

# Hull and East Yorkshire Hospitals NHS Trust

## Quality Report

Anlaby Road  
Hull  
HU3 2JZ  
Tel: 01482 875875  
Website: [www.hey.nhs.uk](http://www.hey.nhs.uk)

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

## Ratings

### Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

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

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

Our key findings were as follows:

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

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

We saw several areas of outstanding practice including:

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

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

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

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

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

- Continues to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.

- It takes further steps to improve the facilities for young people on the 13th floor of HRI.

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

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

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## Background to Hull and East Yorkshire Hospitals NHS Trust

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

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

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

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

Deprivation, Hull was ranked as the third most deprived of all local authorities in England. The East Riding of Yorkshire was significantly better and was ranked the 195th most deprived local authority in England.

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

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

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

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

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Castle Hill Hospital was inspected in June 2013 and found in breach of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2010: Regulation 13 (medication) In October 2013, two further breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding).

## Our inspection team

Our inspection team was led by:

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

**Head of Hospital Inspections Julie Walton:** Care Quality Commission

The inspection team consisted of two inspection managers, 18 CQC Inspectors and 24 specialists

including; an A&E doctor and nurse, a critical care doctor and nurse, two end of life nurses, a maternity doctor and midwife, a medical doctor and nurses, an outpatient doctor and nurse, a paediatric doctor and nurse, a surgery doctor and nurse, radiographer, a junior doctor, two student nurses and three trust-wide specialists.

## How we carried out this inspection

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

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

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

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

We inspected all eight core services at HRI and the five that were provided at CHH. We also inspected the minor

injuries service operated by the trust at the East Riding Community Hospital and outpatient services at the Westbourne NHS Centre. We did not visit any outpatient services which operated in other locations. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

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

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

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



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

## What people who use the trust's services say

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

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

In the national Cancer Patient Experience Survey 2013/14, the trust was in the bottom 20% of trusts for six of the 34

indicators, four of which related to communication. The trust was in the top 20% of trusts for one indicator (which also related to communication): patients being told that they could be given free prescriptions.

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

## Facts and data about this trust

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

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

The medical staff skill mix had similar percentages to the England average with 37% being consultants compared

with 39% nationally; 5% were middle career compared with 9% nationally; specialist registrars were 40% compared with 38% nationally and junior doctors were at 18% compared with 15% nationally.

The financial data for 2015/16 included:

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

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


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

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



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## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>We rated this trust as 'Requires improvement' for safe in 2015. Whilst there had been improvements in some areas the rating remained as 'Requires improvement' because:</p> <ul style="list-style-type: none"><li>• Staff were not always assessing and responding appropriately to patient risk. This included not responding effectively when using early warning score systems to identify deterioration in a patient's condition. The trust was aware of this and was putting actions in place to improve this.</li><li>• In addition, falls and dementia risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in some patient records, and we also found poor compliance with the completion of fluid balance charts.</li><li>• From observations the five steps to safer surgery checklist process was not embedded as a routine part of clinical roles.</li><li>• Nurse staffing shortages were evident across the majority of medical and surgical wards and the trust's safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators. The maternity service did not collect data and therefore could not provide assurance that women received one to one care in labour. There were also some gaps within the medical staffing.</li><li>• We found gaps and errors in the recording of and signing for medicines administration and in the monitoring of checks of controlled drugs. Since our visit the trust informed us it had taken action to strengthen its audit arrangements for medicines.</li><li>• Between May 2015 and April 2016 there had been three never events. Staff in some areas, for example maternity, could not tell us about lessons learned or changes to practice following one of the never events.</li><li>• We had concerns within the children's services that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt.</li><li>• Four safeguarding children guidelines were out of date.</li><li>• In addition, a cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had</li></ul>	<p><b>Requires improvement</b></p> 

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

However,

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

## Duty of Candour

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

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

- Our own review of incidents confirmed that duty of candour was applied effectively.

## Safeguarding

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

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

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

## Incidents

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

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

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

## Staffing

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

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

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



# Summary of findings

## Medicines management

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

# Summary of findings

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

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

# Summary of findings

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

## Assessing and responding to risk

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

# Summary of findings

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

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

# Summary of findings

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

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

## Environment and equipment

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

## Records

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

# Summary of findings

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

## Are services at this trust effective?

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

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

However,

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

## Evidence based care and treatment

**Requires improvement**



# Summary of findings

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

## Patient outcomes

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



# Summary of findings

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

# Summary of findings

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

## Multidisciplinary working

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

# Summary of findings

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

## Competent staff

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

# Summary of findings

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

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

## **Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

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

# Summary of findings

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

## Are services at this trust caring?

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

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

However:

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

## Compassionate care

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

Good



# Summary of findings

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

## **Understanding and involvement of patients and those close to them**

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

# Summary of findings

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

## Emotional support

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

## Are services at this trust responsive?

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

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

However,

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

**Requires improvement**





# Summary of findings

number of bed moves for patients especially at night, a reduction in the number of delayed discharge days and a large reduction in the number of patients who were medical outliers being sent to Castle Hill Hospital.

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

## **Service planning and delivery to meet the needs of local people**

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

# Summary of findings

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

## Meeting people's individual needs

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

# Summary of findings

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

# Summary of findings

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

## Learning disabilities

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

# Summary of findings

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

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

## Dementia

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

# Summary of findings

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

# Summary of findings

distraction and to reduce the possibility of the cast being interfered with. They also had a board with nuts and screws on for patients to concentrate on when being plastered to avoid disruption.

- Within outpatients at HRI there was a quiet waiting room for patients who had dementia termed the Grey room. This has a bus stop sign for people to wait by, a disabled toilet and local art on the wall with familiar scenes.

## Access and flow

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



# Summary of findings

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

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

# Summary of findings

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

## Learning from complaints and concerns

- We saw evidence that the trust was open and transparent in responding to complaints.
- There was a complaints policy in place and this was also accessible from the website.
- The Trust had seen a 17% reduction in formal complaints received between 2014/15 (769) and 2015/16 (642). During 2015/16, 650 complaints were closed (some overlapping from the previous year). Of these, 207 were not upheld, 161 were partly upheld and 282 upheld. Of the 642 new complaints received 28 were not investigated for the following reasons:
  1. they were for another organisation
  2. the Trust did not receive consent from the patient for the complaint to be investigated
  3. the patient did not want it to be investigated formally
- The trust had a local standard of acknowledging complaints within three working days. This had been met in all complaints during the period April 2015 to March 2016. The standard for a response to a complainant was 40 working days which had a 69.8% achievement rate. The trust's target was to have 90% of complaints closed within 40 days in 2016-17. Although performance had improved from 2014/15, none of the health groups had met this standard in 2015/16 with figures ranging from 64-76%.
- Lessons learned from complaints were shared from the board to wards. We saw evidence of this in board papers and the

# Summary of findings

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

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

# Summary of findings

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

## Are services at this trust well-led?

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

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

However,

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

**Requires improvement**



# Summary of findings

be addressed by the weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient transformation project' was also in progress, which was running behind schedule.

- We found an improved staff culture within the trust; staff said it had changed for the better. A programme of professional and cultural transformation training was ongoing for all staff, which included new staff joining the organisation.
- Staff were engaged and told us that there was good teamwork.
- There was a drive for continual change and improvement within the leadership team.

## Vision and strategy

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

# Summary of findings

told us the development of their strategy was about linking the emergency department plan with hospital wide performance and specialities and to embed resilience and ensure consistency of delivery.

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

## **Governance, risk management and quality measurement**

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

# Summary of findings

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

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

# Summary of findings

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

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



# Summary of findings

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

## Leadership of the trust

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

## Culture within the trust

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

# Summary of findings

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

## Fit and Proper Persons

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

## Public engagement

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

# Summary of findings

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

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

## Staff engagement

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

# Summary of findings

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

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

## Innovation, improvement and sustainability

# Summary of findings

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

## Summary of findings

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

# Overview of ratings

## Our ratings for Hull Royal Infirmary

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

# Overview of ratings

## Our ratings for Castle Hill Hospital

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

## Our ratings for Hull and East Yorkshire Hospitals NHS Trust

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



# Outstanding practice and areas for improvement

## Outstanding practice

We saw several areas of outstanding practice including:

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

## Areas for improvement

### Action the trust MUST take to improve

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

# Outstanding practice and areas for improvement

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

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met: There was no policy or protocol in maternity services for staff to assess a young person's (under 16 years of age) understanding using guidance such as Gillick competencies and therefore ability to consent to a proposed treatment. The trust must:</p> <ol style="list-style-type: none"><li>1. ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.</li></ol>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met: Care and treatment was not always provided in a safe way for patients. The trust must:</p> <ol style="list-style-type: none"><li>1. ensure that planning and delivering care meets the national standards for A&amp;E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits. Regulation 12(1)</li><li>2. review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt. Regulation 12(2)(b)</li><li>3. ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns. Regulation 12(2)(a) &amp; (b)</li></ol>

## Requirement notices

4. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b)
5. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b)
6. ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services. Regulation 12(2)(c)
7. take further steps to improve the facilities for young people on the 13th floor of HRI. Regulation 12(2)(e)
8. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy, especially within A&E. Regulation 12(2)(g)
9. ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient. Regulation 12(2)(g)
10. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)
11. ensure that records of the management of controlled drugs are accurately maintained and audited within A&E. Regulation 12(2)(g)
12. ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services. Regulation 12(2)(i)

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

## Requirement notices

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

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

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

How the regulation was not being met: Some patients' food diaries and fluid balance chart were not fully completed therefore it is not possible to monitor whether their needs were being met. The trust must:

1. ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The trust must:

1. ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement Growth Assessment Protocol (GAP). Regulation 17(2)(a)
2. ensure that elective orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a)

## Requirement notices

3. ensure the effective use and auditing of best practice guidance such as the “Five steps to safer surgery” checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)
4. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).
5. ensure outpatient services have timely and effective governance processes in place which identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
6. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient and maternity services. Regulation 17(2)(c)

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. The trust must:

1. ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients’ dependency levels on surgical and medical wards. And specifically ensure critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012). Regulation 18(1)
2. continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour. Regulation 18(1)