admission document; electronic patient record, care plans and record charts duplicated documentation. Therapy staff said in some cases they were repeating entries three times.
- The trust was moving to an electronic patient record system in June 2015.

Safeguarding

- Nursing and medical staff were aware of who to contact regarding safeguarding concerns. Guidance information was readily available.

Medical care (including older people's care)

- There were a number of safeguarding training courses, relating to both children and adults, which staff were required to complete dependent on their roles.
- Training figures showed 71% of medical staff had completed safeguarding children and 64% had completed safeguarding vulnerable adults training. 80% of nursing staff had completed safeguarding adults and children. This was against the national requirement of 80%.
- At the last inspection the medicine health group confirmed that security guards were used to provide one-to-one support for patients with dementia who may be aggressive, however, it was not clear what training had been received for security guards to carry out this role.
- The trust had taken action to improve awareness of dementia. The numbers of training courses had increased and were available for different levels of staff including non-clinical staff.

Mandatory training

- Not all staff groups in medicine were meeting the trust target for mandatory training of 85%.
- Medicine had achieved overall 74% which showed a slight improvement compared to 72% at the last inspection. Data showed 84% of nursing staff and 63% of medical staff had completed mandatory training.

Assessing and responding to patient risk

- The medical wards used a recognised national early warning tool called NEWS. Patients who stayed in the ambulatory care unit for over four hours had physiological observations taken and early warning scores calculated.
- We checked 18 NEWS charts across different wards and found 72% were completed appropriately.
- A critical care outreach team was available to support staff with patients who were at risk of deteriorating.
- The hospital at night handover included discussing individual patients who were most critical or likely to deteriorate to ensure continuity of care and management of their risk of deterioration.
- Management of the deteriorating patient pathways were on display on two wards we visited. Staff told us they had completed NEWS e-learning training.

Nursing staffing

- Although nurse staffing establishments were set and financed at good levels, the challenges remained around recruitment and, whilst this was slowly improving risks remained in terms of the available supply of registered nurses. The trust was considering further international recruitment efforts, particularly in preparation for the next winter period.
- The trust used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. Data for May 2015 showed that eight out of the 11 wards we visited had greater that 10% of registered nurse vacancies. In addition figures showed that eight out of the 12 wards we visited had one or more adverse quality indicators each week that may cause patient harm including falls and pressure ulcers. Of particular concern were wards 8 and 80 which had low registered staffing fill rates both day and night shifts and had the highest number of adverse quality indicators. Staff on Ward 80 confirmed they were regularly understaffed due to staff sickness and vacancies. They told us a ratio of one nurse to 14 patients was a regular occurrence. There were similar issues on ward 10 where a number of staff changes and ward leadership had been made. Newly appointed staff were in the process of starting which would improve the position.
- A safety briefing occurred twice daily and these were led by a senior nurse. The briefing included the numbers of patients on the ward, acuity level, harm rates and numbers, skill mix and levels of experienced staff on duty.
- The hospital at night nurses were used to staff wards overnight which took them away from their responsibilities for prioritising workloads according to the clinical needs of patients. Between January and April 2015, 393 hours of hospital at night nurse time had been spent covering staff shortages on the wards.
- Occupational therapy staff on the stroke unit were unable to provide the 45 minutes of therapy per day in line with the Royal College of Physicians Guidance due to vacancies and seven day rota cover.
- Ward 200, the winter surge ward, remained open. Staff on this ward had all been transferred in temporarily from other clinical areas. Gaps in the rota were covered by bank staff. For example, during December 2014, 31.8% bank staff were used, January 2015 13.1% and February 8.4%. Staff on this ward told us more permanent staff were required if the ward was to remain open.

Medical care (including older people's care)

Medical staffing

- There was consultant presence on AAU Monday to Friday 8.30am to 10pm. Three resident medical officers (RMO) covered out of hours and at weekends. Access was also available to the critical care outreach team to respond to concerns.
- There was consultant cover on EAU Monday to Friday from 9am to 5pm and cover from 5pm to 10pm was provided by the AAU consultant.
- There was a rolling post take ward round on EAU which provided prompt senior medical review for patients.
- There were concerns raised by staff about the movement of staff from HRI to CHH and the provision of medical cover at night at Castle Hill Hospital following the transfer of acute medical wards to the Hull site. Information received from the Medical Director of the medicine health group confirmed that the RMO from Castle Hill had moved to HRI in the context that there would be no medical patients at Castle Hill. If medical patients were to move to Castle Hill this had to be agreed at an executive level and discussion with the medical consultant on-call to agree cover arrangements which included moving a RMO and senior house officer to Castle Hill and agreeing consultant cover.
- A locum consultant had recently been appointed to the winter pressures ward 200 which would ensure improved consultant cover. Two junior doctors were also based on the ward.
- Long term locum doctors were employed to cover consultant and junior vacancies. The average locum usage in medicine was 8%.
- Since the last inspection medical rotas have been reviewed. Medicine had freed up time for junior doctors by increasing the resources in the Hospital at Night team. The additional resource allowed junior doctors to cover smaller geographic areas within the trust, reducing the need for multiple pagers. Junior doctors on wards 200 and 11 confirmed they did not regularly carry multiple pagers. However, one junior doctor at the focus group said they had been carrying four pagers ten days ago to cover sickness absence.
- There was sufficient medical cover on the new ambulatory care unit**.** There was consultant input and two doctors were based on the unit. Gaps in the rota due to annual leave or sickness absence were covered by doctors from AAU.
- The trust acknowledged that there were some gaps in the rotas and reviews were taking place with changes being actioned in the August 2015 doctor in training rotation.

Are medical care services effective?

Requires improvement

Care was planned and delivered in line with evidence based guidance although there was no annual audit or policy for the provision of non-invasive ventilation. The health group had taken action in response to national accreditation standards for example in endoscopy.

Facilities and layout on some wards did not enable patients to be easily visible to staff.

On some wards there was inconsistent use of the red top water jug system to identify patients that required assistance with nutrition and hydration. Fluid balance and food charts were not fully completed by staff.

Information showed that the majority of intended outcomes for patients were being achieved.

The majority of staff were appraised on their performance on an annual basis. There was effective multi-disciplinary team working and staff worked together to assess and plan ongoing care and treatment. There was consideration for assessing mental capacity and discussions were documented relating to the patients best interests.

Evidence-based care and treatment

- Staff on the respiratory ward told us there had been a change in the provision of non-invasive ventilation (NIV) at Hull two weeks prior to our inspection. Acute NIV was no longer commenced on the respiratory high dependency unit but started on ITU or in A&E by the critical care outreach team prior to transfer of the patient to ITU. We were told this was due to out of hour's medical cover on the wards being unable to provide the input recommended by the British Thoracic Society (BTS) guidance. The trust was unable to provide us with evidence of how they followed recommendations in the guidance for 'The Use of Non-Invasive Ventilation in the

management of patients with chronic obstructive pulmonary disease admitted to hospital with acute type II respiratory failure' as there was no trust wide policy for NIV in place or annual audit.

- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) had found that the service at Hull did not meet the accreditation standards during its visit in November 2014. JAG raised concerns relating to endoscope decontamination. The trust had in place a long term plan which provisionally allocated funding for the upgrade and relocation of the decontamination facility at Hull in its 2015/16 capital programme. In the short term remedial works on the decontamination facility and the procurement of new washers had been completed.
- There was evidence that the medicine health group participated in national and local audits which included clinical procedures, documentation and consent. Actions from audits were mainly to re-audit, education and discussion, review processes after the new patient administration system was introduced and to remind staff to familiarise themselves with policy.

Pain relief

- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.

Facilities

- On ward 80 the seven side rooms were away from the nurse's station near the entrance of the ward, the nurse looking after these patients cared for patients in a bay at the other end of the ward. On one occasion when we visited the ward two of the doors were closed for infection purposes, five doors on the other side rooms were fully or partially closed and patients were not visible to staff. A member of staff told us the side rooms were used for patients who disturbed other patients on the ward. We visited the same ward the following day and found two doors of the side rooms which were not being used for infection control were fully closed
- On ward 5 and 200 there was a lack of storage space which meant equipment was being stored in the corridors.
- Some improvements had been made to the AAU to ensure all bed spaces were visible to staff and that patients were not in mixed sex bays. Staff told us an additional cubicle was being developed to support infection control procedures.

Nutrition and hydration

- As part of the productive ward programme the trust had adopted a red top water jug system to identify patients that required assistance with nutrition and hydration. However, on some of the wards there was inconsistent use of the system. For example, across ward areas we observed that 18 patients were identified as requiring a red top water jug; six patients had this at their bedside.
- We reviewed 12 fluid balance charts and seven food charts. None of these 19 charts had been fully completed.
- Some wards had participated in a nutrition project which identified barriers to nutrition and hydration. A whole team approach had been developed to assist patients with eating and fluid intake. Actions taken included staff being allocated to a patient to ensure they were sat up and patients were provided with hand wipes.

Patient outcomes

- There were no current CQC mortality outliers relevant to medicine at Hull Royal Infirmary. This indicated there had been no more deaths than expected for medical patients.
- The Sentinel Stroke National Audit Programme (SSNAP) showed an improvement from an overall SSNAP level of "E" for October to December 2013 to a "C" for October to September 2014. Most areas were rated B or C. However, thrombolysis had deteriorated from a B to a D.
- There was an acute stroke integrated care pathway and record in place for patients and was led by stroke co-ordinators.
- The national diabetes inpatient audit (NaDIA) September 2013 indicated that out of 21 indicators the hospital was better than the England average in 13 areas and worse in eight. Of specific concern were indicators relating to foot risk assessments, visit by specialist diabetes team, medication, prescription and insulin errors, knowledge of staff about diabetes and renal replacement therapy.
- The Myocardial Ischaemia National Audit Programme (MINAP) audit 2013/14 indicated that results for Hull

Royal Infirmary were worse than the England average. For example, for the care of patients with non-ST-elevation myocardial infarction (nSTEMI) 75% of patients were seen by a cardiologist or a member of their team compared to 94% nationally and 10% of nSTEMI patients were admitted to a cardiac unit or ward compared with 53% nationally.

- The national heart failure audit 2012/13 showed that HRI had performed significantly worse than the England average for input from a consultant cardiologist and cardiology inpatient. The trust was meeting three out of seven of the patient discharge indicators. A service redesign was being developed in cardiology to maximise opportunities to improve productivity and deliver all performance and activity targets which included increased consultant cardiology input at Hull.
- The overall relative risk of elective and non-elective medical readmissions was similar to the England average.

Competent staff

- Most staff had received an appraisal. Between April 2014 and February 2015 trust data showed 71% of staff in acute medicine, 79% elderly medicine, 84% cardiology, 87% stroke and 81% of neurology staff had received an appraisal against a trust target of 85%. However, the data held by the wards showed some areas were achieving over 90%.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The results of the General Medical Council (GMC) National Training Scheme Survey 2014 showed some issues were identified relating to supervision. An action plan was put in place and when assessed by the GMC in April 2015 they determined that supervision was good.
- We were informed by senior and educational staff that the current security guards had been given dementia training; however, the dementia lead for the trust told us that due to a change in the security guard contract additional training was required in this area and additional awareness sessions would be held. The number of trust staff trained in dementia awareness had increased from 342 in 2013/2014 to 1,900 in 2014/2015.

Multidisciplinary working

- Staff across the medical care group reported good working relationships within the multidisciplinary teams.
- There was internal multi-disciplinary working (MDT) both between specialities and with allied health professionals. For example between stroke services and neuro-rehabilitation.
- We observed a comprehensive MDT handover on EAU where all patients were discussed three times a day.
- There was a hospital at night system in place which co-ordinated the medical handovers and managed requests for support from the doctors working overnight.
- We observed a hospital at night handover which included verbal and written handovers of acutely ill patients from the day shift to the night shift. Senior nurses were employed as hospital at night co-ordinators and helped to ensure doctors were able to prioritise their workload according to the clinical needs of patients. Doctors commented positively about the effectiveness of the hospital at night team.

Seven-day services

- Allied health professionals, including physiotherapy, occupational therapy, dietetics and speech and language therapy were employed by the trust. All services were available Monday to Friday. There was access to therapy services on EAU and AAU seven days a week until 8pm and seven days a week on the elderly care wards.
- An on-call service was available in cardiology on Saturdays to check pacemakers that had been inserted on Friday afternoon. A cardiac co-ordinator was also based at the cardiac monitoring unit at Castle Hill Hospital 24 hours a day seven days a week to triage calls from GPs, obtain advice from doctors and refer out of area patients to their own local hospital.
- The respiratory team provided seven day specialist in-reach to the AAU.

Pharmacy services were available at both HRI and CHH 7 days a week 365 days of the year. Clinical Pharmacy services were also provided Monday to Friday with targeted clinical pharmacy service provided at weekends and bank holidays to selected clinical areas

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Records showed that most capacity assessments had been completed accurately. There was consideration of capacity issues by medical staff and discussions were documented relating to the patients best interests.
- Staff told us they had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Are medical care services caring?

Requires improvement 

Most patients across the medicine health group received a good standard of care, however less than optimal staffing levels particularly on the elderly care wards meant patients were waiting for staff to assist them with their basic care needs. Call bells were not in reach of patients in some areas; on one ward more than half of the patients could not reach their bell.

Patients were treated with privacy and dignity although there were instances where staff were heard to reference patients by their bed numbers rather than their names and did not greet patients when they arrived on the ward.

The majority of patients said that they were listened to by staff , however some patients and relatives on the elderly care wards felt there was a lack of communication between the nursing staff and patients particularly around discharge planning.

Compassionate care

- The NHS Friends and Family Test results were consistent with the England average. Results for May 2015 showed that the majority of patients in medicine were either 'extremely likely' or 'likely' to recommend services to their family or friends.
- Most patients across the medicine health group said they had received a good standard of care. However, relatives and patients on ward 8 and 80 said they was not sufficient numbers of staff which led to patients being kept waiting before staff were free to assist them to the toilet. For example, one patient told us they had waited an hour after requesting assistance to go to the toilet and staff had given them incontinence pads to wear.
- On most medical wards we observed patients were being treated with privacy and dignity and staff were explaining what was happening to them. However, one patient on an elderly care ward said staff had not greeted her when she arrived; we also observed staff talking about patients in public areas and referring to patients by their bed numbers rather than by their name.
- On a number of wards we saw that call bells were not in reach of patients. For example, on ward 80 we observed 13 patients did not have their call bell within reach, when we visited the same ward the following day, of the patients we were able to observe four patients had their call bells in reach, 16 did not have their call bells in reach. Similarly, on ward 200 we observed three patients out of 13 had access to their patient call bell and on ward 120, 13 out of 20 patients had their call bells within reach. We observed call bells were hung up or on the floor at the back of beds.
- On ward 8 we heard a patient call out at 10:42am from a side room where the door was half open; we observed that the patient's call bell was not within reach. The patient's daughter arrived at 10:46. At 10:56 the patient's daughter approached us and asked if someone could take her mum off the bed pan as she had been on it since before she arrived. We approached a member of staff who said they would attend once they had finished with the current patient they were dealing with.

Understanding and involvement of patients and those close to them

- The majority of patients said that they were listened to by staff however some patients and relatives on the elderly care wards felt there was a lack of communication between the nursing staff and patients particularly around discharge planning.
- Patients were aware of what treatment they were having and understood the reasons for this and, in most cases, had been involved in the decisions.
- There was clear and relevant patient information on display in wards about medical conditions and diagnosis.

Emotional support

- There was a range of clinical nurse specialists at the trust who supported patients, for example, in cardiology, diabetes and neurology.
- The stroke co-ordinator was based on the ward and was available to support patient's relatives and staff.

Medical care (including older people's care)

Are medical care services responsive?

Inadequate

Changes had been made to the acute medical pathway to improve access and flow. However, we found patients were being cared for on non-specialty or other specialty wards due to inpatient capacity issues. The number of transfers after 10pm had increased from 2436 in 2013/14 to 2643 in 2014/15. Data between January and April 2015 showed 779 patients had been internally transferred between 10pm and 8am which was not in line with trust policy for out of hours arrangements for transfer which stated that 'patients should not routinely be internally transferred between 10pm and 8am'. Data indicated that since January 2015 the moves were reducing from 249 in January to 102 in April 2015. There was a team on the medical rota to oversee care and treatment for medical outliers, but there were some delays in doctors being able to see all the patients in the different areas particularly out of hours and weekends. There were a number of bed moves occurring out of hours, although moves to a different site had decreased. Medical patients were sent from ED to wards where discharges were expected as part of "Reverse boarding"; patients were risk assessed by the ward but a bed may not be immediately available.

A programme of transformation and reconfiguration of acute medical services was taking place to meet the needs of the local population. Improvements had been made in the awareness of dementia and dementia friendly environments. There were systems in place for patients to make a complaint or raise a concern with some evidence of lessons learned and action taken to improve the quality of care.

Service planning and delivery to meet the needs of local people

- The trust had established a major programme of transformation of the acute medical pathway of care to meet the needs of the local population. This included the reconfiguration of services, introducing the ambulatory care unit, elderly assessment unit, and three medical wards transferring from Castle Hill Hospital to Hull Royal Infirmary. During the transformation programme the trust had worked with external partners.
- The medical care group had identified its clinical priorities in its operational plan for 2014/15 to 2016/17 which included admitting only those patients with acute medical problems, to use ambulatory emergency care as the norm, focus on general care and reconfigure the bed base with appropriate utilisation of specialist teams, providing GPs with access to hot clinics seven days a week or appropriate specialist opinion and to focus on frail elderly pathways.
- A year round surge and escalation framework had been developed and was managed by a multi-agency discharge hub on the Hull Royal Infirmary site. This model was being developed further to ensure the safe transfer of care, move towards discharge to assess and increase the number of patients enabled to be discharged home.
- There were plans to have a winter pressure escalation plan in place by July 2015. The trust was liaising with community services to support winter planning. However, staff expressed concerns regarding capacity and demand which remained high and had resulted in the winter surge ward being open for much of the time leading up to the inspection.

Access and flow

- The bed occupancy rate was 92.5% which was higher than the national average of 82%.
- At the last inspection we found that patients were experiencing multiple moves between wards and hospitals after 10pm. During this inspection we tracked one patient's admission; they were moved three times during their stay; two of these moves occurring after midnight. Another patient was moved from A&E to EAU after midnight, they sat in a chair for five hours as no bed was available.
- The number of transfers after 10pm had increased from 2436 in 2013/14 to 2643 in 2014/15.
- Data between January and April 2015 showed 779 patients had been internally transferred between 10pm and 8am which was not in line with trust policy for out of hours arrangements for transfer which stated that 'patients should not routinely be internally transferred between 10pm and 8am'. Data indicated that since January 2015 the moves were reducing from 248 in January to 163 in April 2015.

Medical care (including older people's care)

- The number of multiple moves had increased from 470 in 2013/14 to 1071 in 2014/15. Since January 2015 the moves were reducing.
- Transfers to CHH from HRI had reduced from 173 in January 2015 to 95 in April 2015. It was expected that moves between the different hospitals would further decrease following the medical wards had been transferred from Castle Hill Hospital to HRI in April 2015.
- We observed a patient waiting for 19 minutes on a trolley following transfer from EAU to the ward as no bed was available, the nurse in charge informed us this was due to a delay in another patient being discharged as they were waiting for take home medicines.
- Medical patients were sent from ED to wards where discharges were expected as part of "Reverse boarding" which was in the "Standard operating procedure for escalation within the emergency department". We were told patients were risk assessed by the ward but a bed may not have been immediately available. This was a high risk approach in an organisation where patient flow was compromised due to bed availability and most medical patients would be frail and elderly.
- Staff on a medical ward said they have had "reverse boarders" waiting on the ward on a trolley or in a chair for a bed in the last two weeks. We were told by senior staff that a risk assessment was always done with the ward agreeing to the plan but ward staff told us they disagreed with this and said they were told they were to take extra patients when there was a patient due to be discharged that day.
- There were two clinical bed managers in place with a clinical site matron on duty 24hours/day at HRI and 8AM – 8PM at CHH.
- Data for May 2015 showed there were 756 delayed discharges (NHS England) the majority of these related to delays in the completion of assessments, waiting for NHS non acute care and patient and family choice. There were discharge teams at the hospital that supported patients and staff with complex discharges. Discharge planning started as soon as the patient was admitted. We reviewed the electronic patient flow management system which showed an estimated date of discharge had been set for patients.
- EAU had 15 beds, staff on the unit told us more beds were required. Up until a week before the inspection four beds were put in the seating area overnight if extra capacity was needed but no additional staff were on duty. This had been acknowledged by the leadership team who told us they had escalated this as a risk as it had breached the standard operating procedure.
- At HRI the average length of stay was longer than the England average for elective patients and shorter for non-elective patients.
- Rapid access 'hot' clinics had been established to support the acute care model.
- The ambulatory care unit had been open for five months and admitted patients from A&E, AAU, GP referrals and self-referrals. Staff told us the unit had resulted in a positive impact on access and flow of patients in AAU, improvements in patient length of stay and patient flow within EAU although there was no audit data available to support this.
- There were a number of medical patients on non-specialty or non-medical wards. We visited the ophthalmology ward which had medical patients occupying eight of the 12 ophthalmic beds so only four beds were available for the ophthalmic patients. The care provided was good however, the unit was isolated from the main hospital site and staff told us sometimes it was difficult to get a medical review overnight or at weekends. Outlying medical patients were monitored with matrons and bed managers working together to try and move patients on to the correct ward as soon as possible.
- Each medical speciality team had responsibility for medical outliers on a specific ward, there was a plan to trial an MDT to cover medical outliers and a contingency plan to move services if a ward was closed due to infection.
- The winter surge ward had remained open. Patients were admitted from AAU, EAU and ambulatory care.

Meeting people's individual needs

- The trust had medical and nursing dementia leads and improvements in awareness of dementia, training and dementia friendly environments had been undertaken in the last 12 months.
- The environment had been improved on some of the elderly care wards to meet the needs of patients with dementia. There was a reminiscence room on one of the elderly care wards, adapted signage and other dementia-friendly themes.

Medical care (including older people's care)

- Physiotherapists had introduced neon wristbands on the elderly care wards to alert staff if patients needed assistance mobilising or required a walking aid.
- There were a number of specialist nurses to meet the needs of patients with conditions such as epilepsy, Parkinson's disease and Multiple Sclerosis. Nurse led follow up was provided in community clinics and GP surgeries.
- Stroke and neurology physiotherapists provided a number of patient sessions in areas such as upper limb, balance and seated exercise groups.
- A dining group was held three times a week which provided lunchtime support for patients to become more independent before being discharged home.

Learning from complaints and concerns

- There was information in clinical areas for patients and relatives about how to make a complaint and provide feedback.
- Trust-wide data showed that similar levels of complaints were received in 2013/14 (approximately 230) and 2014/15 (Just over 250). The average number of days to process closed complaints was 48 days. 5.6 % of complaints were re-opened.
- The top themes received from complaints related to clinical treatment, admission, transfer and discharge, communication and attitude of staff.
- Some staff told us learning from complaints was shared at ward meetings. An example of changes made following a complaint on ward 10 was the introduction of a checklist to regularly record patient's weight.

Are medical care services well-led?

Requires improvement 

The medical health group had a vision and strategy which included a programme of transformation across a number of medical specialities. There was a new leadership structure and senior managers were aware of the challenges in the health group.

Governance process were in place however these were not fully embedded in all clinical areas and it was not clear what mechanisms there were to ensure lessons were shared with staff for learning. Further work was also required in implementing the Duty of Candour regulations.

The last inspection highlighted issues of staff bullying. During this inspection most staff thought the culture was improving, and work was progressing in this area. Most staff felt supported by managers and acknowledged that the changes in the health group had been positive to improve the quality of patient care; however some staff felt decisions continued to be based on targets. Work was continuing to improve staff engagement.

There were examples of innovative practice and improvement.

Vision and strategy for this service

- The medicine health group vision and strategic goals were set out in its operational plan 2015/16 and 2016/17. The group's strategic vision was that "Every patient will receive high quality, safe and responsive care irrespective of their age, social status and the time and day of the week that they access our services".
- The priority objectives set out the key actions, measurable outcomes and timescales for completion. This included the planned programme of transformation across a number of specialties that would implement integrated pathway redesign.
- Elderly medicine had plans to work with and utilise community services which included discharge to assess beds, intermediate care beds and piloting a scheme to reduce unnecessary hospital admissions from care homes.

Governance, risk management and quality measurement

- Integrated governance group meetings were chaired by the nurse director for the health group and attended by the medical director and governance leads. Serious incident reviews and risks for escalation to the trust risk register were some of the agenda items discussed.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned an initial, current and target risk rating. Controls were identified to mitigate the level of risk and where there were gaps in the controls, action plans were developed. The health group risk registers identified areas such as nurse

staffing, medical cover and recognition and management of deteriorating patients on AAU. The risk register showed that controls were in place to help mitigate these risks.

- There was a mechanism for wards to escalate risks. High level risks were notified to the health group triumvirate to be dealt with immediately whilst lower level risks were discussed at specialty governance meetings. However, we found governance arrangements were not fully embedded on all wards and it was not clear what mechanisms were in place in these areas to ensure lessons were shared with staff for learning.
- There were good governance arrangements in the stroke unit. Multi-disciplinary governance meetings were held each month. Areas discussed included complaints, incidents and stroke performance indicators. Learning was shared with staff during safety huddles, one to one meetings and ward meetings.
- Most staff had an awareness of the Duty of Candour regulations. A report provided by the trust showed that between December 2014 and April 2015 the medical health group had achieved 33% against the duty of providing an apology and 40% against providing patients with feedback. A trust wide audit was undertaken by the risk team and 54 case notes were reviewed where the patient had experienced a level of harm of moderate or above. Only six case notes had evidence of an apology being provided to the patient or relevant person (11%).

Leadership of service

- During the last inspection leadership and accountability issues in the medical care group had been identified. Since then there had been a number of changes in the senior leadership and restructuring of services across the group which had only been functional for a few weeks. From our discussions with the senior team it was clear that they were aware of the challenges in the health group such as staffing, culture, governance and service performance and had operational and strategic plans in place to address these.
- A workforce plan was in place and work was ongoing to achieve key performance indicators such as developing a culture of high performance, recruitment and retention, staff development, succession planning and consultant revalidation.
- The majority of medical and nursing staff told us that they felt well supported by managers however a few staff commented that from an operational level upwards specialities continued to work in silos.
- Ward sisters were encouraged to attend the Great Leaders programme and this learning was supplemented through health group support and mentorship. A number of ward sisters spoke positively about the programme.
- Staff on the elderly care wards told us there had been a high turnover of staff in the last year. Turnover rates for nursing staff between April 2014 and February 2015 was 10% in acute medicine and 7% in elderly medicine.
- On certain wards we observed strong ward leadership. For example in neurology and on the acute stroke unit there was evidence of a cohesive medical and nursing team who were aware of the challenges for providing good quality care and had actions and strategies in place to achieve this.
- Staff in one clinical area told us the executive team were visible on the unit and there was good staff engagement with the nominated executive board member.

Culture within the service

- The last CQC inspection highlighted issues of bullying at the trust and this was confirmed following an independent review by ACAS. In the medical care group we found that most staff thought the culture was improving, there was still a lot of work to do but that it was moving in the right direction particularly in areas such as working relationships and staff empowerment.
- Staff were aware of the trust initiative 'speak out against bullying', a confidential staff advice and liaison service for staff experiencing bullying in the workplace. The trust had developed an anti-bullying group action plan which had specific actions in relation to culture, visibility and communication and policies and procedures. AAU staff were piloting a corrective treatment programme based on the Harvard cultural model which gave staff the opportunity to participate in scenario based sessions and provide solutions.
- In some areas staff morale fluctuated depending on staffing levels particularly if staff were regularly leaving late or missing breaks.
- We observed good team working between medical and nursing staff in most areas. Staff were proud of the quality of care they delivered. Most staff accepted that the changes to ways of working had come from

concerns about patient safety and delays in receiving treatment; however some staff felt decisions continued to be based on targets rather than the quality of service to patients.
- Staff sickness levels for medicine were 3.86% which was better than the trust target.

Public engagement and Staff engagement

- The National NHS Staff Survey 2014 showed that the trust scored in the worse 20% of organisations nationally for staff engagement and the percentage of staff agreeing that feedback from patients was used to make informed decisions in their directorate or department.
- The CQC Inpatient Survey 2014 showed Hull Royal Infirmary performed about the same as other trusts for overall patient experience.
- The stroke unit worked closely with Citizens Advice who visited stroke patients weekly to provide support to patients regarding benefits and services that they may be able to access
- The trust had formed a partnership with the Red Cross for a 12 week pilot where volunteers supported patients who had been discharged from hospital with the intention to reduce hospital readmission rates.

Innovation, improvement and sustainability

- Some of the medical wards were piloting the use of IT tablets to record patients' vital signs electronically. The equipment was being issued to staff as part of a project called 'e-observations', where staff regularly monitored and recorded key clinical details about a patient, such as their blood pressure, temperature and heart rate. Staff could have access to a patient's information wherever they were on the ward.
- Work had been introduced to improve the experience for dementia patients and further work was planned including changing the menu, introducing open visiting and the use of dining companions.
- The stroke unit had introduced charge nurse and matron clinics for patients and relatives to discuss concerns.
- Physiotherapists had introduced neon wristbands on the elderly care wards to alert staff if patients needed assistance mobilising or required a walking aid.

Surgery

Safe	Inadequate
Well-led	Requires improvement
Overall	Inadequate

Information about the service

The hospital provides elective and non-elective treatments for acute surgery, breast surgery, trauma and orthopaedics, plastics, neurosurgery, vascular surgery and ophthalmology. There are nine main theatres in the tower block, five theatres in the Women's and children's hospital, three for ophthalmology (eye surgery), and one for surgical outpatients. There are two day surgery theatres. There are also two specific rooms of interventional radiology and two for maxilla facial day surgery.

We visited a sample of the surgical wards, theatres and recovery areas on site and observed care being given and surgical procedures being undertaken. We spoke with patients, relatives and members of staff and observed care and treatment and reviewed patient care records.

Summary of findings

There had been three Never Events reported for the surgical health group between April 2014 and March

2015; two in relation to wrong site spinal surgery on the Hull Royal Infirmary site (between December 14 and March 2015) and one on the Castle Hill Hospital site involving a retained foreign object. Within the surgical health group 21 serious incidents reported for surgery in the last twelve months. Incidents were investigated however external support was being put in place as there were delays in investigating incidents and securing clinical staff for panel members to investigate incidents. The rate of incidents reported in this trust was lower than the England average.

A number of concerns in relation to infection prevention and control were identified. This included potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols: hand washing facilities for clinical procedures were poor on ward 6 and; inappropriate access to store rooms and temporary repairs to flooring in wards and clinical areas which hindered effective cleaning processes.

There was a lack of assurance of the governance systems in place to maintain safety. There was a risk register and an integrated governance group , however the group had not been quorate for two of three meetings we reviewed and the risks were not been addressed in a timely manner. We saw reports for visual inspections and compliance with performance measures: these identified issues such as "rotten plant" and the presence of dirt and rust within the ventilation systems that served the theatres.

Surgery

There was a backlog of complaints requiring investigation across the Health Groups. Matrons were unable to attend the monthly Patient Experience Committee due to their clinical workloads.

The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. National data indicated that the number of cancelled operations had been increasing and were above the national average. A number of issues affecting patient flow through the hospital had been identified.

Nurse staffing levels varied from a 67% to 98% fill rate against the planned establishment which was confirmed on review of rotas for the two weeks in the previous month to the inspection.

There was no clinical strategy for the health group. Members of staff were able to articulate the Health group's values and short term operational plan, although they were not aware of the plans to manage winter pressures. Senior managers told us the health group's objectives was to make decisions affecting the present and medium-term and not about the longer-term. Staff said health group managers were available and approachable and leadership of the service was good. Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.

During meetings with staff a history of a poor culture between qualified and non-qualified staff was mentioned. We were told that senior managers were aware of this and had addressed it. Staff told us that an open and honest culture had been developed and significant change in the culture of the service had been achieved.

Are surgery services safe?

Inadequate

We identified a number of concerns in relation to infection prevention and control. Infection prevention and control (IPC) assessments indicated 'requires improvement' and 'inadequate' categories for some wards and theatres. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols. Hand-washing facilities for clinical procedures were poor on ward 6We saw inappropriate access to store rooms, and temporary repairs to flooring in ward and clinical areas which hindered effective cleaning processes.

We saw reports for visual inspections and compliance with performance measures: these The reports we saw identified issues such as "rotten plant" and the presence of dirt and rust within the ventilation systems that served the theatres. The environment in the theatre suite was damaged with exposed plaster, exposed timber, damaged flooring, loose wall protection and damaged light switches. Environmental damage within the theatre suit hampers effective cleaning procedures and has the potential to increases the risk of surgical site infections to patients.

There had been three Never Events reported for the surgical health group between April 2014 and March

2015; two on the Hull Royal Infirmary site in relation to wrong site spinal surgery (between December 14 and March 2015) and one on the Castle Hill Hospital site in relations to a retained foreign object. We saw that these had been investigated. Within the surgical health group, 21 serious incidents had been reported in the last twelve months. The rate of incidents in this trust was lower than the England average. Members of staff told us they were encouraged to report incidents, near misses and accidents using the trust electronic systems, including those triggering Duty of Candour requirements.

Nurse staffing levels varied from a 67% to 98% fill rate against the planned establishment which was confirmed on review of rotas for the two weeks in the previous month to the inspection.

The numbers of falls, pressure ulcers and urinary tract infections reported was low. Incidences of MRSA and Clostridium difficile were similar to the England average.

Surgery

Incidents

- There had been three Never Events reported in surgery across the Trust between April 2014 and March 2015; two in relation to wrong site spinal surgery on the Hull Royal Infirmary site (between December 14 and March 2015) and one on the Castle Hill Hospital site in relation to a retained foreign object. The trust had consequently commissioned a review by the Royal College of Surgeons. At the time of the inspection the terms of reference were being agreed and the review had yet to begin.
- Within the surgical health group 21 serious incidents had been reported in the twelve months prior to our inspection.
- Incidents were investigated however a delay in investigations and a backlog of incidents requiring investigation had led to external support being put into place, delays in securing panel members to investigate incidents was also noted.
- We saw that incidents were reviewed by Quality Service Managers to identify trends and were discussed at ward and clinic manager meetings from across the trust to promote shared learning, however due to the backlog of incident investigations, incidents discussed were not always the most up to date incidents, learning from the incidents could be diluted due to the gaps in the timescales.
- The rate of incidents was lower in this trust than the England average. Staff said that they were encouraged to report incidents; they also told us that there was low level reporting as not many incidents occurred.
- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic systems.
- Feedback was given on reported incidents and outcomes at staff meetings, or cascaded via email.
- Mortality and morbidity meetings were held monthly in all relevant specialities. All relevant staff participated in mortality case note reviews and reflective practice.

Duty of Candour

- We saw that information about duty of candour was displayed on the staff intranet.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements.

Safety thermometer

- The trust used the NHS Safety Thermometer, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety Thermometer information included information about all new harms, falls with harm, and new pressure ulcers. Information was displayed on boards on all wards and theatre areas visited.
- The surgical health group across both CHH and HRI was reporting within expected levels for these measures – the numbers of falls (nine), pressure ulcers (27) and urinary tract infections (26) across the health group had all remained low in the twelve months to December 2014. This was reflected in information displayed within ward areas.
- Care records showed that risk assessments for these were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- There were a number of infection prevention and control issues identified. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols. Hand-washing facilities for clinical procedures were poor on ward 6. We saw inappropriate access to store rooms, and temporary repairs to flooring in ward and clinical areas.
- Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections. Increased health risks to patients will occur if ventilation systems do not achieve and maintain the required standards Health technical memorandum 03-01: specialised ventilation for healthcare premises. The Health Act 2008: code of practice for the prevention and control of healthcare associated infections, sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risks of infection is kept as low as possible. We saw reports for visual inspections and compliance with performance measures: these The reports we saw identified issues such as "rotten plant" and the presence of dirt and rust within the ventilation systems that served the theatres
- The environment in the theatre suite was damaged with exposed plaster, exposed timber, damaged flooring, loose wall protection and damaged light switches. Environmental damage within the theatre suit hampers effective cleaning procedures and has the potential to increases the risk of surgical site infections to patients.

Surgery

- A concern was noted as a risk by the trust in September 2014 regarding some patients being operated on in an environment that left them vulnerable to infection because there was no laminar flow system in theatres 2 or 3. Patients were therefore at risk of infection from the air in the theatre. Some controls had been put in place to mitigate this: “Surgeons were aware and alert for infection risks; Rescheduling high risk cases into other theatres with laminar flow (when one was available); ensuring that if a laminar flow is required that this is requested at the appropriate point; complex spinal operations were undertaken in Theatre 1 and; an audit was planned to compare infection rates on previous years - the outcome of the audit would be used to inform this risk."
- Infection control information was visible in all ward and patient areas.
- Infection prevention and control (IPC) assessments (March 2015) indicated a ‘requires improvement’ category, scoring for theatres 4 and 5 of 87% and 88% for theatres 6 and 7. The assessments indicated an ‘inadequate’ category for women and children’s theatres scoring 51%.
- We saw potential risks of contamination caused by patient linen stored on trolleys in a communal corridor and display boards made of difficult to clean materials in the ward corridor.
- Items such as patient wipes were inappropriately stored in the sluice room.
- We saw bed cleaning checklists above empty beds and dated from the previous month. These did not provide assurance beds had been cleaned appropriately.
- Commodes were all clean on inspection.
- Almost all wards and patient areas were clean. Cleaning stickers were in use but we saw dust and debris underneath bed bases on ward 6.
- We saw members of staff wash their hands when appropriate, use hand-gel between patient contacts and comply with Bare Below the Elbow policies. Hand wash basins had been installed at the entrances to the ward areas and this resulted staff and visitors waiting to wash their hands. Highly visible signage was in place to encourage hand hygiene.
- All patients undergoing elective surgery were screened for Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia and procedures were in place to isolate patients when appropriate in accordance with infection control policies.
- There had been two cases of MRSA in the trust between April 2013 and March 2014 and the prevalence rate of Clostridium difficile (C.difficile) was similar to the England average (95 cases).
- Nursing staff had received training in aseptic non-touch techniques. This covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at health group meetings and actions identified if required.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADS) guidelines.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in all areas had been checked daily.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly.
- There was adequate equipment in the wards to ensure safe care.
- The assessment room on ward 6 had no hand-washing facilities and was used for clinical procedures (e.g. taking blood and internal examinations). The ward was divided into four bays and a high observation bay; at one end of the ward the bays had no hand-washing facilities within in them. Staff had to leave the bay to use hand washing basins in the circulating area.
- Access to store rooms was through the bathroom lobby area. This meant clinical kit was transported through a dirty area and equipment was stored in the bathroom.
- Adhesive tape had been used to cover damage and marked flooring in some wards and clinical areas. Lockers on ward 6 were damaged and the laminate was peeling and difficult to clean appropriately.

Medicines

- Medicines and fluids used within theatres were stored correctly in locked cupboards or fridges where necessary.
- Fridge temperatures were checked and were within required limits.

- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use and included enhanced recovery pathways.
- Wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- Care records showed appropriate completion of the Early Warning Score documentation and the undertaking of appropriate action.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Nursing documentation was kept at the ends of beds and centrally within the wards and was completed appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patient consent had been obtained in line with the trust's policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.

Safeguarding

- Staff were aware of the trust's safeguarding policies and procedures and had undergone training in this area. They were also aware of the appropriate action to be taken if required, including contacting the safeguarding team for advice and support.
- Information provided by the trust showed that 86% of staff requiring training in safeguarding adults and safeguarding children within the health group had completed this training.
- Members of staff with whom we spoke were able to describe action they would take if they had any safeguarding concerns. A board was present in the ward area displaying safeguarding information including the definitions of abuse and contact details.

Mandatory training

- Performance reports within the health group showed that members of staff were up to date with their mandatory training; this was confirmed during interviews with staff. For example, 83% of staff had attended Deprivation of Liberty Safeguards (DoLS) training, 82% had attended Mental Capacity Act (MCA) training and 86% had attended appropriate Safeguarding Vulnerable Adults training.
- Senior members of staff were aware of health group compliance with mandatory training and accessed relevant information to develop plans to meet expected compliance levels.
- During group and individual meetings, members of staff confirmed that they felt confident they had received the mandatory training necessary to enable them to perform their roles effectively.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and members of staff we spoke with were aware of the appropriate action to be taken if patients' scores were higher than expected.
- We looked at a sample of completed charts and saw that staff had escalated correctly and repeat observations were taken within appropriate time scales.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to ensure that staffing establishments reflected the acuity of patients. The newly appointed chief nurse was reviewing staffing levels and how these were reported regularly to the Board.
- At least three member of staff told us about a "vacancy holding/recruitment freeze" that had been in place for the previous six to seven months and had been lifted prior to our inspection. However, the senior

management team informed us that no such vacancy controls had ever been in place. The Trust had being actively recruiting to vacancies including overseas campaign for both nursing and medical staff.

- Information provided by the trust prior to the inspection indicated that for registered nurses both wards H4 and H40 were staffed to their establishment of 14.5 nurses and wards H60 and H90 were staffed above their establishment. Other wards had vacancies: 2.5 to 4 WTE registered nurse vacancies.
- We reviewed nurse staffing levels (April 2015) on wards visited and within theatres and found that the fill rates for qualified staff during the day varied between 68.5% (Ward 9) and 92% (Ward 60) against establishment. For non-qualified staff the fill rates were between 77% (Ward 6) and 97% (Ward 9) against establishment.
- During the night the fill rates for qualified staff were between 67% (Ward 6 and 100) and 78% (Ward 60) against establishment. For non-qualified staff the fill rates were between 97% (Ward 4) and 197% (Ward 6) against establishment.
- Some members of staff told us that staffing levels were poor and that this increased their stress levels. They told us that beds had been closed on some wards for a number of months and had then been re-opened over the winter period without any increase in staffing levels.
- Ward 6 had 26 beds including a high observation bay (HOB). The planned levels of registered nurse (RNs)s were four on day duty and three on night duty. We reviewed nurse staffing establishment against actual numbers and saw that, on the days of our inspection, staffing levels on ward 6 were the same as the establishment levels. However, during two weeks in the month prior to our inspection, there were 17 occasions (29%) when there were three RNs on day shifts (out of 42 shifts reviewed) and 11 occasions (34%) when there were two RN on night shifts (out of 21 shifts reviewed). On these occasions the ratio was one nurse to 8.6 patients (including caring for patients on the HOB) and overnight one nurse to 13 patients.
- The senior management team told us that occasionally wards ran with two instead of three qualified nurses due to staffing vacancies but that this did not happen when dependency levels of patients indicated that a reduction of staff numbers would be unsafe, we noted 162 staffing Datix reports Dec 2014 to April 2015.
- Matrons across all health groups were rotated into "Patient placement" roles on a daily basis. A project was in place for a patient placement / site management team.
- Safety briefings were held twice daily, and included discussions about staffing, falls risks and safeguarding, and the allocation of members of staff to other work areas. Members of staff felt that this made allocations fair and agreed with its principle, but also felt that it led to risk in two clinical areas rather than in only one. The senior management team told us that moving staff caused anguish and was on their 'worry list'.
- Recruitment processes had been developed including recruitment from overseas and the use of generic band 5 staff nurse recruitment to address staffing issues.

Surgical medical staffing

- Surgical consultants from all specialities were on-call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on-call team comprised the general consultant surgeon and a consultant vascular surgeon.
- Patients who required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. Medical staffing within the health group was made up of 41% at consultant level (England average 40%), 38% registrar level (England average 37%), middle career 7% (England average 11%), and 14% junior doctors (England average 13%).

Major incident awareness and training

- Business continuity plans for surgery were in place. These included information about risks specific to clinical areas and actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Surgery

Are surgery services well-led?

Requires improvement

There was no clear long term strategy or vision for the service. Staff were able to articulate the health group's operational plan. Senior managers within the health group commented that the health group's focus was to make decisions affecting the present and medium term and not the longer-term.

The risk register had a number of risks that had been "open" for some time and whilst some controls had been put in place they had not been resolved. There was an Integrated Governance Group meeting held each month, although two of three recent meeting had not been quorate. We noted six procedural documents which were past their review date. Staff reported serious incidents and could describe the dissemination of issues and learning. We saw evidence of investigations and root cause analyses. During our inspection we were told of two serious incidents that had been subject to significant delays in reporting which may have resulted in a lack of timely action to investigate and take action from lessons learnt.

Members of staff said that health group managers were available and approachable and they thought leadership of the service was good. They spoke positively about the service that they provided for patients and emphasised quality and patient experience as priorities. Members of medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings. Members of staff commented that the trust was actively addressing the issues of the "Bullying culture" evident at the CQC inspection in 2014. During meetings with staff a history of a poor culture between qualified and non-qualified staff was mentioned. We were told that senior managers were aware of this and had addressed it. Staff told us that an open and honest culture had been developed and significant change in the culture of the service had been achieved.

Vision and strategy for this service

- There was no clear long term strategy or vision for the service.
- There was a surgical health group operational plan for 2015/16-2016/17. Within it was a strategic aim: "The Health Group continues to work towards its strategic vision of splitting elective and non-elective activities, ensuring that patients are treated in the right place, at the right time, by the right people, first time and within budget."
- Members of staff were able to articulate to us the health group's objectives across the surgical wards.
- Members of staff told us that the large number of temporary and acting posts within the senior management team had led to a less than strong vision for the future of the service, and they believed the vision for the health group was to carry out more surgery and cover the backlog of waiting lists that had developed. They said that the health group was not running efficiently since surgical beds had been re-assigned as medical beds.
- We met with senior managers within the health group who told us that the health group's strategy was to make decisions affecting the present and medium term rather than about the longer-term. One example given was the development of a surgical rehabilitation unit.
- The trust had developed a Theatres Transformation Programme in May 2015 to focus on maximising efficiency. Data provided by the trust showed the utilisation of theatres varied between 51.3% and 94.1%.
- An external agency had been commissioned to conduct a review of how theatres worked and to suggest means of achieving increased efficiency, review pathways, post-operative care and surgical bed prioritisation.

Governance, risk management and quality measurement

- We reviewed the information supplied by the trust regarding risks for the surgical health group. There were 38 "open" risks and a number that had been "open" for some time. For example, insufficient senior house officer (SHO) cover for neurosurgical patients overnight and during the day. Doctors from other surgical specialities, who may not have the knowledge or experience to effectively treat neurosurgical patients, were used to support the service. This caused a further risk across the trust as doctors were covering an increased number of patients. This had been first recorded in October 2010. Robust controls were not in place to mitigate this. The register stated: "Physicians apprentice roles to be considered. Consultants to support as required". Other risks, whilst recorded showed limited evidence of effective controls in place.

- Integrated Governance Group meetings were held each month. Agendas and minutes showed that audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed.
- We reviewed the minutes of the January - March 2015 Integrated Governance group meetings; two of the three meetings had not been quorate which may have added delay to any decision making processes, For example, in the March 2015 minutes some policies, "Urology surveillance and staging imaging requesting" and "Flushing of IV devices for patients receiving an anaesthetic" had not been approved.
- We requested data to review quality measurements. Not all of this data could be provided for us, for example, for the number of cancelled operations. The surgical senior management team may not have been fully conversant with any quality concerns or been able to respond in a timely manner. Following a further request after the inspection quality information was provided including theatre utilisation performance dashboards and cancelled operations and other audit information.
- Staff reported serious incidents and could describe the dissemination of issues and learning. We saw evidence of investigations and root cause analyses. During our inspection we were told of two serious incidents that had been subject to significant delays in reporting which may have resulted in a lack of timely action to investigate and take action from lessons learnt. There was a backlog of 32 incidents across both sites, the oldest one dating from 19 February 2015 with a classification as a moderate incident.

Leadership of service

- Nursing staff we spoke with stated that they were well supported by their managers although we were told one-to-one meetings were informal.
- Members of medical staff said that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.
- Members of staff said that health group managers were available, visible within the health group and approachable. Staff also said that leadership of the service was good, there was good staff morale and they felt supported at ward level. However, some members of staff told us that recent changes in health group management and structures had resulted in the appointment of inexperienced and temporary managers. Nonetheless, leadership had improved through a visible presence of senior managers.
- Staff told us about recent structural changes to line management, nurse management, health group nurse management and clinical leadership. We were told that most matrons had worked clinically for the previous eight weeks, due to staffing pressures, and this had had an adverse impact on support, complaints and incident management.
- Senior nursing staff told us that they had lost some of their supernumerary time and they felt that, because of this, they did not have adequate management time to ensure safety controls were as effective as they could be.

Culture within the service

- We saw good team-working on the wards between members of staff of different disciplines and grades. At ward and theatre levels we saw that they worked well together and there was respect between specialities and across disciplines.
- Members of staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority and they were aware of their responsibilities under Duty of Candour.
- Members of staff told us that an open and honest culture was being developed and significant change in the culture of the service had been achieved. They were aware of the recent report into bullying at the hospital and recent surveys about values.
- Staff recognised the history of a "bullying culture" as documented in the CQC 2014 inspection report and the ACAS (Advisory, Conciliation and Arbitration Service) report commissioned by the Trust in 2014. Staff we spoke with had not witnessed any bullying behaviours.
- They told us some areas now had "Bullying support" staff in place and that a professional and cultural transformation (PACT) training course which had been introduced for all staff.
- Members of staff told us that the trust was "More relaxed now and the leadership team (was) more visible".
- Directors had been appointed as links between clinical areas and the board. However, this approach did not appear to be consistent as some members of staff told us that the leadership team did not visit all areas.

Surgery

- Staff told us recent changes had resulted in a less hierarchical board and information was now disseminated from ward to board more effectively.
- Although we were told about a history of poor communication within the senior nursing team, we were also told that this had been addressed through recent appointments, which had resulted in increased motivation amongst nursing staff. Senior members of nursing staff told us that the culture was now calmer and encouraged change.

Public and staff engagement

- Between December 2013 and November 2014 the hospital's Friends and Family Test (FFT) survey response rate was 43%, which compared favourably with the England average of 32% during that period, and its scores were similar to the England average across all areas.
- Members of staff told us that they had regular staff meetings and the Friends and Family Test (FFT) survey results were shared with them.
- Friends and Family Test (FFT) survey results were highlighted and displayed throughout the hospital.
- The senior management team told us that professional nurse meetings were held and professional nurse issues were discussed; ward nurses and specialist nurses were included in these meetings.
- The senior management team told us that regular one-to-one meetings were held.
- The senior management team held weekly matron meetings, which included the health group nurses, health group manager and Director of Operations.
- The NHS 'Hello my name is…' scheme had been adapted in the hospital and this encouraged staff to proactively introduce themselves to patients and ascertain the patient's preferred name.

Innovation, improvement and sustainability

- Members of the senior management team told us that they were very proud of the nurse-led services that they had developed in the health group, such as the extended roles of nurses in covering consultant shortages.

Maternity and gynaecology

Safe	Good
Overall	Good

Information about the service

The maternity service at Hull Royal Infirmary provided antenatal, intra partum and postnatal care. Inpatient maternity care was provided on the antenatal ward (Maple ward), the labour ward and the postnatal ward (Rowan ward) 24 hours a day, seven days a week. Care was also provided on the antenatal day unit; this unit together with the antenatal clinic were both open Monday to Thursday 8.30am to 6pm, and Friday, Saturday and Sunday, 8.30am to 5pm.

Between April 2014 and March 2015 the total number of births at the hospital was 5580.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was good. The safe domain was rated as required improvement as the availability of midwives and consultants on the labour ward was below the national recommendations.

This inspection was to follow up the outstanding requirement relating to insufficient staffing. Safeguarding training was also looked at as part of this inspection. We inspected the antenatal clinic, antenatal day unit, the antenatal and postnatal wards, and the labour ward. We spoke with eight women who used the service and 15 staff, including midwives, doctors, a consultant obstetrician and senior managers. We also observed care and treatment and reviewed the trust's performance data.

Summary of findings

This inspection was to follow up the outstanding requirement relating to insufficient staffing within the midwifery services. We therefore only inspected the safe domain which we rated as good. The trust had a full time named midwife for safeguarding and staff confirmed they had received safeguarding training and supervision relevant to their role. There were systems in place to manage and review risks to vulnerable adults, young people and children; safeguarding policies and procedures were in place and available to staff.

Staff reported an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014. Consultant cover on the Labour ward remained at similar levels to the previous inspection at 101 hours per week. We were told that the recent recruitment of three WTE consultant obstetricians increased the hours up to 147 hours a week. The skill mix of the junior medical staff at the unit was similar to the England average. Patients told us they received 1:1 care from a midwife during labour and consultant and medical care which met their needs.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Overall at this inspection we rated the service as good for safety. The midwifery service had a full time named midwife for safeguarding; staff received safeguarding training relevant to their role and knew the procedures to follow to keep patients safe.

Staff reported an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014 but was not yet in line with national guidance. Patients told us they received 1:1 care from a midwife during labour and consultant and medical care which met their needs.

The junior medical staff skill mix at the unit was similar to the England average. Consultant cover on the Labour ward remained at similar levels to the previous inspection at 101 hours per week. We were told that the recent recruitment of three WTE consultant obstetricians increased the hours up to 147 hours a week. Although the cover was not in line with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance of 168 hours for units with 5000 to 6000 births, there were effective systems in place and we had assurance from the Clinical Director of the Women's Health Group the service was safe.

Safeguarding

- At our inspection in February 2014 we found there were procedures in place for protecting adults and children from abuse. There was also a named midwife for safeguarding however the post was only funded for 15 hours per week. This had been identified as a risk by the head of midwifery and a business case had been made for a full time post. At this inspection we found the named midwife, safeguarding post was full time. The Monthly, Quality, Safety and Performance report for May 2015, showed 44 staff had been trained to offer safeguarding supervision and staff told us they received it four times a year.
- Additionally the trust had a midwife who had the role of 'Vulnerable Adults, Teenage Pregnancy, and Healthy Lifestyle Midwife,' and staff told us they were able to refer patients to this member of staff.
- Staff we spoke with knew the procedure for reporting allegations or suspected incidents of abuse, including adults and children and confirmed they had received training. Staff knew they had a responsibility to report any concerns they had for a patient's safety. They were aware of the signs of abuse and neglect and there were examples from community midwives of when they had recognised and escalated such concerns appropriately.
- On each unit within women's services for example Labour Ward, there was a training board with details of each staff member and the training they had attended. Staff showed us their individual computer held training record which confirmed they had received safeguarding training relevant to their role; including level three adult and children training for clinicians. We were also informed the trust was updating their centrally held records to reflect the training attended and held by individual staff members.
- There were processes in place to identify and support women with female genital mutilation.

Midwifery staffing

- Staff reported an increase in the recruitment of midwives and also reported further recruitment was taking place. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014. The 1:32 ratio has been consistently maintained since November 2014.
- We saw the trust had 'Maternity Services Staffing Levels and Escalation Guidelines.' Staff in each area we inspected (including community midwives,) were aware of the safe staffing and escalation protocol should staffing levels per shift fall below the agreed levels. Each area had a manager, and a supernumerary shift leader. The shift leader had responsibility for reporting the bed status and staffing levels at each shift change to the Midwifery, Labour Ward Sister/coordinator (in line with the standard required for Safer Childbirth guidance). We also saw the trust used a computerised staffing tool to assist in monitor staffing levels.
- Senior staff told us core midwifery staff worked in each area, whilst other staff rotated between departments

and this included the community midwives. This meant staff had the knowledge and skills to be able to work in different areas and flexibly to meet the needs of patients on the maternity unit.

- There were minimum staffing levels set for each ward/ unit area. We saw at the entrance to each unit and ward area information about the planned and actual staffing levels for each shift.

During the inspection we saw there was an increase in patient activity on labour ward which meant they needed an extra member of staff to work in the unit. To manage the risk, the Labour Ward Sister/coordinator assessed the staffing levels in the unit and transferred a member of staff from the postnatal ward. The staffing levels on the postnatal ward were higher than needed for the number/ dependency level of the patients. Staff reported they used cross department/site team working when needed to address shortfalls.

- The coordinators told us they reported the staffing levels twice a day to the Labour Ward Sister/ coordinator, and that person then met with representatives from each zone in the trust and from Castle Hill hospital. High level of activity together with staffing levels were determined and escalated in line with the trust's staffing and escalation protocol.
- The midwife to patient ratio of 1:32 was not in line with the nationally recommended number of 1: 28, however we were told 100% of women received one to one care in established labour. National guidance for the birth to midwife ratio was 1:28. However the King's Fund report ("Staffing in Maternity Units -Getting the right people in the right place at the right time" 2011) suggested, that whilst staffing levels were important, employing more staff may not necessarily improve safety and maternity services had found it unrealistic to increase staff numbers to meet this ratio.
- Women said there were sufficient staff on the wards to meet their needs and they had received continuity of care and 1:1 support from a midwife during labour.
- We saw minutes of a trust board meeting dated 30 April 2015. They showed staffing had been discussed, together with action taken and that the trust board would receive monthly updates on workforce information. This was to include the number of actual staff on duty during the previous month compared to the planned levels and the action taken. The information showed staffing levels would be reviewed six monthly utilising Birthrate Plus and NICE guidance as their validation tools.
- The Monthly Quality Safety and Performance report for May 2015 showed the midwife to birth ration was 1:32 and this was reflected in the trust dash board, risk register and considered to be a low risk.
- Staff reported and minutes we reviewed of the Obstetric Multidisciplinary team meeting dated 14 April 2015, showed incidents were reviewed and learning was discussed. There were no incidents reported as a result of an insufficient number or level of staff i.e. consultant or midwife in the incidents reviewed.

Medical staffing

- The monthly Quality, Safety and Performance report for January, February, March and May 2015, showed the average, weekly hours of consultant cover on labour ward were 101 which was in line with the trust goal of 98 hours. However this was still not achieving the Royal College of Obstetricians & Gynaecologists (RCOG) guidance of 168 hours for units with 5000 to 6000 births per year.
- We were told that the recent recruitment of three WTE consultant obstetricians, had increased the cover up to 147 hours a week.
- Staff reported the consultant obstetricians were available when needed and also reported antenatal patients were seen each day in line with current guidance. Patients told us they received consultant and medical care which met their needs.
- There was a nationally reported shortage of junior medical staff and the skill mix at the unit was similar to the England average. The Clinical Director told us the Deanery (which organised medical education and training throughout the region) had agreed the trust could recruit an additional, speciality trainee tier. They had tried to do this without success and had locum cover as an interim measure.
- We saw the trust had 'Maternity Services Staffing Levels and Escalation Guidelines' and staff were aware of the procedures to follow. Junior staff we spoke with told us they felt supported by the consultants and midwives.
- The Clinical Director of the Women's Health Group assured us there was enough medical staff to provide

timely treatment and review of patients at all times; included out of hours. They told us vacancies and shortfalls would be covered by locum, bank or agency staff when required.

Services for children and young people

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

Information about the service

The children's and young people's division is part of the trust's family and women's health group. The service is based at Hull Royal Infirmary and provides 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 services serve a population of approximately 150,000 children living in the Hull and East Yorkshire area, with the trust having around 12,500 admissions (elective and non-elective) and around 53,000 outpatient attendances per year. There were approximately 7,600 episodes of care from July 2013 to June 2104.

Children's services were split between the 13th floor of the main hospital tower block and the Women and Children's Hospital. The 13th floor of the tower block accommodated Ward 130 (paediatric medicine), a paediatric assessment unit (PAU) and a high dependency unit (PHDU) with four Level 2 critical care beds. A neonatal unit provided a tertiary Level 3 critical care service with 16 special care, seven high dependency and five intensive care cots.

The surgical ward (Acorn Ward) had relocated to the adjacent Women and Children's Hospital in 2014 where a dedicated children's outpatient department was based. Plans had been made for phase two of this move which would involve moving the remaining children's services to the Women and Children's Hospital, but this had yet to take place.

At the February 2014 inspection, we rated services for children and young people as requires improvement for safety and responsiveness and good for effective, caring and well-led. 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. 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.

During our inspection in May 2015, we visited Ward 130, PAU, HDU, Acorn Ward, and children's outpatients. We spoke with 23 members of staff of varying grades and specialties and 20 children and young people or members of their families. We also looked at 11 sets of children's records and considered the data provided to us by the trust.

Services for children and young people

Summary of findings

At the May 2015 inspection overall we rated services for children and young people as requires improvement. We rated the trust's services for children and young people as good for caring and requires improvement for safe, effective, responsive, and well led..

Many areas of concern highlighted in our previous inspection had not been addressed. Concerns relating to the lack of facilities available for parents and the suitability of facilities on the 13th floor were still outstanding. We found the trust had no timescale as to when phase two of the move for children's services to the Women and Children's Hospital would take place. At the time of the inspection concern was raised that the windows in Ward 130 did not all appear to have effective window restrictors in place and whether risk assessments had been completed. .We made the trust aware of this at the time of the inspection and following the inspection the trust provided written assurance that they had checked all the windows in the building and they met the appropriate standards. Beds were not always available for children and young people who needed them. The delay in addressing estates issues had created problems with patient flow by reducing bed capacity.

We had concerns about the treatment of children and young people with mental health needs in our previous inspection. At this inspection, we found access to local Child and Adolescent Mental Health Services (CAMHS) was limited. We saw no evidence of any risk assessments or specific mental health care plans to show staff how these children and young people should be cared for. We saw a number of ligature/anchor points within the ward; this meant children and young people could be at risk of self-harm. There was a 'Green Room' for children who required a "safe bed space" where they could be closely and continuously observed. Staff told us this was not fit for purpose. We reviewed the space and noted that it would be difficult to observe children and young people if the room was in use. All the staff we spoke with told us that they did not feel confident in caring for children and young people with mental health needs and that they required additional training in this regard. There was limited evidence of clear transitional arrangements being in place for children moving on to adult services.

There were gaps in the recording of information on some medication charts and the wastage of controlled drugs was not recorded.

Concerns about a shortage of consultant paediatric surgeons were still outstanding from our last inspection, there were three consultant surgeons in post and they were required to work a 1:3 on call rota. Our inspection in 2014 highlighted concerns about nurse staffing levels in the service. The trust had responded well by increasing staffing levels and we saw evidence that appropriate nurse staffing was available across the service on most occasions. We also saw evidence that staff morale had improved within the service.

Children and young people, and the parents, we spoke with were mainly positive about the care and communication they received from staff. We saw evidence that demonstrated parents and older children were involved in the planning of care through discussions with staff. However, no parent or older child reported having been shown a written care plan.

A number of trust policies, generic care plans and information leaflets were out of date and had not been reviewed. For example, a hand hygiene leaflet which should have been reviewed in 2010. We saw little written evidence as to how multidisciplinary working was taking place effectively within the service. Although staff identified risks, and some were noted on the risk register, we saw limited evidence of actions being taken to address the risks and many had been active for some time without resolution.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The majority of the care records we reviewed were incomplete and generic care plans were in place, with little specific information recorded which related to the individual's needs. We saw that some children's records were also incomplete and were being stored in areas accessible to the public. The wastage of controlled drugs was not recorded in the records we viewed. Staff we spoke with told us they were concerned about the lack of CAMHS support and had not received an appropriate level of training to help them care for children with mental health needs.

At the time of the inspection concern was raised that the windows in Ward 130 did not all appear to have effective window restrictors in place and whether risk assessments had been completed. . We made the trust aware of this at the time of the inspection and following the inspection the trust provided written assurance that they had checked all the windows in the building and they met the appropriate standards.

We noted that children and young people with mental health needs on Ward 130 did not have appropriate risk assessments in place. We found that children and young people with mental health needs were nursed regularly on this ward. There was a specific 'Green Room' for children who required a "safe bed space" where they could be closely and continuously observed. Staff told us this was not fit for purpose. We reviewed the space and noted that it would be difficult to observe children if the room was in use. We saw a number of ligature and anchor points on the ward. This meant children and young people could be at risk of self-harm and/or injury. Following the inspection the Trust told us it was working with the local Child and Adolescent Mental Health Service (CAMHS) to provide staff training and to introduce an accepted anti-ligature risk assessment as part of its health and safety audits.

The trust had made progress in ensuring that nurse staffing levels were safe and we saw evidence that appropriate nurse staffing was available across the service on most occasions. There was no improvement on the number of surgeons available and they were still working to a 1:3 rota.

Incidents

- There were 162 incidents recorded in the service between February 2014 and March 2015. Of these incidents, three incidents were recorded as serious incidents. The main themes recorded for all incidents in the service were; patient care, staffing, and medication.
- Staff were encouraged to report incidents and told us that learning from incidents was disseminated. We saw evidence of incident reporting and learning from incidents being passed on For example, within a communication folder on ward 130.
- A monthly meeting was held with clinical leads and the paediatric team to discuss incidents. This was the forum in which lessons were learnt and feedback was given to staff, including arranging any additional training if required.

Safety thermometer and Safer Care Audit

- Weights were routinely recorded on drug charts. Wards scored 100% except for Ward 130 which scored 92%.
- Safer care audit checks for tissue viability, fluids and nutrition, clinical observations, and documentation achieved 95-100% except for Acorn ward where tissue viability checks were 61%, fluids & nutrition and documentation were 83% and 82% respectively.

Environment and equipment

- There was a lack of appropriate accommodation for children having oncology treatments; they were nursed within cubicles that did not meet the NICE IOG (Improving Outcomes Guidance); Children who required isolation did not have access to rooms with en-suite facilities on Ward 130. There were no toilet facilities and commodes had to be used which led to a lack of privacy & dignity for children with oncology" During the inspection, work was being undertaken to upgrade the bathroom facilities on ward 130.
- Trust documentation acknowledged that the proposed move had been put on hold due to the recognised pressures within the adult medical pathway being risk assessed as a priority for the available capital resource. As a temporary solution the service was looking at modifying one cubicle and/or a four bedded area to offer en-suite facilities. This had not been actioned.

- There was a lack of space for storing equipment on the 13th floor which led to a cluttered environment. We were told the service had plans in place to centralise stores across the 13th floor.
- Cubicles holding four or more cots on the neonatal unit were cramped and was not in accordance with the British association of Perinatal medicine (BAPM) Designing a Neonatal Unit guidance in 2004. This meant there could be problems for staff when providing resuscitation or medical intervention.
- The PAT testing dates for three out of fifteen medical devices we checked and one fan were out of date in the HDU area on Ward 130.
- Repairs were not always actioned promptly. For example, a hinge on one of the doors on the Acorn Ward had fallen off and had been reported to the estates department four days previously. This had not been repaired at the time of our visit. This meant the room was unavailable for patients.
- We saw sharps boxes open on work surfaces in HDU.
- We saw a changing mat placed on a narrow surface and we judged there was a risk that this may be used inappropriately.

Medicines

- We observed controlled drugs checks being carried out and reviewed the control drugs book and records of checks on Acorn ward and HDU. These checks were completed daily. There were some gaps in the records we checked, but the majority of the checks had been completed appropriately.
- The wastage of controlled drugs was not recorded in the records we viewed.
- We found insulin left out on a side in HDU. We handed this to staff and made them aware of the incident.
- We saw gaps in information in medication charts. For example, only one out of five charts we reviewed on Ward 130 had been appropriately completed to record the medications given and with an appropriate signature. Medication errors were noted as an issue of concern in the May 2015 "Divisional Monthly report" with 17 medication errors reported for April 2015. The majority of these were prescribing errors on NICU. No injury or adverse outcomes were noted; two were recorded as a near miss. Actions and lessons learnt were recorded.
- We were told every medication incident was reported back to the staff concerned and staff were given a reflective learning form to complete.
- Staff reported that the main medication incidents related to antibiotics prescribed for babies arriving from the post-natal wards. Staff in both services were working together to ensure children were not missing medications.

Records

- We reviewed 11 sets of care records during our inspection; five on Acorn Ward, five on Ward 130 and a set of neonatal notes. There was an inconsistent approach to record keeping in the records we reviewed.
- In the majority of the care records reviewed, we found observation charts and paediatric early warning scores had not been fully completed. In one care record a child with renal problems had not had their fluid balance chart totalled which meant this child may have not received appropriate management of fluids.
- Generic care plans were in place. However, the care records we reviewed had little information about the specific child's needs or interactions and made it difficult for staff to provide safe and effective care and treatment to children and young people. Staff made generic entries in care plans to describe the care being provided, with little specific information tailored to the individual child or their needs. We saw generic entries to record children's interactions, such as 'play', 'family', 'discharge'. This did not provide specific information on the child's needs or interactions at that time. For example, two children with specific care needs did not have appropriate care plans in place. One young person's records indicated that a CAMHS family session had taken place but the outcome of this was not documented in the nursing or medical records. There was no evidence of MDT involvement or discharge planning within the nursing or medical records. The young person had not had a malnutrition risk assessment completed, although other children and young people on the ward had.
- The care plan templates were out of date for review, had been photocopied a number of times, and this resulted in the templates being hard to read.
- We saw care records with information that could identify children were stored in areas which were accessible to staff and members of the public.

- There were no separate MDT notes in the records we reviewed. Most of the care records reviewed did not contain notes of MDT meetings and decisions.
- Parents and children and young people told us that they were kept up to date with plans about their care verbally. However, we saw limited evidence of comprehensive written care plans being in place or records of discussions with parents being reflected in the documentation.

Safeguarding

- Safeguarding training figures for the children and young people's services were monitored within the Family and Women's health group. For this health group 91% had received safeguarding children training and 86.3% had received vulnerable adults training as of the 1 May 2015
- Not all named professionals for safeguarding children had accessed Level 4 training as outlined in the intercollegiate document.
- Supervision training for staff had taken place. Further training was required as some staff had since left.
- Staff we spoke with were aware of the safeguarding processes in place at the Trust and were able to explain these to us including how to make a safeguarding referral. They were also aware of who to contact in regard to child protection concerns, both in and out of hours.
- A child's GP was informed via letter of any instance where a child did not attend (DNA) for an appointment so that the child could be followed up.
- There was no trust policy in place for the arranging and managing visits from celebrities or visiting religious groups. Staff we spoke to understood that celebrity visits would be arranged via the trust's communications team.

Mandatory training

- We saw that 96% of medical staff had completed mandatory training.
- We saw that mandatory training rates for nursing staff, including safeguarding training, was 86%.
- The trust had identified that the rate for moving and handling training was lower due to the availability of ward based assessors to sign off on training. This ranged from 63% on PAU to 88% on PHDU in March 2015
- Mandatory training was available online and staff received e-mail reminders about training needs.
- Arrangements were in place to allow staff to take time back if they undertook mandatory training out of working hours.

Assessing and responding to patient risk

- The windows in Ward 130 did not all appear to have effective window restrictors in place and no risk assessment had been completed. In the opinion of the CQC inspectors and the ward manager there was a risk that young people could force the windows open. We made the trust aware of this at the time of the inspection and following the inspection the trust provided written assurance that they had checked all the windows in the building and they met the appropriate standards.
- Ward 130 also had a number of ligature and anchor points. We were not provided with any evidence to demonstrate that the ward environment had been risk assessed to ensure that it met the needs of children and young people with mental health issues.
- We found that all of the upper windows on the 13th floor were unlocked. The lower windows were locked.
- We saw no evidence of an assessment of window restrictors taking place in line with Department of Health Building Note 00-10 and no action had been taken to address this situation since it was recorded on the risk register in August 2014.
- Staff raised concerns with us about the management of children and young people with mental health needs. Children and young people with mental health needs were cared for on Ward 130. Staff were concerned about the lack of a specific inpatient unit for children and young people with mental health needs as they felt the trust's general inpatient facilities were not suitable.
- There was a dedicated 'Green Room' for children with mental health needs who required a "safe bed space" where they could be closely and continuously observed. Staff told us this was not fit for purpose. We reviewed the space and noted that it would be difficult to observe a child if the room was in use. At the time of the inspection this room was not being used.
- We were told of one occasion when there were six young people with eating disorders on the ward. Staff had been supported by the local CAMHS service, which provided a mental health worker on each shift during this period.

- Pregnancy testing was carried out for young people prior to undergoing surgical procedures on a case by case basis. There was no specific policy in place for pregnancy tests prior to surgery in young people.

Nursing staffing

- Nursing staffing across the service had improved since our previous inspection and we saw evidence that the majority of shifts were regularly filled and an appropriate number of staff were available
- Management staff told us that the neonatal unit was currently 3.5 whole time equivalent nursing staff under its establishment of 69. The service was recruiting to these posts. Staff shortages on neonatal intensive care were on the neonatal risk register at the last inspection. We found the situation had not been fully resolved since the last inspection and that this was still identified as an issue on the neonatal risk register.
- Staffing on the neonatal unit had been changed to allow one Band 6 staff member to become mainly supernumerary and to deal specifically with the transition of babies care. There were two Band 6 staff members on each shift.
- Staff sickness on the neonatal unit was at around 3% and was in line with the trust target.
- Nursing staff covered the three areas on the 13th floor if there were any staffing shortages. A trial had begun to rotate nurse staff between the three areas and staff told us that they had enjoyed this. The ward manager, junior sister, and clinical staff also worked across the floor to provide flexibility in time of need.
- We were told that there were a minimum of four registered nurses and one HCA on each shift covering the PHDU and the assessment unit.
- There was a 1:2 child to nursing ratio for PHDU beds in place during our inspection. This was sufficient for the children in HDU at that time.
- A supernumerary Band 6 was available to cover when areas were short staffed and the specialist nurses were also available for cover.
- We found there was a lack of dietician support within the service. This meant dieticians were limited in their ability to input into MDT discussions or to routinely review children and young people on the children's wards.

Medical staffing

- There were five consultant neonatologists employed by the service.
- There was sickness absence in the junior grade medical staff. This was being covered by the consultants and locum medical staff. We were told it was a requirement that locum medical staff must have experience of working in a tertiary neonatal intensive care in the UK; there had been no issues in obtaining cover by appropriate locum medical staff.
- Medical staff raised concerns about the lack of administrative support. At the time of the inspection there was one secretary supporting the five consultants. They reported clinical time was reduced as they were spending time organising rotas, and other administrative tasks.
- Three paediatric surgeons were employed by the service. This meant the paediatric surgeons had to undertake a one in three on-call rota. This was not compliant with the requirements of the European Working Time Directive. The trust informed us that the surgeons had opted out of the EWTD. Recruitment to new posts had not been successful.
- The resignation of the trust's paediatric gastroenterologist around 12 months prior to the inspection meant the trust was unable to deliver the current model of paediatric gastroenterology to children and young people using services. The trust had a joint working relationship with Sheffield Children's Hospital to offer in-reach services and was working with adult gastroenterologists to look at shared care for older children.
- A locum consultant paediatric gastroenterologist had been recruited to support the service until the substantive post was recruited to. Discussions had taken place with Sheffield Children's Hospital and an agreement had been reached that this could be a joint post (four days a week at the trust and one day a week in Sheffield).
- We were told a ward round took place every morning, although we did not witness this during our inspection.

Services for children and young people

Are services for children and young people effective?

Requires improvement

A number of trust policies and information leaflets were out of date and had not been reviewed. The number of nursing staff that had an up to date appraisal was variable across the service, with an average of 76%, the lowest being 50% of nurse managers having an up to date appraisal.

Staff raised concerns about communication with and accessing other services. We saw little evidence to show multidisciplinary working was taking place effectively within the service. We found access to CAMHS, occupational therapy and dietetic support for children and young people could be challenging and we saw limited evidence of a multidisciplinary approach to care planning.

Evidence-based care and treatment

- The trust had a BLISS liaison nurse and followed the BLISS charter in individual care planning. BLISS is a practical guide to help hospitals provide the best possible family-centred care for premature and sick babies.
- Neonatal facilities were using NICE (National Institute for Health and Care Excellence) quality standards and guidance relating neonatal jaundice appropriately.
- A number of policies and leaflets we reviewed were out of date, with the review dates of the policies having already passed with no evidence of review having taken place. An example of this included the hand hygiene leaflet available for children and visitors. This was due for review in 2010. This meant staff did not have current documents to refer to and there was a risk procedures may not be correct.

Competent staff

- We were informed that clinical supervision had begun in March 2015. However, on reading the minutes provided to us to evidence this, it appeared to be a ward meeting. We saw no further evidence of active clinical supervision taking place.
- We were told that 70% of neonatal intensive care staff were Qualified in Specialty (QIS) trained.
- Staff appraisal rates varied considerably between different areas. The lowest appraisal rate was in Paediatric Nurse Management (50%) and the highest PDR rate was in PHDU (93%). On average, 76% of nursing staff working in children's services had an up to date appraisal.
- We were told that medical handovers with junior staff now took place in a 'sit down' environment. Staff told us that junior staff found this less stressful and this aided learning and information sharing related to patient care.
- Staff were concerned that they had not had specific training in caring for children and young people with mental health needs.

Patient outcomes

- The National Paediatric Diabetes Audit (published October 2014) indicated that there were proportionately fewer children (11.7%) with diabetes that had an HbA1c measurement of < 7.5% which was better than the England average (15.8%). However, the median HbA1c measurement was similar (71%) to the England average (69%). HbA1c is usually done from a fingertip blood test and measures diabetes management over two to three months. The recommended level for children is generally <58mmol/mol (7.5%).
- There were emergency readmissions after elective admission among children in the under one age group between October 2013 to September 2014. However no treatment speciality reported six or more readmissions.
- There were emergency readmissions after elective admission at Hull and East Yorkshire Hospitals NHS Trust among children in the one to 17 age group between October 2013 to September 2014. However, no treatment speciality reported six or more readmissions.
- Emergency readmission rates were higher than the England average for the under 1s, and lower for children aged 1-17.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (November 2013 to October 2014) was very similar to the England average for children with diabetes and asthma. However, the rate for children with epilepsy was 34.7% compared with 29.1% nationally.

Multidisciplinary working

- There were monthly leadership meetings in place, with senior staff invited bi-monthly to aid communication. However, this was limited to the staff working in the children and young people's service.
- There was also a monthly service meeting on the neonatal unit which consultants, specialist nurses and community nurses could attend to discuss issues and make decisions on matters affecting the service. Management staff were starting to roll this type of meeting out to include the other locations within children's services.
- Staff told us about delays in accessing physiotherapy support.
- Staff said there was no regular relationship or meeting structure in place with the local CAMHS service to assist in the discussion and care of children and young people with mental health concerns.
- There were issues with accessing dietetic and occupational therapy support. Dietetic services were on the risk register. There was a lack of capacity to input into MDTs and an inability to routinely review children on wards. Controls put in place to manage this included the dietetic department trying to recruit locums and dieticians prioritising workloads.
- We saw limited evidence of staff outside of the children's service being involved in the care provided to children and young people. We saw evidence that services found it difficult to access support, with no multidisciplinary ward rounds in place and no multidisciplinary notes.

Are services for children and young people caring?

Good

Children, young people, and the parents we spoke with were mainly positive about the care and communication they received from staff. Most parents spoke highly about the nursing staff and care provided. However, a number of parents did raise concerns about the communication from medical staff. We saw evidence which demonstrated parents and older children were involved in the planning of care and staff engaged with children and young people and families effectively.

We saw good examples of children and their families being involved in care, including the 'Say hello' diary for young siblings. Support and equipment was also provided for mothers on the neonatal unit to assist with breast-feeding. Emotional support was available via the chaplaincy service and a multi-faith prayer room.

Compassionate care

- For the Friends and family test all areas received good scores from ward130 (26 responses) and a score of 4.46 out of 5 to NICU (six responses) which scored 5/5.
- Parents we spoke with were mainly positive about their experiences. One parent told us that, 'The doctors and nurses are wonderful'.
- One young person we spoke with told us they felt the staff were caring and involved them in decisions about their care.
- The mother of a breastfeeding baby reported she had been well supported to breast feed and had been given all the equipment she needed to assist her in doing so.
- A parent we spoke with was sleeping in the room with their child. They reported the bed provided to them was comfortable and there was a bathroom available to use.
- The parent of one child told us how they were asked to leave a bay so that a private discussion could take place with the family of another child in the bay. This showed staff respected people's privacy.
- We saw and heard staff delivering kind and compassionate care to the children and young people in their care.
- We overheard confidential, clinical conversations taking place on the dedicated landline telephone in the HDU. We highlighted to staff as this constituted a breach of patient confidentiality.
- We had evidence that a young person's concerns raised with us were not acted upon by the ward staff.

Understanding and involvement of patients and those close to them

- Most parents we spoke with felt involved in their child's care and told us they were kept up to date by nursing staff.
- Seven parents we spoke with felt the medical staff did not always explain the care provided to their child. They also felt medical staff did not communicate with them effectively. This meant children, young people and their families were not always supported to understand the care and treatment choices available to them.

Services for children and young people

- Older children we spoke with felt they were kept updated about their care by staff and could be involved in making decisions as appropriate.
- None of the parents we spoke with had seen the written care plans for their child which may have limited involvement in planning of care.
- We saw the use of 'Say hello' diaries on the neonatal unit. These were used to engage young siblings of babies resident on the unit. The diaries explained the care a baby needed and encouraging the sibling to write, add drawings, or pictures to the diary in response.
- One young person told us they liked the fact that visiting hours on Ward 130 were between 8am to 8pm. This allowed their friends and family to visit at different times.

Emotional support

- A chaplaincy service was available for children and families.
- The chaplain visited children's services approximately twice per week.
- A multi-faith prayer room was available on the ground floor at the trust.
- There were bereavement services available to support families.

Are services for children and young people responsive?

Requires improvement

Facilities for children and young people and parents on the 13th floor remained unsuitable and did not provide a holistic caring environment. There was a lack of facilities for parents, such as seating and suitable parental areas, and there was no designated room for breaking bad news or discussing a child's care.

We saw limited evidence of clear pathways and policies being in place for the transition of young people into adult services. Service planning was limited whilst the move to the women's and children's hospital was on hold.

Service planning and delivery to meet the needs of local people

- The service had been planning a move to the Women and children's hospital following the February 2015 inspection. The management team did not know when the move to the Women and Children's Hospital would take place. Trust documentation acknowledged that the proposed move had been put on hold due to the recognised pressures within the adult medical pathway being risk assessed as a priority for the available capital resource.
- Management staff reported to us that there had been discussions about setting up a charity to fund the phase two development of children's services.
- The trust did recognise that the current physical split in children's services was not ideal. For example, staff on Acorn Ward had reported feeling isolated from the rest of the service.

Access and flow

- The trust was not achieving the 18 Weeks; the non-admitted patient pathway for medicine for the months February - April 2015 was delivering at 93 – 94%.
- The surgery 18 weeks admitted pathway showed an improving picture of 51.2% for February, 68.1% for March and 83.7% for April 2015.
- Staff raised concerns with us in regard to managing the transition of care for children and young people moving from children's services to adult services. Staff told us transitional care services were in place for some medical conditions, such as asthma and diabetes. However, we saw limited evidence of clear pathways and policies being in place for the transition of young people into adult services.
- Staff we spoke with gave different accounts of whether there was a transition policy was in place and we saw no evidence of this during out inspection.
- A discharge liaison team was in place to ensure that babies were discharged from the neonatal unit in a timely way. Staff described that there had previously been a 'bottleneck' in discharges. This showed the service had responded to problems with access and flow in this unit.
- A community team of specialist nurses was available to provide continuing care on discharge from the neonatal unit.
- Children and young people spent no more than six hours in PAU and, once seen by a clinician, a plan of care was put in place. We saw examples of this being clearly communicated to children and young people.

Services for children and young people

- We saw children and young people being assessed and treated in a timely manner.
- Staff told us that beds were sometimes moved from the Acorn Ward overnight for use in other areas of the trust and these were sometimes not replaced. We witnessed a surgical procedure being cancelled due to the lack of a bed being available in the Acorn Ward.
- We witnessed a nurse on HDU having great difficulty contacting a clinician in order to make a decision about discharging a child. We did not witness any medical staff reviewing the child prior to their discharge. This meant children who were fit for discharge may experience delays.
- The median length of stay was the same as the England average.

Meeting people's individual needs

- Staff told us that they had access to interpreter services on the ward for children who may not speak English as a first language.
- Staff explained that they tried to nurse male and female children and young people in separate bays from eight years of age upwards. We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow children to be segregated by gender.
- The facilities on the 13th floor had limited areas and services available for parents. Some children's rooms were isolated and there were a lack of specialist children's and family facilities available (such as comfortable seating or more beds for parents to use). This limited the service's ability to provide holistic, family centred care.
- There was a parent's room available on Ward 130, but there was no parent's room on the PHDU.
- Staff were concerned that they were not able to use two camp beds for parents, as they would block access to equipment.
- Parents told us they found the facilities to be poor, with uncomfortable seating, a lack of hot food and drink, and cramped conditions.
- A playroom was available in PAU for children and young people that were well enough to wait to see a doctor following triage.
- There was seating available for four parents in the neonatal sitting room with a small kitchen area.
- There were two 'rooming in' rooms available for parents in the neonatal unit. These contained two single beds, an armchair, a changing area, and space for cots. Staff explained that demand for these rooms was high and that they often had to 'juggle' things around to try and meet demand.
- A shower and toilet for parents was only available in one of the 'rooming in' rooms on the neonatal unit.
- Two further sleeping rooms were available for parents on the neonatal unit. Both had double beds and were ensuite. One of these rooms had a wet room, which was suitable for parents with physical disabilities.
- There was no specific room available to allow staff to break bad news to children and young people or parents.
- A schoolroom and teacher was available during term time on the ward. Children who were inpatients for five days or more could access schooling. We were told of a good example where the teaching staff at the hospital liaised with invigilators for a young person sitting their GCSE's.
- A wide choice of menu options was available for children and young people. However, portion sizes were small for older children. Staff said that they would provide a larger portion when demand allowed.
- We were told that food was not provided for parents staying with their children.
- There was an infant feeding and changing room available in the children's outpatient department. However, there was no curtain separating the feeding area from the changing area. This meant there could be a lack of privacy for the parents if both the infant feeding and changing areas were in use.
- The 2014 NHS National Children's Inpatient and Day Case Survey highlighted that the Trust had performed worse that other units in relation to parents and children not being actively involved in changes to the child's care. The Trust performed about the same as other NHS trust's in other areas of the survey.

Are services for children and young people well-led?

Requires improvement

We found that the service's strategic vision did not always match the wider vision of services as stated by the trust.

Services for children and young people

Many staff we spoke with could not articulate the trust's vision and values to us. A small number said they had been involved in the development of the values. There was a lack of a clear strategic vision within the service, beyond moving the children's services together onto one site in the Women and Children's hospital.

A risk register was in place, but this did not include some of the risks we identified during our inspection (for example, concerns regarding access to services and a safe environment for children with mental health needs). Many risks on the risk register had been present for some time and there was a lack of clear action or planning in place for many of the risks to be addressed.

The majority of staff we spoke with were happy with the leadership from their immediate management. Staff also said that senior members of the trust were visible and had visited the service. There had been improvements made in relation to bullying at the trust, and a majority of staff felt that this had improved. However, a minority of staff still felt that there was some way to go in order to a previous culture of bullying to be eradicated.

Vision and strategy for this service

- We found that the service's strategic vision did not always match the wider vision of services as stated by the trust. Many staff we spoke with could not articulate the trust's vision and values to us. A small number said they had been involved in the development of the values.
- The management team shared a vision for children's services to return to a single site going forward.
- Management staff were unaware 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. The trust had been under financial pressure and the funding that had been allocated to this project had been prioritised for other areas.

Governance, risk management and quality measurement

- There were regular governance meetings in place to discuss and consider risks within the directorate. We saw evidence of monthly reporting on risk and governance issues within the service.
- There was risk register in place that had 10 active risks for Children & Young People's services, one of which was classed as high and the rest were categorised as moderate or low. The high risk related to the shortage of paediatric surgeons and the non-compliance with the European working time directive.
- Many risks on the risk register had been present for some time and there was a lack of clear action or planning in place for how many of the risks would be addressed. For example, children having oncology treatments were nursed within cubicles that did not meet the NICE IOG (Improving Outcomes Guidance) which compromised privacy and dignity. The register stated that there were no controls possible to mitigate this. The register did not include some of the risks we identified during our inspection. For example, concerns regarding access to services and a safe environment for children with mental health needs. The service was also not always taking appropriate action to mitigate any such risks.
- Concerns relating to the lack of facilities available for parents and the suitability of facilities on the 13th floor were still outstanding. We found the trust had no timescale as to when phase two of the move for children's services to the Women and Children's Hospital would take place. We saw no evidence that the service had considered the risks posed to children and young people who had mental health needs and were being cared for on Ward 130. This meant care and treatment was not being provided in a safe way.

Leadership of service

- Many staff felt that senior staff were visible and spoke positively about their immediate line managers.
- Staff gave examples of senior staff and the chief executive visiting areas to speak with staff, children and young people and their families.

Culture within the service

- Most staff we spoke with were positive about the Trust and their experiences.
- Staff told us that they had been given the opportunity to attend a session on 'Professional and Cultural Transformation' that related to changes to the culture of the trust. Staff felt that this was a positive step.
- Four staff explained that a previous culture of bullying had greatly diminished.

- Three staff reflected that, although this had improved, there was still some work to be done to continue with that improvement.
- A member of the junior medical staff told us that there was a divide between medical and nursing staff and that communication could be a problem.
- Staff felt confident in their colleagues and reported good working relationships within their teams.

Outpatients and diagnostic imaging

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

Information about the service

Hull Royal Infirmary (HRI) provides outpatient services for a number of specialities including children's, women's health, surgical and medical, orthopaedics, chest and fracture clinics and ophthalmology. There were a total of 393,017 outpatient appointments at HRI between July 2013 and June 2014. The ratio of new appointments to review appointments was approximately 1:2. HRI had a did not attend rate for patients of 10%.

Surgical outpatient departments included neurology, vascular surgery, plastics, gastroenterology and colorectal surgical clinics. There was also a plastics trauma clinic which was a see and treat provision receiving both adult and child patients from accident and emergency and also from other hospitals.

The Trust's radiology services were mainly provided at the Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). The trust provided all types of imaging which included general and plain film x-rays, fluoroscopy which means the use of radiation where images are viewed on a television monitor during the examination, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, interventional radiological procedures and nuclear medicine.

The blood sciences department offered approximately 80 different tests. The laboratories were a regional reference centre for certain tests; this meant other laboratories referred tests to them. However, the trust did send samples externally to the haematological malignancy diagnostic service (HMDS).

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of

the service was requires improvement. The service was good for safety and caring. However, the responsive domain was rated as inadequate and the well led domain required improvement. There was insufficient evidence to rate effective. Diagnostic imaging was not inspected in February 2014.

We spoke with 41 patients and relatives/ carers using outpatients and diagnostic services and approximately 60 staff including; doctors, nursing staff, radiologists, non-clinical staff and managers. We visited medical, gynaecology, ophthalmology, dermatology and surgical outpatients as well as the radiology areas. Before our inspection, we reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Outpatients and diagnostic imaging

Summary of findings

The outpatients and diagnostic imaging service was judged as good overall. The service was rated as good for safety, caring and being well-led. Responsiveness was rated as requires improvement and the effective domain was inspected but not rated. Throughout our inspection we witnessed good care being given. Most patients were happy with the care they received.

Incidents were reported and managed appropriately. Patient areas were clean and infection prevention

and control procedures were adhered to. Records were almost always available for clinics. Staff knew their responsibilities within adult and children safeguarding. There were a small number of concerns noted regarding audit of records and vacant consultant histopathologist posts.

Staff had access to evidence based protocols and pathways. Internal and external audits of radiation regulations showed good compliance. Systems and processes were in place to monitor report and address any issues with patient outcomes. However there was little audit of waiting times within departments. Access to information was generally good for staff but patients reported some issues regarding accessing and timeliness of results. Turnaround for results times was acknowledged as an issue and there were

some mitigating actions in place to improve this situation. During our visit to the gynaecology outpatient department it was observed that women were undergoing flexible hysteroscopy without being asked for

written consent. This was raised as an urgent issue with the Trust and assurances were received that this

was addressed.

The trust had performed worse than the England average for the three waiting time measures for “all cancers” since April 2013. There were four reported breaches trust-wide of 52 weeks before completion of care pathways during January 2015. Improvements had been made to waiting times but there were still significant improvements needed, particularly with reviewing follow up patients. For cancer waiting times and diagnostic waiting times the trust was better than the England average.

Both staff and managers were clear about the vision and strategies for both the Trust and their own departments. Priorities, challenges and risks were well understood; there were clear governance structures and good progress was being made to improve services for patients and reduce waiting lists for both new and follow up patients. We found evidence of good local leadership and a positive culture of support, teamwork and innovation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated this service as good overall for safety, however there were a small number of concerns noted.

Incidents were reported and managed appropriately and actions and outcomes were disseminated to staff. Patient areas were clean and infection prevention and control procedures were adhered to. There was a concern regarding shared use of a clinic room for clean and dirty procedures in the surgical outpatient area. Patient waiting areas for the main x-ray areas and CT were small and cramped. Chairs were placed on the corridor in attempt to offer further seating for patients waiting for CT and waiting facilities for children were limited.

Decontamination and maintenance arrangements were in place for equipment. There was a replacement plan in place for ageing equipment in Radiology. Medicine management arrangements were in place. Records were almost always available for clinics and enough information was held electronically to see patients safely if notes were missing.

There was no evidence available to demonstrate that the quality of patient records or the use of radiological intervention patient safety checklists or WHO surgical checklists were audited. Although individual risk assessments did take place there were no written guidelines for staff in surgical outpatients regarding recovery of postoperative patients.

Staff knew their responsibilities with adult and children safeguarding, however there were some areas where training compliance needed to be improved. There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health.

Staffing establishments and skill mix were being reviewed at the time of our visit and departments were adequately staffed with few staffing issues reported. The main staffing concern was in relation to consultant vacancies in the Histopathology team. Five out of 13 posts were vacant and although there was some mitigation in place, this was adversely affecting reporting times.

Incidents

- There were 130 incidents reported across outpatients and diagnostic areas between December 2014 and March 2015. Of these 28 were attributable to outpatient departments (OPDs), two to medical physics, 16 to nuclear medicine and 84 were reported by Radiology. The main themes from the incidents were incidents relating to equipment issues & failure (14), extravasation (leakage of fluid from a vein) incidents (19) and issues with correct or incomplete documentation. The majority of incidents were low or no harm.
- There were six serious incidents report by this trust across all outpatient departments and locations. A root cause analysis was undertaken as part of incident investigations.
- The radiology and outpatient managers told us they encouraged a culture of open incident reporting across all areas and staff we spoke with confirmed they received appropriate feedback and reviewed learning outcomes from incident reports.
- Staff we spoke with across all departments were able to describe how they reported incidents and how they used 'Datix', (the hospital incident reporting system).
- Staff we spoke with told us that incidents were discussed at departmental meetings and at radiation protection supervisor (RPS) group meetings. Staff in outpatients told us where changes were needed action plans were put in place. There was a good learning environment within the clinics, staff felt well informed and were keen to improve practices from lessons learned. We looked at minutes which confirmed that incidents were discussed at the morning "huddle" in the eye department along with other relevant information from patient feedback and complaints.
- Staff in the eye clinic told us how infection control practices had changed as a result of an incident of an eye infection following a procedure 2-3 years ago. There had been no further incidences of infection since the new control measures had been introduced.
- The trust provided the radiology datix incident log 01/02/2014 to 31/03/2015 and we saw incidents were categorised with actions and feedback to staff along with completed dates.
- We also saw, from the quarterly RPS group meetings November 2014 and April 2015, radiology management team/ governance and strategy monthly meetings December 2014 to March 2015, non-clinical quality

committee January 2015 and the radiation protection advisers' annual report 2014 dated 01/04/2015, that radiation incidents were reported, reviewed and the learning outcomes identified and shared.

- The trust reported radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and responded to actions as determined by CQC. The trust provided information from two recent reported incidents 20/05/2014 and 19/01/2015 and we saw both incidents had been reviewed and the learning outcomes identified and shared. CQC had no concerns regarding the level or type of incidents reported.
- The blood sciences laboratory manager told us that all blood transfusion incidents were reported to SHOT (Serious Hazards of Transfusion) and SABRE (Serious Adverse Blood Reactions and Events) via an online reporting system. Incidents were investigated using root cause analysis and were discussed by the hospital transfusion team and the hospital transfusion committee.
- Incidents in the laboratories were recorded on the laboratory quality management system (Q-pulse), if the risk assessment showed that the risk rating was moderate or above then it would be entered onto the electronic trust incident reporting system (Datix).
- The manager also explained that anything which had an impact on a patient, such as blood samples needing to be taken again, would be rated as a moderate incident.
- A patient told us about an incident involving a lost tissue sample which resulted in a second biopsy having to be done. Staff in dermatology were able to recall this incident and were able to show us the systems and process implemented as a result of the investigation to prevent similar incidents happening in the future.
- The staff in surgical outpatients and plastics trauma clinic had a good understanding of the systems and policy to report incidents. Incidents were reported as they happened and staff felt they were encouraged to report.
- There were no 'never events' reported in 2014, (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- The sister from one department told us it was not so easy to share lessons across other outpatient areas following a restructure as the regular outpatient sisters' meeting was no longer a formal, regular occurrence.
- Student nurses praised the staff in the plastics area and the debriefing held following a critical incident.
- Staff understood their obligations with regard to duty of candour and were confident in the systems in place to ensure patients were fully informed of the circumstances which led to any incident resulting in moderate harm.

Cleanliness, infection control and hygiene

- The outpatient areas were visibly clean and records of daily cleaning were visible on the doors.
- All OPDs had adequate supplies of personal protective equipment (PPE), hand gel and liquid soap.
- Waste was appropriately segregated using different bins.
- We noted that instruments from outpatient theatres and from interventional procedures were sterilised on site at the local sterilising and decontamination unit and returned to the relevant departments in individual sterile packaging. There were no reported problems with supply of equipment.
- There were adequate hand washing facilities and posters prompting hand hygiene were displayed.
- We observed staff using good infection control practices and they told us there were sufficient supplies of PPE. Staff were observed to be bare below the elbows in accordance with Trust policy. Hand washing practice and use of PPE was observed to be carried out between patients, using the correct technique, PPE, used linen and other waste was seen to be disposed of correctly.
- The radiology departments appeared clean, tidy and uncluttered overall. Patient waiting, private changing and toilet areas were also generally clean and tidy.
- Radiology staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. We were told that room cleaning schedules were available in all areas. We saw these schedules were available and up to date in the areas we looked at. We saw a number of radiology staff using PPE appropriately throughout our visit, we also observed two members of staff not using PPE, whilst cleaning equipment. The manager dealt with this issue immediately when it was raised with them.
- We saw in one of the dirty utility rooms mops not stored correctly, the room was generally untidy and items were stored on the floor. This was dealt with immediately, when it was raised.

- Appropriate containers for disposing of clinical waste were available and in use across the departments. We saw one sharps box was not labelled correctly in one x-ray room and this was rectified immediately.
- The trust provided evidence of Patient-Led Assessments of the Care Environment for both outpatients and Radiology 2014. The assessment showed that the department passed on cleanliness, condition and appearance, cleaning schedules and hand hygiene.

Environment and equipment

- The trust kept an inventory of all of the imaging equipment in use across all locations (updated May 2015). The inventory also included the manufacturing and installation dates.
- The department's risk register included replacing ageing imaging equipment and upgrading of treatment room areas. The manager showed us that the risk registers were reviewed regularly and we saw the register was up to date.
- We also saw from the radiology management team/ governance and strategy monthly meetings December 2014 to March 2015, and non-clinical quality committee monthly meetings January 2015 that risk registers were monitored and reviewed at these meetings.
- During the course of our inspection we observed staff wearing specialised personal protective aprons and these were available for use within all radiation areas and on mobile equipment.
- Staff were seen wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- The manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- Patient waiting areas particularly for the main x-ray areas and CT were small and cramped. Chairs were placed on the corridor in an attempt to offer further seating for patients waiting for CT. Waiting facilities for children were limited. One parent we spoke with told us they were not happy about the lack of resources for children and the waiting area was, "not child friendly."
- At the time of our visit we saw a new interventional theatre suite had been commissioned and opened. The manager told us work was due to commence in the near future to upgrade a second interventional treatment room.
- Within the diagnostic laboratory services, we visited the microbiology specimen reception area in the main building and saw the physical environment appeared old and worn but functional.
- Facilities in the pathology block were well-maintained. The manager told us there had been good investment in pathology by the trust.
- The environment in surgical outpatients was observed to be in need of redecoration with chipped and peeling paint visible. It appeared that redecoration had commenced with chips and cracks having been filled.
- The surgical outpatients' area was used by a number of surgical specialities including plastics that held a trauma clinic there on a daily basis. Waiting areas were small and could be cramped at busy times. The children's waiting area was also very small. This area did have a door which could separate the children's area from the adult area however it was observed that this was open most of the time due to the room being very small, without external windows or ventilation. It was necessary to walk through the adult area to get to the children's room and there was little in the way of child friendly decoration or toys.
- There was a minor procedure room used for minor operations such as lumps and bumps and treatment of minor traumatic wounds.
- Space in the surgical department was clearly at a premium with some rooms serving a dual purpose. The use of space was not ideal as clean and dirty procedures or testing was carried out in a single room. For example patients were weighed and had observations recorded in a room which doubled as a dirty utility where urine testing was performed. Another room was used for vascular dressings but also contained stores. Half of the room was curtained off and used as an area where phlebotomy was undertaken as well as housing the drugs and other store cupboards.
- Staff in the surgical / plastics area told us if clinics became busy or overcrowded, they could usually negotiate the use of an extra room in the adjacent outpatient area.
- The eye and dermatology clinics were housed in a purpose built facility; the environment in these areas was spacious, airy, clean and well maintained. The single issue in these areas was the lack of air conditioning. Staff told us these areas could become very hot and uncomfortable during the summer

months. The theatre rooms in dermatology were reported as the most problematic room with regards to overheating. Fans were available to be used in the waiting areas when necessary.

- There was easy access to emergency resuscitation equipment in all outpatient & radiology areas. There was a dedicated resuscitation trolley in the theatre in the plastics trauma/ surgical outpatient clinic.
- We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis in all areas except one. The manager of the area where checks were not up to date dealt with this issue when it was brought to their attention.
- Anaphylaxis boxes were available, fully stocked and in date in treatment rooms and were easily accessible to staff.
- All OPDs had access to sufficient, appropriate equipment which was visibly clean.
- Technical equipment such as that used for phototherapy was regularly checked, calibrated and maintained.

Medicines

- Surgical outpatients kept limited medicines, largely analgesia and local anaesthetics. There was a suitable locked cupboard for the storage of medicines.
- We were told that the drug cupboard key was not held on the person of the nurse in charge but was kept "hidden". This was discussed with the OPD sister as being a potential security risk and it was agreed that the key should be held by the nurse in charge. The OPD sister actioned this immediately. A similar situation was found in the plastics treatment area where the key was held in a drawer. Again this was discussed and immediate action taken.
- Paper prescription pads were in use in outpatients. Although these were not individually recorded they did need to be ordered by an authorised individual. Prescriptions were audited and tracked by the pharmacy department and pads were locked away at the end of every clinic. In the gynaecology department we observed that prescription pads were locked in the controlled drug cupboard.
- We looked at drug fridges and medicine cupboards in relation to stock control and safety and security of keys and in medical outpatients and found checks and processes in place with good documentation to ensure fridge temperatures were checked regularly, keys were held securely and stock was in date.
- We looked at controlled drug registers in the gynaecology department and found that daily checks were maintained and records were completed correctly.
- In Radiology, medicines including controlled drugs were stored and checked correctly. The senior nurses were responsible for medicines and medicine key controls. We looked at a random sample of the medicines stored, including controlled drugs and found all of the items were in date.
- Medicines were stored at the appropriate temperature and checks were recorded.

Records

- Records used in the outpatient department were a mixture of scanned and electronic information which included test results, reports and paper records.
- The department was moving towards a paperless system "Lorenzo" but at the time of inspection historical records were kept in paper format while newer attendances and results were accessible through the IT system. Both the current and new systems allowed for ready access to patient information such as letters and diagnostic results.
- Paper records were available in the outpatient department. It was reported that very occasionally paper notes may not be available for example if needed by another clinic or department but recent electronic records were always available and these provided enough information to carry out a clinical assessment safely. The Trust estimated that clinic records were unavailable between 0% and 5% of the time. Nursing staff in all outpatient areas we visited confirmed that they received patient records in a timely manner
- Records were prepared a week ahead and were taken to the clinics the day before appointments. Notes were safely stored in a locked office until the start of the clinic.
- It was observed that the room used for preparing notes was sometimes used for patients which meant that computer screens had to be minimised to preserve confidentiality.
- The trust had a central electronic patient records database, the Reporting Information System (RIS). This system was used to record comprehensive details of

each patient's imaging history. The Trust also used the Picture Archiving and Communications System (PACS), a nationally recognised system to report and store patient images.

- MRI paper safety checklists were completed by the patient and checked and signed by the radiographer prior to the patient scan. The manager told us that the paper checklists were scanned onto the patient's individual electronic record on the RIS system and the paper copy was then safely destroyed.
- We looked at the MRI records of five patients at the HRI site. We saw that four records included the safety checklists completed by the patient. Three of these checklists had not been signed by the radiographer.
- The manager confirmed they would follow up on the recording issues observed with staff, and planned to audit records in the future. At the time of inspection records were not subject to regular audit.
- We saw patient personal information and medical records were managed safely and securely.

Safeguarding

- Due to alignment of outpatient specialities within different health groups and across both sites it was not possible to identify the entire outpatient and diagnostic services training data. However, where data was available there was a mixed picture regarding compliance with the 85% target for safeguarding training.
- Surgical outpatients showed that the qualified nursing staff group exceeded the 85% target for both adult and children's safeguarding training while health care assistants (HCAs) were at 75% compliance for both types of training. For general outpatients all staff groups were at over 90% compliance with children and adult safeguarding training.
- Within imaging medical, nursing and HCA staff groups were not compliant with safeguarding adult training with compliance at 74%, 81% and 67% respectively. Medical staff and HCA staff groups were also under target for children's safeguarding at 76% and 67% respectively.
- Other services such as pathology, dermatology and ophthalmology all showed good compliance with safeguarding training for both children and adults.
- Staff we spoke with in the surgical & plastics trauma outpatient areas confirmed they had received adult and children's safeguarding training and that this was required every 3 years. Training was provided via e-learning and provision of a resource pack.
- Staff demonstrated they understood safeguarding processes such as how to raise an alert. They could access policies and procedures or support from senior staff if needed.
- We observed patients reporting to the main reception areas were identified by name, DOB and GP and radiography staff confirmed these checks prior to treatment.

Mandatory training

- Mandatory training for all staff at Hull and East Yorkshire Trust covered seven subjects including the two safeguarding elements mentioned above. The other mandatory training topics were; fire, information governance, major incident, moving and handling and safety. The trust target for all mandatory training was 85%. Again there was a mixed picture regarding compliance with the remaining five subjects.
- For general and surgical outpatients there was good compliance with mandatory training across all topics with very few exceptions. HCAs were non-compliant with information governance and moving and handling and nursing staff were non-compliant with fire training. In general outpatients' scientific staff were non-compliant with fire and moving and handling training targets.
- Within imaging, medical, nursing and HCA staff groups were non-compliant with all training modules.
- Pathology, dermatology and ophthalmology all showed good compliance with the majority of mandatory training. In Ophthalmology the HCA and Medical staff groups had compliance between 80% and 82% missing the target of 85% while qualified nurses and scientific staff exceeded the target.
- Staff we spoke with reported they were up to date with mandatory training and that they were responsible for ensuring they kept up to date. Ward sisters received spread sheets from the training department to alert them when staff training was due.
- Mandatory training included e-learning modules and face to face events.

Assessing and responding to patient risk

Outpatients and diagnostic imaging

- The trust had an up to date policy for staff to follow on the use of ionising radiation including x-rays and radioactive substances which had been endorsed by the health and safety committee and trust directors. This policy included the procedures for staff and patient safety. The trust also had in place the written procedures required under the IR(ME)R.
- We saw local rules were produced and available for staff to follow in all of the imaging areas we visited. These were available on one of the mobile imaging machines we looked at in accordance with IR(ME)R.
- The managers and staff we spoke with confirmed that the local rules were available within all of the diagnostic imaging areas and attached to all of the mobile x-ray machines.
- The manager told us there were formal governance arrangements in place for all specialities to seek advice from the Radiation Protection Advisor (RPA). There were also informal working arrangements in place for advice and support.
- The RPA produced annual reports in compliance with relevant legislation and attended a range of governance meetings. They reported on all matters relating to radiation legislation and these were covered in their annual report for 2014.
- The RPAs also chaired the quarterly radiology protection supervisors' (RPS) group meetings to ensure that clinical radiation procedures and supporting activities in the trust were undertaken in compliance with ionising and non-ionising radiation legislation.
- The manager confirmed that all specialities had an appointed and trained RPS, whose role was to ensure that departmental equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There is a legal requirement to protect the public from unnecessary radiation exposure. This includes clear signage on all doors that enter into an 'x-ray controlled area'. These signs are warning signs and were in place throughout the department.
- The service used adapted versions of the world health organisation (WHO) surgical safety checklist when carrying out all interventional radiology procedures. They included the 'Safety Checklist for Radiological Interventional Procedures and the preoperative and operative safety checklists.'
- The nursing and radiography staff we spoke with confirmed that these checklists were used across the trust for all interventional radiological procedures. We saw a sample of these checklists and observed that they were completed correctly.
- Staff told us that an audit had been planned regarding use of the safety checklists but this had not been carried out by the time of our visit.
- The nurses told us that clinical observations such as temperature, pulse rate and blood pressures were monitored and recorded to detect any deterioration in the patient's condition prior to, during and following their interventional procedure.
- We saw signs displayed throughout the department alerting female patients to ensure that pregnancy information was brought to the attention of the staff. Staff also confirmed they completed checks to ensure women who may be pregnant informed them before exposure to radiation. This information was recorded in the patient's electronic records.
- In the outpatient departments we observed that consultation rooms did not have an emergency call system and staff shouted to raise an alarm if needed. Staff felt that this was an adequate process for raising an immediate alarm and worked well.
- The WHO checklist was used in the minor operations theatres situated in the plastics/ surgical area and the dermatology and eye outpatient clinics and the use of this checklist was audited. We observed that checklists in these areas were being used and completed fully in most instances. Actions were taken if any omissions were noted through the audit process.
- In the surgical outpatients department there was a small recovery area which was occasionally used when there was no available space on the surgical day unit for plastics trauma patients who had undergone a surgical procedure. The area accommodated one patient at a time in a comfortable chair. We were told that the criteria for accepting patients into this area were strict and the nurse in charge would make the decision as to whether the patient was suitable to be recovered in this area. There was no written guidance for categories of patients (level of risk) who could use this facility.
- Patients' physical observations were taken and recorded before during and after surgical procedures in the plastics / trauma theatre and during recovery when patients returned to the outpatient area. Early warning

scores were used to identify any patients whose condition may be deteriorating and there were procedures and protocols to be followed in case of emergency.

Radiology/Pathology and Nursing staffing

- Surgical outpatients did not have any nurse staffing vacancies at the time of inspection. There were enough nurses available for chaperoning when needed.
- The team leader felt that staffing levels were adequate and that although there was not an acuity tool in use, workload measurement exercises had been undertaken to review numbers of staff required. We were told that staffing levels were determined by the numbers of clinics and attending patients and the type of clinics running on particular days of the weeks. In the main the same clinics ran at the same time and on the same day each week. Clinics were therefore largely predictable in terms of staffing requirements. The exception to this was the plastics trauma clinic which catered for unplanned attendances and was therefore unpredictable in terms of numbers of patients and degree of trauma suffered. Numbers of patients and outcomes were monitored to help predict future demand for services and staffing.
- Skill mix varied across departments with some clinics having a higher proportion of trained nurses than others. There was an on-going workforce analysis and reconfiguration within the OPDs to review the numbers and skill mix of staff available.
- As the plastics clinic ran seven days, this had created a need for weekend staffing. This had been covered by substantive staff working additional hours or occasionally bank staff to increase numbers of staff where needed.
- Dermatology outpatients had two members of staff on long term sick and two on maternity leave. The manager told us she was able to cover the vacant shifts by people working extra hours, staff were working more flexibly and also she access to agency staff when needed.
- The trust provided details of the existing radiology staffing establishment and we saw from this information there were a number of vacancies in general radiography and MRI. These vacancies were being covered by locum radiographers at the time of our visit.
- Specialist nurse vacancies to cover the busy interventional radiology services were of particular concern. There was an existing establishment of approximately 25 whole time equivalent (WTE) specialist nurses within medical imaging. At the time of our visit there were 7.40 WTE vacancies and along with leave and sickness the manager acknowledged this was placing the service under pressure.
- Both the radiology manager and matron explained that discussions were on-going to explore the options to address the shortfall in specialist radiology nurses. The manager showed us that the current vacancies in nurses had been risk assessed and escalated onto the departments risk register. We also saw from the radiology management team/ governance and strategy monthly meetings that nurse recruitment was reviewed regularly.
- Radiology workforce planning was a standing agenda item of the radiology management team/ governance and strategy monthly meetings, December 2014 to March 2015. The minutes provided details on the work the service was undertaking to address its recruitment and selection of all staff
- The majority of the staff we spoke with told us that staff shortages were of concern but they were aware of the service recruitment plans. The interviews for a new PACs manager had been completed just before our visit but the appointment had not yet occurred.
- There were 135 lab staff in blood sciences and there were two vacancies at each of the bands, two, five and six. There were no reported problems with sickness in blood sciences.
- In cell pathology there had been recent problems with sickness, but this had been better than the trust target for the last two months. There was one vacancy among the technical staff in cell pathology.
- The manager told us there had been problems recruiting healthcare scientists at band 5 and band 6 and it had been difficult to ensure enough qualified staff on the out-of-hours rotas.

Medical staffing

- There were 26.55 WTE Radiologists with two vacancies. Both posts had been advertised but recruitment had not proved successful at the time of our visit.
- It was reported that the radiology service was able to maintain support to all the multidisciplinary team (MDT) specialities for patient related meetings where Radiologist input was needed.
- The pathology clinical lead position was vacant but each discipline within pathology also had a clinical lead.

Outpatients and diagnostic imaging

- There were five vacant Histopathologist posts out of an establishment of 13. To mitigate medical staff shortages, the service was outsourcing some consultant work such as routine, non-cancerous histology, for example gall bladders, tonsils, and GP skin biopsies. The department manager was also in the process of developing new and extended roles for scientific staff to cover some of the workload. All cancerous samples were processed in the laboratories on site and examined by the departmental consultants.
- Two cell pathology technical staff had been trained as advanced practitioners in histological dissection; this meant they could carry out some of the 'cut up' work which had previously only been carried out by Histopathologist, saving on consultant time. Two more laboratory staff were about to undertake the training to become advanced practitioners in histological dissection.
- There were two consultant vacancies in microbiology out of an establishment of five. The pathology manager told us these were being covered by medium to long term locum consultants.
- The recent move of plastics trauma from CHH to HRI to support the main trauma centre and split the elective and trauma patients was generally thought to be good idea. However, this had a negative effect on training and support as the medical team had been split between two sites. Staff reported that this was not a major concern but made it more difficult to provide and access the regular training sessions which had been in place prior to the move.
- Junior doctors reported that generally there was very good senior medical support, training and development.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the case of a major incident.
- The blood sciences laboratory manager told us the staff were always very responsive in the event of machine or IT system failure. They would revert to manual systems and phone results through to users. They said everyone had stayed late when this had last happened, in order to ensure that patients got their results.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Outpatient and diagnostic services were inspected for effectiveness but not rated. Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines. The 2014 annual RPA's report showed that internal and external audits of radiation regulations demonstrated good compliance.

Systems and processes were in place to monitor report and address any issues with patient outcomes such as Radiology reporting times.

There was generally good compliance with appraisals and training and evidence of good multidisciplinary team working. There were some seven day services and plans were in place to extend seven day working.

Access to information was generally good for staff but patients reported some issues regarding accessing and timeliness of results. Turnaround times for test results were acknowledged as an issue and there were some mitigating actions in place to improve this situation.

During our visit to the gynaecology outpatient department it was observed that women were undergoing flexible hysteroscopy without being asked for written consent. This was raised as an urgent issue with the Trust and action was taken.

Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on NICE and Royal College guidelines.
- The 2014 annual RPA's report showed that internal audits of compliance with radiation regulations showed good compliance. The report also highlighted that an external audit undertaken in October 2014 was satisfactory.
- It was also reported that audits throughout 2014 across a number of areas, on patient radiation doses, showed good compliance with local and national diagnostic reference levels. Diagnostic reference levels (DRLs) are used as an aid to optimisation in medical exposures.
- The trust had systems and processes in place to monitor its performance for reporting times for all specialities.

Outpatients and diagnostic imaging

- The trust provided audit evidence on the quality of the sonographer scans and reports.
- Outpatient departments had clear protocols to follow for relevant treatments such as phototherapy or for other interventional treatments or investigations.

Pain relief

- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.
- Pain relief was offered and provided to patients who had suffered skin trauma and who were waiting for surgical intervention. Medical staff were available to prescribe analgesia for pre-operative patients when needed although on occasions nurses had to go off department to get repeat analgesia prescribed.
- Analgesia was offered on arrival and mostly prescribed to be administered “as required”.

Patient outcomes

- The ratio of new appointments to review appointments was approximately 1:2 in comparison to the England average of 1:2.4 and CHH which had an average of 1:3.4. As a whole the Trust new to follow up rate was the same as the England average.
- HRI had a DNA rate of 10% in comparison to CHH 7% and the Trust and England average of 9%.
- Radiology used a monthly scorecard to report and monitor patient outcomes against breaches of the six week wait target for diagnostics and percentage of reporting at two, seven, 10 and 14 days post investigation.
- There were no breaches in the other specialities, during this period. The scorecard for February 2015 showed that this was an improving trend.
- Average percentages, across all specialities of reporting at two, seven, 10 and 14 days post investigation were 75%, 88%, 91% and 93% respectively at February 2015. CT reporting was 81%, 94%, 97% and 98% for this month. The main pressure being seen in plain film reporting with averages of 65%, 79%, 81% and 83%.
- There were reporting radiographers who had dedicated reporting time.
- The trust was outsourcing some of its radiology reporting to support capacity demands and improve reporting times. There were systems and processes in place for monitoring the quality, tracking and timings of outsourced radiology reporting.
- We saw evidence that the trust also audited the quality of the sonographer scans and reports.
- Quality management was well-developed within pathology, for example audits, incident reporting and performance monitoring.

Competent staff

- The majority of the staff we spoke with told us they received appraisals and they were up to date with their mandatory training.
- Some radiography staff reported that they had experienced difficulties in keeping up to date with their continuing professional development (CPD). This was mainly due to staffing shortfalls.
- 27 staff were trained and qualified to undertake the role of RPS across the service. There was evidence of up to date in house training for RPS at the quarterly meetings.
- The trust provided up to date evidence of certificates of competence for its RPAs.
- The blood sciences laboratory manager told us the haematology service worked closely with the transfusion nurse practitioners. They told us the nurses carried out competency assessments with staff on the wards, and trained staff to administer blood transfusions.
- The pathology managers had been on the ‘achieving breakthrough’ leadership programme.
- Within the fracture clinic nurses had been trained to be able to order plain x-rays.
- Staff we spoke with in outpatients had received an annual appraisal and felt this was a worthwhile process to identify and plan their development needs.
- Within all OPDs, staff told us that activities for learning and development were encouraged in line with individuals’ career plans.
- The Trust target for appraisals was 85% of staff to have had an appraisal within the last 12 months. Many of the areas within Radiology had achieved or exceeded this but there were some areas not achieving this level of appraisals, CT and MRI staff had achieved rates of 76.7% and 61.5% compliance, respectively.
- Across the health groups that had outpatients as part of their portfolio, achievement of appraisal rate targets was generally good for nursing, scientific and medical staff groups. There was also evident improvement from the

previous year's figures. There were however some areas where improvement was still needed. For example, within imaging the rates for CT and MRI staff appraisals were 76.7% and 61.5% respectively.
- Women's services had a practice development nurse who worked with staff to develop and implement guidance and provide training.
- There were processes in place for preceptorship of new staff and for mentoring student nurses.

Multidisciplinary working

- There was good evidence of MDT working. Specialist radiologists were part of the multi-disciplinary teams such as the gastrointestinal and breast MDTs. The radiology clinical lead told us that the service was able to maintain support to all of the MDT specialities.
- Cell pathology had good working relationships with other trust departments and pathology consultants attended MDT meetings where appropriate.
- The pathology manager told us they worked closely with infectious diseases and the infection control nurses. They also told us that there was a good dialogue with the local clinical commissioning group, especially relating to demand for pathology services.
- The one stop shop for skin trauma patients was a good example of effective MDT working across specialities and disciplines.
- Medical and nursing staff reported good multidisciplinary team working and good working relationships between speciality teams such as surgery and plastics.
- Specialist nurses ran clinics alongside consultant led clinics.

Seven-day services

- In the main, surgical outpatients were open 8.30am until 5pm weekdays. Some weekend and evening clinics were offered on an ad hoc basis mainly to help meet demand / waiting list initiatives. When additional clinics ran, they tended to be staffed by nursing and medical staff who had agreed to work additional hours over and above their contracted hours.
- The plastics trauma clinic did run seven days a week and was in the main staffed by nursing staff who wished to work additional hours.
- Although the trust was working towards seven day services, plans were not yet fully developed as to how this would be taken forward. The department was currently looking at capacity and demand to identify areas which most needed this expansion.
- Dermatology outpatients ran clinics from 7.30am until 8pm Mondays, Wednesdays and Fridays, to facilitate working people to access regular treatments without needing to take time off work, and Tuesdays and Thursdays 8am until 5pm. Waiting list initiative clinics had been held on Saturdays to reduce waiting lists on an ad hoc basis when needed. If clinics ran over the end of the working day, staff shared responsibility and took turns to stay behind. Time off in lieu was given back as necessary.
- The radiology and diagnostic services provided a range of services, some covering 24 hour, seven days a week and some within normal and or extended working hours Monday to Friday. On-call radiographers and radiologists provided cover for emergency X-ray and CT and MRI scanning outside of regular hours.
- The blood sciences laboratory was open 24 hours a day, seven days a week and ran a shift system. There were two staff from haematology and two staff from biochemistry working in the blood sciences laboratory out of hours.
- The cell pathology laboratory was open from 8am to 5pm Monday to Friday; the laboratory manager told us they were looking into options for working extended days and weekends. The laboratory manager said this would help get rid of 'peaks and troughs' in the work flow.
- There was a staff and union consultation on-going regarding proposed changes to contracts for those staff only contracted to working Monday to Friday to incorporate weekend working.

Access to information

- Records and diagnostic information was readily available through the OPD electronic records system, paper records were almost always available for clinics and tracking systems were in place.
- Staff told us that blood and x-ray results, letters and notes were usually available and records were prepared for clinics the day before. This gave the opportunity to identify if there was any missing information prior to the clinic and therefore be able to chase information needed.

- Staff had easy access to policies, procedures, news and training through the staff intranet.
- The trust had a system which allowed GPs to 'dial in' and listen to the patient's report. This system is due to be replaced in the near future to allow GP's access to see the reports electronically. The trust clinicians already accessed reports electronically.
- Discharge / consultation letters were dictated in the clinic and typed by the medical secretaries based at the HRI site. In the main clinic letters were typed within five working days. Administration staff told us that they were improving on this target and were working towards a two day target.
- The blood sciences laboratory manager told us all pathology results were available electronically and the laboratories did not generate many paper reports. They told us the laboratories generated paper reports for those users who wanted them, such as the outpatient department. The long term plan for the trust was to become paperless.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies and procedures in place for staff to follow in obtaining consent from patients receiving diagnostic procedures.
- The majority of general x-ray procedures were carried out using implied consent from the patient. The trusts consent procedures were followed when performing more complex or invasive radiological procedures and patient consent was part of the interventional radiology safety checks.
- During our visit to the gynaecology outpatient department it was observed that women were undergoing some procedures, including flexible hysteroscopy without being asked for written consent. Women were verbally asked for consent and this was recorded in the patient record. Flexible hysteroscopies were also carried out without use of the WHO surgical checklist.
- This issue was reported back immediately to senior executives at the Trust and the following actions were taken;
  - The information and requirement was shared with relevant staff and a patient consent form for women undergoing a hysteroscopy was developed and implemented with effect from the 27 May 2015.
  - The WHO checklist was also implemented for patients undergoing hysteroscopy in outpatient settings.
  - The implementation of the consent form and the WHO checklist will be monitored by the clinical leads and the Health Group triumvirate and performance will be reported to the Health Group Governance Committee
- Staff we spoke with told us they were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards and they all told us they had received training.
- Compliance with MCA and DoLS training was around 80% across all health groups who had outpatient areas as part of their portfolio. The 80% compliance level was also reflected across all relevant staff groups for outpatient and diagnostic areas however data was not disaggregated to outpatient specific areas.
- We observed very good practice in relation to consent in the eye department for patients undergoing vitreal injections and in relation to dermatology patients receiving treatments.

Are outpatient and diagnostic imaging services caring?

Good

We rated this service as good for caring. Throughout our inspection we witnessed good care being given. Patients were given emotional support and involved in treatment decisions.

Patients were happy with the care they received and found the service to be caring and compassionate. Most patients spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. Patients did not always report good experiences with secretaries and admin staff when raising queries about appointments.

Compassionate care

- We spoke with 41 patients and carers in the radiology and outpatient departments. The vast majority told us they were very happy with the services provided. There were no negative aspects about care highlighted to us.

Outpatients and diagnostic imaging

- During our inspection we saw patients being treated respectfully by all staff and staff were seen responding to patients' individual needs in a timely manner.
- People's privacy and dignity were respected.
- Patients reported that most of the time, staff made sure that patients were kept up to date with waiting times in clinic.
- We saw that patients and staff had a good rapport. Staff were friendly and made sure that patients were at ease. It was clear in some areas such as dermatology that patients were regular attenders and were seen to have developed good relationships with staff.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- Staff in surgical outpatients were particularly proactive in carrying out comfort rounds and ensuring patients who waited for long periods were offered drinks and food.
- A patient was observed waiting in a gown in the same area as other clothed patients in the surgical outpatient area.
- Friends and Family Test data for the month displayed in the outpatient departments indicated that out of 148 respondents, 93.2% would recommend the service and 14% were unlikely to recommend.
- Feedback from the listening event indicated that patients weren't always happy with staff who handled telephone enquiries about appointments. People who attended the listening event understood that callers may be cross and upset at times, however felt that sometimes staff were defensive and made excuses rather than just apologising and sorting the problem out. It was also felt that the secretaries acted as gatekeepers for consultant appointments and did not always return calls.
- Our observation of secretaries taking calls in the Dermatology outpatient area was that the calls were handled sensitively and in a caring manner.

Understanding and involvement of patients and those close to them

- All but one person we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and given time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care however they respected the decision of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted prior to radiology procedures and staff were attentive to the needs of the patients.
- There were no delays evident to patients care and treatment during the course of our visit to the radiology department.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were give the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups.
- There was formal counselling support available for patients who needed it.
- There was a bereavement service and dedicated bereavement officers who were available to support families needing to return to the hospital following the loss of a loved one.
- Staff in dermatology proactively encouraged patients regarding the importance of regular treatments and offered emotional support when necessary. Patients were contacted by phone if they missed an appointment to check whether everything was alright and to discuss on-going treatment.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated this service as requires improvement for responsiveness. The trust had performed worse than the England average for the three waiting time measures for

Outpatients and diagnostic imaging

"all cancers" since April 2013. There were four reported breaches of 52 weeks before completion of pathway in January 2015. The number of vacant histopathologist posts was impacting on the reporting times for biopsy samples.

The Trust was actively managing its waiting lists for both new and follow-up patients. The trust had implemented and was further developing initiatives to tackle backlogs and to meet the growing demand for their services. Improvements had been made to waiting times but there were still significant improvements needed, particularly with reviewing follow up patients. The trust had exceeded the target of 93% for; Cancer Waiting Times and Diagnostic waiting times for the trust were better than the England average.

A one stop plastics trauma service had been introduced to improve patient experience and flow and work was ongoing to improve patient flow through work to reduce or reuse clinic cancellations and to reduce the number of patients not attending appointments.

Staff worked to meet individual patients' needs and prevent complaints through the promotion of patient comfort when in the departments. Patients in the eye clinic did not always find it easy to navigate the environment or access food and drink.

Service planning and delivery to meet the needs of local people

- To meet the demands of the radiology and diagnostic services some services were provided over extended working hours Monday to Friday. To assist in managing demands for MRI, an extra eight to 12 days per month had been purchased and were being provided by an external mobile MRI service.
- To improve referral to treatment times and cancer waits and the performance team was rolling out training to all staff to facilitate a trust wide approach to improvement and sustainability.
- Some of the services developed to meet local need included; the development of a one stop shop for patients suffering from trauma which required plastics intervention, phlebotomy was provided in in the outpatient areas and nurses and some HCAs were trained to take blood to save patients having to go to other areas of the hospital for these tests.
- Outsourcing to local independent hospitals was also being used as a means of tackling demand for orthopaedic work.
- Capacity for urgent referrals was built in to clinic lists.
- The eye service had implemented and was further developing initiatives to tackle waiting list issues and to meet the growing demand for their service. The service had worked with A&E and had introduced a gold card for iritis patients to ensure they received timely urgent treatment when needed. Glaucoma nurse practitioners had been introduced and the service were hoping to introduce virtual clinics. There were systems in place to identify and see follow up patients in order of the longest waits first. Ophthalmic nurse practitioners had been given additional training so that they could undertake intra-vitreal injections for patients suffering with macular eye degeneration.
- A flexible job plan had been introduced for an ophthalmologist to pick up lists to improve the waiting list situation.

Access and flow

- The trust had performed worse than the England average for the three waiting time measures for "all cancers" since April 2013. (18 weeks Referral to Treatment Admitted, 18 weeks Referral to Treatment Non Admitted and 18 weeks Referral to Treatment Incomplete)
- However the trust had exceeded the target of 93% for; Cancer Waiting Times: Two Week Wait Standard and Cancer Waiting Times: Breast Symptom Two Week Wait Standard.
- Generally the follow up to new rate was similar to the England average.
- Diagnostic waiting times for the trust were better than the England average between September 2013 and November 2014.
- People waiting over six weeks fluctuated between 0.1% and 1.2% during this time period. There were 279 patients who had waited longer than 6 weeks for an investigation between April 2014 and February 2015. 163 patients had waited longer than six weeks for a CT scan and 116 patients had waited longer than 6 weeks for an MRI scan.
- The trust reported four breaches of the 52 week wait target for completed patient pathway. Each breach was investigated and the trust was taking appropriate action.

Outpatients and diagnostic imaging

- To reduce waiting lists, weekly performance meetings were held to monitor backlogs of appointments and progress against incremental monthly targets. Waiting list initiatives had demonstrated effectiveness against waiting times.
- There was recognition that there was still work to be done regarding validation and cleansing of data, a need to look at how rearranged appointments are monitored and recorded as well as a need to focus on reducing longest waits. Ophthalmology had commenced a retrospective review of longest waiting patients and those potentially lost to follow up
- Staff told us that there was capacity in clinics to see patients who were referred urgently. Patients arriving from outpatient clinics and walk in GP services for x-rays were accommodated into time slots within the department. Secretaries could also book extra appointments at the discretion of the consultant for urgent cases.
- Requests for diagnostic tests were sent to the laboratories electronically from wards and GP surgeries. Patient samples had a bar code which was scanned in on receipt. Results were also available electronically.
- Demand for diagnostic tests was increasing, for example pathology requests had increased by 9% in the previous year and vitamin D tests had gone up by 40%.
- Cell pathology had a backlog of unreported tests, which impacted on turnaround times for results. A patient told us they had waited up to six weeks for the results of biopsies. There were also a small number of complaints relating to delay in receiving results. Vacant consultant Histopathologist posts were the main cause of the backlog. The histology service outsourced some work and was developing the roles of non-medical staff to help mitigate the effect of the vacancies on workflow. The service generally met the targets for the breast screening programme and bowel cancer screening programme and 90% of cell pathology samples were 'turned around' within one working week.
- Outpatient appointments usually originated 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), the central call centre or by consultant to consultant referral. Currently 70% of referrals were on paper and 30% choose and book. The managers were working with the clinical commissioning groups (CCGs) to try and improve GP uptake of the use of Choose and Book.
- The plastics trauma clinic accepted patient referrals from accident and emergency and other hospitals. There were unpredictable patient numbers and degree of trauma attending this clinic and both adults and children were treated here. The plastics speciality offered a one stop shop to appropriate patients' who may be seen and assessed in the department. Surgical intervention requiring local anaesthetic could be carried out in the department which contained a small operating theatre. Patients' requiring more major intervention or general anaesthetic could be listed for surgery in the main theatre department for a procedure that day and were kept on the department until transfer to theatre. In the main post-operative patients would go to the surgical day unit until fully recovered and be discharged home. However, it was reported that lack of day surgery beds on occasion meant that patients returned to the outpatient department until recovered enough to be discharged home.
- The plastics team held a paediatric clinic between 9am and 10am every morning and were trialling separating the adult and paediatric flows.
- Follow up appointments for patients were made as patients left the department if this was to be within 6 weeks. This system had been shown to reduce clinic cancellations as it meant that medical staff availability could be checked prior to making the appointment.
- There was work ongoing to reduce the number of clinic cancellations and improve alternative use of clinic availability when cancellations did occur. For example doctors' study leave and annual leave had to be requested at least six weeks in advance so clinics could be rescheduled or covered more effectively and reduce the number of cancellations. The OPD sisters checked each clinic and Dr availability one week in advance to reduce the number of appointments being cancelled on the day of or day before appointment. During March 2015 there were 18 cancelled clinics trust-wide and 12 of these were able to be filled by other specialities.
- HRI had a DNA rate of 10% in comparison to CHH 7% and the Trust and England average of 9%.

- The DNA rates varied across specialities and the trust has taken various actions to improve this. For example there is a texting reminder service in place for patients who have chosen this option.
- It was reported that clinics did overrun on occasion, particularly vascular clinics due to the nature of the patients dressings required or due to extra "urgent" appointments being added to the list. We were told that on average the vascular clinics over ran by 30-45 minutes.
- Other clinics such as dermatology and eyes also overran and there were escalation plans in place if times were prolonged. There were no audits in place for auditing clinic start and finish times or regarding the length of time patients were in the departments, in most of the areas we visited. We were told that eye clinics and the respiratory clinic did audit waiting time.

Meeting people's individual needs

- Staff told us they reviewed patients' records prior to appointment to screen for more vulnerable patients - for example, people with learning disabilities, dementia or more frail patients.
- Known dementia patients' records were marked with a blue butterfly to alert staff to the need for extra care needs such as time and space. New patients identified as having dementia had their records marked in the same way to alert the other services involved in the patients' pathway, such as radiology / diagnostics, pre-assessment or an admitting ward.
- There was a dementia link nurse available to staff for advice and support if needed.
- Patients with learning disabilities were encouraged to phone the department ahead of their appointment if possible and receptionists would make sure their appointments were fast tracked if necessary and ensure extra help was offered on arrival.
- Vulnerable patients could be offered first or last appointments if extra time was needed or could be provided with a room to wait in if waiting in the main area was likely to cause distress. Staff were aware of Learning Disability (LD) passports.
- Nurses were available and present throughout consultations where needed; to welcome, chaperone, ensure privacy and dignity and provide assistance where required.
- Facilities for children attending the plastics clinic were limited. The clinic was trialling the separation of children and adult flows.
- Paediatric nurses were provided by the Acorn ward to care for children when they were in the surgical outpatient department and to manage their admission to the ward when needed. The move of the paediatric clinic from the Acorn ward to outpatients had reduced the delays experienced by children waiting for dressing changes. The eye department had a registered paediatric nurse as part of their team and ran a separate clinic for children with its own waiting area.
- Staff were able to provide patients with hot drinks and biscuits if waiting times were going to be very long. There was access to drinking water.
- Interpreting services were available for patients on request and these services were available at the main receptions and through appointment bookings. Staff told us they were aware of the services available and knew what procedures to follow to book interpreters. There were also services for people who were deaf and used sign language. Leaflets and posters were seen to provide this information for patients.
- Radiology staff were able to describe how they cared for patients with memory impairments and learning disabilities and they would fast track patients through the departments to reduce waiting times for these patients whenever possible.
- Patients reported a lack of responsiveness in some areas. For example, that there was some inconsistency in the process to access results, sometimes patients received these at a follow up clinic and sometimes they had to go back to the GP. Patients told us that systems regarding appointments seemed inconsistent at times with appointments not received or sent with misinformation. For example, two patients told us they had been sent to the wrong clinic.
- Patients in the eye services department told us that they got bored in departments when they were attending for multiple treatments or investigations. Not all areas had TVs. Patients also told us signage to the eye departments could be improved and volunteers would be a helpful addition to help patients find their way around. We observed that some patients were struggling to find rooms and no-one appeared to be available to help.
- Patients were concerned if they left to go to the cafe that they would miss their slot. A partially sighted patient

told us he was a regular visitor and he needed additional help to access food and drink and find rooms but this was not offered. Feedback regarding Drs and nurses was otherwise very positive.
- The dermatology department offered private washing / showering facilities for patients who needed them following treatments.
- Quiet rooms were available in outpatients for staff to use when delivering bad news and for patients who were distressed.
- In the newer buildings doors on treatment rooms were lockable and were used to maintain patients' privacy and dignity.
- During the visit we saw inpatients left waiting on the corridor to be x-rayed/scanned with their nurse escorts. This raised issues of privacy and dignity and on speaking with the manager they and the staff were aware of and acknowledged that waiting space for all patients was an issue.
- A range of information leaflets were available to patients and this information was also available on the trusts website.

Learning from complaints and concerns

- There were 193 complaints recorded by outpatients between April 2014 and March 2015 only 34 of these directly related to outpatients and diagnostic services. Themes from outpatient complaints included; consultant attitude and difficulties with appointments such as; long waits, cancellations or having to chase appointments. Complaints regarding x-ray or diagnostics were mainly to do with waiting for results and potentially missed or unreported fractures.
- The manager told us that the service had within the last 12 months provided staff with customer care training to assist staff with reducing and managing complaints and improve customer satisfaction.
- The manager told us that complaints and compliments were discussed through the governance structures. Staff we spoke with confirmed that learning from complaints was discussed at team meetings.
- Staff in a number of departments told us that they tried to tackle concerns before they became a big issue and had learnt from historical complaints that waiting times, lack of food and drink and lack of explanation regarding delays were the most frequent causes of complaints.
- Information about how to access the PALS (patient advice and liaison service) or make a complaint was available within waiting areas.

Are outpatient and diagnostic imaging services well-led?

Good

We rated this service as good for well-led. Both staff and managers were clear about the vision and strategies for both the Trust and their own departments. Priorities, challenges and risks were well understood and good progress was being made against targets to improve services for patients and reduce waiting lists for both new and follow up patients.

There were clear governance structures and clearly defined reporting structures in compliance with ionising and non-ionising regulations. Risks were clearly identified and mitigating actions were put in place.

We found evidence of good local leadership and a positive culture of support, teamwork and innovation. Not all staff were aware of or felt involved with the work of the outpatient transformation board.

Vision and strategy for this service

- There had been a recent management reorganisation to align the speciality clinics with the four core health groups. For example the surgical clinics were managed from the surgical health group. This meant there was not a single management structure or identified individual responsible for the whole of outpatients.
- Despite this there was clear understanding among managers and staff that their service vision incorporated addressing capacity and demand issues, improving referral to treatment times while maintaining follow up appointments and treatments, reducing DNA rates and using resources more effectively and efficiently to achieve cost efficiencies.
- There was a recognition that there had been particular problems with following up patients with long term, chronic conditions and there were plans & processes in place to address backlogs, long waits and (within eye services) to identify any patients who were potentially lost to follow up due to historical long waiting times.

- There was an OPD transformation group to bring together four different ways of working within the health groups. The core management team members we spoke with told us that it had been difficult getting people to the transformation board and that the group had not met for some time. It was generally felt it was difficult to maintain the momentum of the transformation work and an identified lead was needed to re-launch the process and engage the workforce in sustainable progress.
- There was little awareness of the work of the outpatient transformation group among staff and staff expressed a wish to be involved with this work but had not been invited to take part as yet.
- The radiology staff we spoke with were aware of the trust vision and strategy and had an imaging and medical physics division forward plan – 2015/16 onwards which outlined the priority objectives and detailed the specific actions that the division is taking to address its current and anticipated quality priorities, performance issues and the outputs from its specialties' clinical service strategies

Governance, risk management and quality measurement

- There were governance structures and clearly defined reporting structures in compliance with ionising and non-ionising regulations. The reporting structure included local and operational meetings, quarterly RPS group meetings, radiology management team/ governance and strategy monthly meetings, health group quality governance assurance committee and non-clinical quality committee. The non-clinical quality committee was a formal sub-committee of the Executive Management Committee (EMC).
- Imaging departmental risk registers were up to date. The risk registers were regularly reviewed by the manager and at the radiology management team/ governance and strategy meetings and non-clinical quality committee.
- We saw from the minutes of the multi-disciplinary meetings radiology discrepancies were reviewed in accordance with the Royal College of Radiology (RCR) Standards. The purpose of these reviews was to facilitate collective learning from radiology discrepancies and errors with a view to improving patient safety.
- Following peer review at the radiology discrepancy meeting a process had been developed for staff to follow when a grade 2 or 3 error was identified. This involved reporting onto the datix system and following the duty of candour processes. The peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.
- We saw from the December 2014 radiology management team/governance and strategy meeting that the trust had identified inpatient plain film reporting had become an issue. 231 delayed reporting incidents were reported trust-wide from 01/01/2014 – 31/12/2014. The 231 cases had been reviewed and there were two delayed diagnosis incidents identified. Both cases had been medically reviewed and the trust took actions to address both incidents in accordance with their governance procedures.
- The trust also reported a further 91 incidents reported from 01/01/2015 – 21/05/15. The review of these incidents did not identify any further incidents of delayed diagnosis.
- The reporting capacity for plain x-rays was inadequate to cope with the demand hence a plain film strategy paper had been produced in January 2015. Outsourcing of some plain film reporting had been undertaken to alleviate the problems identified. There were mechanisms in place to monitor the quality of externally reported x-rays.
- The pathology directorate was part of the clinical support health group. There was a governance team within the health group.
- The blood sciences laboratory manager told us the biochemistry, haematology and microbiology laboratories had been inspected by Clinical Pathology Accreditation (CPA) in March 2015 and had achieved full compliance. CPA assesses and declares the competence of medical laboratories. This provided independent assurance that the accredited laboratory services were meeting current standards for quality and risk management.
- We were told the cell pathology service was the "first histology laboratory in the country to get ISO 15189." This meant the laboratory was accredited under the new UKAS (United Kingdom Accreditation Service) standards. UKAS is currently managing the transition of all CPA accredited laboratories to UKAS accreditation to

the internationally recognised standard ISO 15189:2012, Medical Laboratories – particular requirements for quality, competence. The immunology service was awaiting inspection by UKAS.
- The mortuary and cell pathology service had recently been inspected and accredited by the Human Tissue Authority.
- The shortfall in histopathologist capacity was on the risk register. Turnaround times for cell pathology were also on the risk register as a moderate risk.
- Quality management was well-developed within pathology, for example audits, incident reporting and performance monitoring. Pathology was keen to share their quality management skills and knowledge with other areas of the trust.
- There were risk registers in place for each health group and risk was discussed at team meetings. Staff understood how to highlight risks through governance structures and processes.
- Outpatient department teams collected data regarding activity and patient flow and analysis of patient activity and flow data was used to inform planning of clinics and use of staff resources.

Leadership of service

- Staff reported good local support and leadership and all departments we visited reported that their manager was approachable and they experienced good team work.
- Visibility and accessibility of matrons was reported as being good in some departments such as women's services, eyes and dermatology.
- Two of the sisters reported that monthly 1:1 meetings had recently been introduced.
- All of the staff we spoke with were aware of the changes at trust level and could access the relevant information from the intranet.
- Staff were overall very positive about the recent and future management of medical imaging. It was felt that the present management structure was supportive and the direction in which it was going was clear.
- The core management team recognised that were many areas of good practice and innovation and passion for delivering good quality seven day services. They also recognised that some current seven day services had been operating on goodwill from staff working extra hours or voluntarily adjusting their shift patterns to accommodate the new services. The team understood they needed to share the good practice and instil the same vision and passion across all areas.
- Both staff and managers we talked to were highly motivated to provide good quality services.
- There were recent changes to the divisional structure for the OPD areas with new managers. Although it was recognised that change and uncertainty does affect staff morale we were told that there was some unhappiness with how the changes were being managed and a feeling that communication could be improved.
- Recent divisional restructure had resulted in the loss of the formal OPD sisters' monthly meeting but the surgical sister told us that informal meetings were still in place for sharing of governance information, good practice and peer support, whenever possible.
- The Chief Executive Officer (CEO) retained overall responsibility for ensuring that systems were in place to manage risks arising out of the use of ionising and non-ionising radiations. Radiology services across the trust were managed by a Radiology Manager, supported by a deputy and a number of speciality section leaders. Staffing for imaging services covered both hospitals and a number of small satellite units.
- Pathology services across the trust were managed by a Pathology Manager supported by a number of specialist laboratory managers. The clinical lead post for pathology was vacant at the time of the visit.

Culture within the service

- Staff we spoke with in pathology reported good teamwork and staff were extremely dedicated and responds well to adversity.
- Radiology staff we spoke with had a positive, optimistic and confident view about the work within the department and direction of the service as a whole.
- There was a can do attitude from the staff we spoke with and they were loyal to the trust
- Within outpatients most areas had positive staff morale, staff felt they were encouraged to report incidents.
- Staff reported they were actively encouraged to undertake learning and development and were helped to develop their careers if they wished.
- Staff and managers told us there was a lot of goodwill towards providing seven day services and some staff worked extra to ensure evening and weekend clinics could run.

Outpatients and diagnostic imaging

- All staff were aware of the pressures on their services particularly in relation to reducing waiting lists and ensuring patients received timely follow up appointments and they could contribute ideas to their local managers for improving services for their patients.
- Staff in the dermatology department felt there was an excellent team approach including administration staff, nurses and medical staff and other support staff which had resulted in the disappearance of the waiting list and backlog of patient appointments.

Public and staff engagement

- At the time of the inspection a formal consultation had started regarding staffing and sustainability of the outpatient services including seven day provision.
- Staff did not feel their opinions were valued and they were not as involved as they would like to be in the recent changes and generation of further proposals for service developments.
- The performance team were rolling out an awareness programme for all staff to understand the challenges the trust faced regarding referral to treatment times with the aim of engaging them in contributing to improving processes and achievement of targets.
- Within the eye services the managers and clinicians had worked effectively together to improve the performance in their department.
- The trust was engaged with national patient surveys and friends and family test and had demonstrated improvements made towards addressing patient and public concerns through their waiting list initiative work and improvements made.
- Recommendations from local patient feedback through a recent Health watch survey were reflected in the actions the Trust was taking to improve its performance generally and with specific regard to patient using eye services. The eye department staff told us some changes made as a result of patients' feedback. These included: TVs for the department, installation of a ramp, rearrangement of chairs to improve accessibility for wheelchair users and the opening of a café in the adjoining part of the building.

Innovation, improvement and sustainability

- Six of the 86 GP surgeries who used the laboratories were trialling a new test requesting system (Cyber lab). The IT systems in local GP surgeries were not compatible with the hospital systems and this caused problems. The new system would provide the requester and the laboratory with improved clinical safety and more reliable and accurate test requesting and result reporting. There was a dedicated pathology IT team who were visiting GP practices and installing the new system.
- Pathology had recently appointed an 'innovation adoption manager' who went out to speak with service users and ask what ideas or problems pathology can help them with. This had led to good engagement with clinical users. For example, pathology was working with A&E and GPs on their pathways for taking pathology samples.
- Radiology "Backtrack Pioneer Team" undertook a project which improved patient transfers to and from the Radiology Department, created a more pleasant environment for patients by clearing corridor space and creating a working space for the portering team.
- Other examples of innovation in radiology included development of a handover form and contribution to the proposals for the establishment of a pathway for investigation and management of knee problems in primary care.
- The plastics trauma team had developed a one stop service for patients to attend the department and be immediately listed for theatre when appropriate.
- Implementation of the Lorenzo system will facilitate easier access to patient results for GPs.
- The development of extended roles and the exploration of technical apprenticeships along with the glaucoma monitoring scheme and the introduction of nurse practitioners and virtual clinics were improving the management of increasing demand as well as dealing with historical waiting lists.

Outstanding practice and areas for improvement

Outstanding practice

- The plastics trauma team, based in outpatients, had developed a one stop service for patients to attend the department and be immediately listed for theatre when appropriate.
- In relation to Radiology discrepancies we saw that the peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.

Areas for improvement

Action the hospital MUST take to improve

- The hospital must address the breaches to the national targets for A & E and referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard to eye services and longest waits.
- The hospital must ensure there is a sustainable action plan to improve the reporting performance of histopathologist service.
- The hospital must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the elderly care wards, consultant and nursing cover within A & E; histopathologists, echocardiography teams and surgical wards.
- The hospital must ensure that all incidents are investigated in a timely manner, that lessons are learnt and that duty of candour requirements are effectively acted upon and audited.
- The hospital must ensure that there is a policy and procedures in place to ensure that there is effective transition for young people to adult services
- The trust hospital ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.
- The hospital must ensure appropriate arrangements are in place to respond to major trauma and incidents within ED.
- The hospital must ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.
- The hospital must take further steps to improve the facilities for children, young people and parents on the 13th floor.
- The hospital must take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, and that there is an appropriate "safe bed space" for the use of children and young people with mental health needs.
- The hospital must ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.
- The hospital must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the hospital must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.
- The hospital must ensure that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance
- The trust must ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014).

Outstanding practice and areas for improvement

- The hospital must review its patient pathways and patient flow through services to ensure:
- The plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management
- the seating area on the elderly assessment unit is not used for beds
- plans for dealing with extra capacity are reviewed including the "reverse boarding" policy.
- internal patient transfers take place in accordance with trust policy and reduce the number of patient bed moves 'out of hours' unless for clinical reasons
- more timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.
- The hospital must ensure use of best practice guidance, such as the "Safer steps to surgery" checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- The hospital must ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients.
- The hospital must review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres

Action the trust SHOULD take to improve services at HRI

Urgent and Emergency care

- The trust should continue to audit and monitor the effectiveness of the minors self-check-in system in the A & E department
- The Trust should record and monitor daily temperatures of fridges used for storage of medicines within A & E
- The trust should ensure the emergency department adheres to hygiene procedures.
- The trust should ensure that information is always recorded in A&E about children in the same households as adults with risk taking behaviours or other vulnerabilities so that they could be brought to the attention of paediatric liaison services.
- The trust should ensure that all relevant staff receive level 3 child safeguarding training especially within the A&E department.

Medical Care

- The trust should ensure that staff are submitting reportable incidents in line with trust policy
- The trust should ensure that systems are improved so that investigations into serious incidents are completed in a responsive and timely way.
- The trust should ensure that all patient interactions are recorded in patient's records accurately and in a timely way.
- The trust should ensure that labelling of clean equipment, across all wards, is consistent.
- The trust should ensure that there is adequate equipment for dependant patients within the ambulatory care unit.
- The trust should take steps to ensure that all staff groups meet the trust target for mandatory training.

Maternity

- The trust should ensure they continue to work towards the National birth to midwife ratio of 1:28.
- The trust should ensure they continue to work towards the Royal College of Obstetricians & Gynaecologists (RCOG) "Setting standards to improve women's health" "Good practice No.10 January 2010" Hours of consultant presence on the labour ward; 168 hours for units with 5000 to 6000 births.

Children and young peoples' services

- The trust should ensure all named professionals for safeguarding children have access to Level 3 and 4 training as outlined in the intercollegiate document.
- The trust should ensure that trust policies and information leaflets are current and reviewed within the appropriate timescales.
- The trust should ensure that paediatric care records are legible and fully completed. Moreover individualised care plans should be in place to address each child's needs. Additionally the trust should ensure that records are stored confidentially.
- The trust should address the shortage of consultant paediatric surgeons.

Outstanding practice and areas for improvement

- The trust should ensure the sustainability of the paediatric surgeons' rota, occupational therapy and dietetic support for children and young people.

Outpatients and Diagnostics

- The trust should review its programme of audit for outpatient and imaging departments to include; monitor the quality and accuracy of patient waiting times, cancelled clinics and appointments and take action to improve cancellations by the hospital.

The trust should review the use of the treatment room for phlebotomy and vascular leg ulcers, in the surgical outpatient area to provide separate rooms for clean and dirty procedures if possible. And provide assurance that adequate infection control standards are maintained

- The trust should ensure all areas but particularly the imaging department should continue to take action to improve compliance with mandatory training and appraisals.
- The trust should develop written guidance / policy for the recovery of patients in the surgical / plastics outpatient area.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Care and treatment was not always provided in a safe way for patients. The provider must: 1. ensure that planning and delivering care always reflects published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice specifically in relation to: breaches to the national targets for A & E; lack of compliance with the guidance issued by the College of Emergency Medicine; breaches to the referral-to-treatment times with particular regard to eye services and longest waits. Regulation 12(1) 2. review all incidents in a timely manner and ensure shared learning Regulation 12(2)(b) 3. put in place policies and procedures to ensure that there is effective transition for young people to adult services Regulation 12(2)(i) 4. take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, Regulation 12(2)(a) 5. ensure appropriate arrangements are in place to respond to major trauma and incidents within ED.

This section is primarily information for the provider

Requirement notices

Regulation 12(1)

6. ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.

Regulation 12(2)(e)

7. take further steps to improve the facilities for children, young people and parents on the 13th floor of HRI.

Regulation 12(2)(d)

8. ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.

Regulation 12(2)(g)

9. review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres

Regulation 12(2)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. The provider must:

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and ensure compliance with the regulations. The provider must: 1. Ensure the use of best practice guidance, such as the "Five steps to safer surgery" checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
	1. ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the: · elderly care wards, · consultant and nursing cover within A & E, · histopathologists, · echocardiography teams and · surgical wards. Regulation 18(1) 2. ensure that appropriate support is in place to develop staff specifically sustaining the Trust's work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014) Regulation 18(2)(a)

This section is primarily information for the provider

Requirement notices

Regulation 17 (2) (b)

2. Ensure there is a sustainable action plan to improve the reporting performance of histopathology service.

Regulation 17(2)(a)

3. Ensure incidents and duty of candour requirements are effectively acted upon and audited

Regulation 17(2)(a)

4. Ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.

Regulation 17(1) & (2)(a)

5. Review its patient pathways and patient flow through services to ensure:

· The plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management

· The seating area on the elderly assessment unit is not used for beds

· Plans for dealing with extra capacity are reviewed including the "reverse boarding" policy.

· internal patient transfers take place in accordance with trust policy and reduce the number

· of patient bed moves 'out of hours' unless for clinical reasons

· more timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Requirement notices

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.

Patients were not always treated with dignity and respect. The provider must:

1. The provider must ensure that patients' privacy and dignity is maintained when being cared for specifically that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance.

Regulation 10(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs.

The nutritional and hydration needs of patients were not always met. The provider must:

1. ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.

Regulation 14(1), (4)(a) & (4)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Care and treatment of service users was not always provided with the consent of the relevant person. The provider must:

1. ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients.

Regulation 11(1)