

Hull University Teaching Hospitals NHS Trust

Inspection report

Hull Royal Infirmary
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Date of inspection visit: 1st-3rd November 2022 and
6th-8th December 2022
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Ratings

Overall trust quality rating

Requires Improvement 

Are services safe?	Inadequate 
Are services effective?	Requires Improvement 
Are services caring?	Good 
Are services responsive?	Requires Improvement 
Are services well-led?	Requires Improvement 

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

This report describes our judgement of the quality of care provided by this trust. We base it on a combination of what we found when we inspected and other information available to us. It includes information given to us from staff at the trust, people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We carried out this unannounced inspection of three acute services provided by this trust as part of our continual checks on the safety and quality of healthcare services

We also inspected the well-led key question for the trust overall.

Overall summary

- Hull University Teaching Hospitals NHS Trust (HUTH) offered a comprehensive secondary care service portfolio covering the major medical and surgical specialties, routine and specialist diagnostic services and other clinical support services. These services were primarily provided to a catchment population of approximately 600,000 in Hull and the East Riding.
- HUTH provided specialist and tertiary services to a population of 1-1.25m people, this covered the area from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire.
- HUTH was also a designated centre for:
 - Cancer
 - Cardiology
 - Vascular

Our findings

- Major trauma
- The only major services not provided by HUTH were:
 - Transplant Surgery
 - Major Burns
 - Some Specialist paediatric services
- The organisation sat within the Humber and North Yorkshire Integrated Care System (ICS).
- HUTH was situated in the geographical area of Kingston upon Hull and the East Riding of Yorkshire. The two main sites being Hull Royal Infirmary and Castle Hill Hospital.
- The Trust was established in October 1999 and on 1st March 2019 changed its name to Hull University Teaching Hospitals NHS Trust to strengthen links with Hull University, particularly around teaching and academic opportunities.

We inspected Emergency and Urgent Care, Medicine and Surgery. We also inspected the well-led key question for the trust overall. We did not inspect maternity, critical care, children and young people services, outpatients and end of life services at this inspection.

At our last inspection in 2020 we rated the trust overall as requires improvement. CQC temporarily suspended all routine inspections on 16 March 2020 to support and reduce the pressure on health and social care services during the COVID-19 pandemic. This inspection, in terms of core services, was already underway at the time of the suspension and therefore could not be completed in the usual way. The report included the findings from the completed service level inspections, but the well-led inspection was not completed. We did complete a well led inspection as part of this inspection.

Our rating of services stayed the same. We rated them as requires improvement because:

- Overall, we rated safe as inadequate, effective and responsive as requires improvement and caring as good. We rated well-led as requires improvement.
- We rated Emergency and Urgent Care as inadequate. We rated safe, effective, responsive and well-led as inadequate. We rated caring as requires improvement.
- We rated Medicine as requires improvement. We rated safe, effective, responsive and well-led as requires improvement and rated caring as good.
- We rated Surgery as requires improvement. We rated safe as inadequate, effective, responsive and well-led as requires improvement and rated caring as good.
- In rating the trust, we took into account the current ratings of the other core services that were not inspected this time.

What we found

Our rating of services stayed the same. We rated them as requires improvement because:

- Senior Leaders understood and managed the priorities and issues the service faced. However, whilst they were aware of the issues and significant challenges, they did not always manage services with timely and decisive action, and this

Our findings

had an impact on patient care. Although, they used systems to manage performance effectively, they did not always operate effective governance processes to escalate relevant risks and issues, and identify actions to reduce their impact. There were significant challenges in some key areas that were not addressed timely and in a way that had the required impact on patient care.

- Services we inspected did not have enough staff to keep patients safe. Staff did not always assess risks to patients and failed to identify risks and could not evidence how these risks were acted upon. Care records were incomplete. The service did not always manage safety incidents well or learn lessons from them.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always monitor the effectiveness of the service. Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.
- Staff did not always respect people's privacy and dignity, and take account of their individual needs.
- People could not always access the service when they needed it and did not always receive the right care promptly. People did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages resulting in some patients needing longer stays while they awaited treatment and discharge. There were significant challenges with performance and patient flow across the trust which had not yet been fully addressed.
- During our inspection we found that local leadership at core service level varied. In the most recent NHS Staff Survey, scores for 'Staff Engagement' and 'Morale' were similar to the sector average but had significantly declined since the last inspection. Some staff did not always feel respected, supported and valued.

However:

- Staff treated people with compassion and kindness.
- The service had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

How we carried out the inspection

The team that carried out the well led inspection included one inspection manager, 6 inspectors, one assistant inspector and an inspection planner. In addition, there was an executive reviewer plus four specialist advisors experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Action the trust MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements. This action related to the following services.

Trust wide

- The trust must ensure care and treatment of service users must only be provided with the consent of the relevant person. (Regulation 11 (1) (2) (3) (4)).
- The trust must ensure that mandatory training compliance, including training, meets the trust target. (Regulation 12 (1) (2) (c)).
- The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2) (c)).
- The trust must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users. (Regulation 12 (2) (i)).

Hull Royal Infirmary

Urgent and Emergency Care Services

- The service must ensure that the care and treatment of service users is appropriate, meets their needs and reflects their preferences. (Regulation 9 (1) (a) (b) (c)).
- The service must ensure that it is effectively assessing the risks to the health and safety of service users of receiving the care or treatment. (Regulation 12 (2) (a)).
- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2) (c)).
- The service must develop systems to allow for the assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. (Regulation 12 (2) (h)).
- The service must ensure that systems and processes are established and operated effectively to safeguard patients. (Regulations 13 (2)).
- The service must ensure that care or treatment for service users is not provided in a way that includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. (Regulation 13 (4) (b)).
- The service must ensure that a service user is not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (Regulation 13 (5)).
- The service must ensure that the nutritional and hydration needs of service users are met. (Regulation 14 (1)).
- The service must ensure that all premises and equipment are clean, secure, suitable for the purpose for which they are being used, properly used and properly maintained. (Regulation 15 (1) (a) (b) (c) (d) (e)).
- The service must ensure that systems or processes are established and operated effectively. (Regulation (17) (1)).

Our findings

- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). (Regulation (17) (2) (a)).
- The service must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (Regulation (17) (2) (b)).
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation (17) (2) (c)).
- The service must ensure that controlled drug registers are completed in line with legal requirements (Regulation 17 (2) (d)).
- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 18 (1) (2) (a) (b)).

Medicine

- The service must ensure that assessment of the risks to the health and safety of service users of receiving the care or treatment are undertaken within agreed guidelines and target. (Regulation 12 (1) (a)).
- The service must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users. (Regulation 12 (2) (i)).
- The service must ensure that an effective and timely system for identifying, receiving, recording, handling and responding to complaints is clear to those raising concerns or making a complaint. (Regulation 16 (2)).
- The service must ensure it establishes and operates systems that enable the development and use of up to date, effective and relevant policies and procedural documents. (Regulation 17 (1)).
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced nursing staff are deployed to meet regulatory requirements. (Regulation 18 (1)).
- The service must ensure sufficient numbers of suitably qualified, competent, skilled and experienced medical staff are deployed to meet regulatory requirements, particularly in evenings and weekends. (Regulation 18 (1)).
- The service must ensure staff receive appropriate support, training and professional development as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (2) (a)).

Surgery

- The service must ensure the designated safeguarding lead has completed the appropriate level of safeguarding training in line with intercollegiate guidance. (Regulation 11).
- The service must ensure that staff adhere to infection prevention and control guidance and the environment is suitable to promote safe care. (Regulation 12).
- The service must ensure systems are in place to ensure equipment is serviced and COSHH chemicals are appropriately and securely stored. (Regulation 12).

Our findings

- The service must have robust procedures in place for the identification, review and management of risk. (Regulation 12).
- The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 12).
- The service must ensure robust oversight and management of incidents and ensure incidents are shared across the health group. (Regulation 12).
- The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation (WHO) surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance. (Regulation 12 (1) (2) (a) (b)).
- The service must ensure that mandatory training compliance, including training, meets the service target. (Regulation 12 (1) (2) (c)).
- The service must ensure all staff are aware of and consistently follow the service policy to safely prescribe, administer, record and store and dispose of medicines. (Regulation 12 (1) (2) (g)).
- The service must ensure that staff complete mental capacity and best interest decisions, when obtaining consent and that they clearly document the assessment and decision making-making process. (Regulation 13).
- The service must ensure that all complaints are managed in accordance with service policy. (Regulation 16).
- The service must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17).
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17).
- The service must ensure staff treat patients with privacy and dignity and take account of individual needs. (Regulation 17)
- The service must ensure learning from never events is shared with all staff. (Regulation 17).
- The service must improve its monitoring and auditing of surgical safety checklists and ensure the finding of these audits are shared with staff. (Regulation 17).
- The service must ensure staff have access to up to date evidence-based policies and procedures. (Regulation 17 (1)).
- The service must improve the monitoring of the effectiveness of care and treatment, timeliness of investigations, reviews and audits and implementation of change. (Regulation 17(1)).
- The service must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. (Regulation 17(1)).
- The service must ensure a robust audit plan is in place and key audits are conducted, including record keeping, medicines management and infection prevention and control audits. The service must ensure relevant actions identified by local audits are acted on. (Regulation 17 (1) (2) (a) (b)).
- Senior managers must ensure robust systems and processes are in place to identify, manage, mitigate and if appropriate escalate risks. This must ensure senior managers and the board members have clear oversight of service risks. (Regulation 17 (1) (2) (a) (b)).
- The service must ensure they have an up to date and robust risk register in place, and there is appropriate oversight and management of this. (Regulation 17 (1) (2) (a) (b)).

Our findings

- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. (Regulation 17 (2) (c)).
- The service must ensure systems or processes are established, operated and audited effectively to ensure compliance with the requirements to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. (Regulation 17 (1) (3)).
- Bank and agency staff working at the hospital must receive an induction to the area(s) they are required to cover. (Regulation 18 (1) (2) (a)).

Castle Hill Hospital

Medicine

- The service must ensure it ensures that assessment of the risks to the health and safety of service users of receiving the care or treatment are undertaken within agreed guidelines and target. (Regulation 12 (1) (a)).
- The service must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users. (Regulation 12 (2) (i)).
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Surgery

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Our findings

- The service must improve its monitoring and auditing of surgical safety checklists and ensure the finding of these audits are shared with staff. (Regulation 17).
- Bank and agency staff working at the hospital must receive an induction to the area(s) they are required to cover. (Regulation 18 (1) (2) (a)).

Action the service SHOULD take to improve:

Hull Royal Infirmary

Urgent and Emergency Care Services

- The service should consider how it can increase access to health promotion literature in alternative formats.
- The service should consider how it can increase patient engagement.
- The service should consider how it can improve on patient feedback.

Surgery

- The service should ensure that recent safety and performance audits for each ward are visible.
- The service should ensure it can demonstrate participation in all national level audits.
- The service should ensure it has current, ongoing action plans to address the failure to meet national performance standards.
- The service should ensure that confidential records are stored securely in line with national guidance.
- The service should continue to monitor the average length of stay for elective and non-elective patients to improve performance standards measured against the England average
- The service should continue to work to improve theatre utilisation.
- The service must develop a clear strategy for the health group
- The service should consider reviewing and revising the electronic system to ensure all staff have access and the system allows personalisation of care plans
- The service should seek to further collate and review patient and family feedback to improve services.
- The service should further develop environmental auditing to include the appropriate management of stock.
- The service should ensure that version-controlled documents are reviewed in line with service policy and national guidance.
- The service should consider reviewing children's waiting area within day surgery environments
- The service should consider how it could promote its services to minority groups to ensure its services are accessible to diverse groups.

Castle Hill Hospital

Surgery

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Our findings

- The service should ensure it can demonstrate participation in all national level audits.
- The service should ensure it has current, ongoing action plans to address the failure to meet national performance standards.
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- The service should further develop environmental auditing to include the appropriate management of stock.
- The service should ensure that version-controlled documents are reviewed in line with service policy and national guidance.
- The service should consider how it could promote its services to minority groups to ensure its services are accessible to diverse groups.

Is this organisation well-led?

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, leaders, whilst aware of the issues and significant challenges, they did not always manage services with timely and decisive action, and this had an impact on patient care. Feedback regarding the visibility and approachability of senior leaders within the service was mixed from both patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of the trust has had some changes since our last well led inspection in 2018. There have been joint appointments made with a neighbouring trust for the posts of Chair, Chief Information Officer and Chief Finance Officer. A Director of Quality Governance was now in place and there was an interim Chief Nurse in post. The Chief Finance Officer is the longest serving executive, since March 2013, and is also the Deputy Chief Executive. He took up the joint role across both trusts in March 2020.

The Chief Executive had also taken on the role of the Chair of the Collaborative of Acute Providers with all executives fully engaged in this work. We also discussed the group model plans with a local Trust with a number of executives who were focussed on the benefits this could provide to patients. The Board had been in unanimous support of the group model proposal.

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The trust had several significant challenges in terms of performance, quality of patient care, culture and its role in the Integrated Care System (ICS). Although the board was sighted on these challenges and had the appropriate skills and knowledge, these challenges were significant and on a scale that required action, however we found that actions were not always timely or effective and this impacted on patient care within services.

There had been changes with the non-executive directors. A new Chair has been appointed which was a joint appointment with a neighbouring trust and there had been appointments of other non-executive directors, one of whom was the chair of the Quality Committee. During our inspection there was mixed feedback regarding the visibility and engagement with the executive team, with some staff within surgery expressing that at times engagement and presence on the wards was rare.

During our inspection we found that local leadership at core service level varied. For example, in urgent and emergency care, although senior leaders could articulate the priorities and issues the service faced, we saw little evidence of senior leaders making contributions to either improving patient care or managing patient improvements. Whilst senior leaders and the board were aware of the challenges within the department, we also did not see consistent action taken to reduce risks to patients and support staff within the service. Within medicine, we found visible leadership on wards by matrons and ward managers. Staff told us they felt supported by matrons and senior nurses.

Board Development was well established and linked to the Board Assurance Framework. The programme for the year is set in April following the regular Board Development session to review progress against the Strategy and develop the BAF. It is reviewed at every meeting of the Trust Board.

There were also leadership development programmes for medical and nursing staff.

Providers are required to ensure that directors were fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience to ensure compliance with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). During the inspection we carried out checks to determine if the trust was compliant with this regulation. We reviewed four director files, two executive and two non-executive directors. All files reviewed contained the employment checks for executive and non-executive staff in line with the Fit and Proper Persons Requirement (FPPR) Regulation 5. The trust had a policy for the requirement of the Fit and Proper Persons Test (FPPT) for directors.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Whilst this was in place, some strategies required further embedding. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust Strategy 2022-25 detailed the vision for - Great Staff; Great Care; Great Future. It had the appropriate and relevant supporting strategies in place. These included a leadership strategy, quality strategy, workforce strategy, governance and risk management strategy, and staff, patient and public strategies. The trust did not have a clinical strategy in place as it was awaiting the outcome of the Humber Acute Services Review.

Our findings

The Trust reviewed its strategy on an annual basis with a full refresh being taken to the Trust Board in March 2022. The Board also receives an annual Board Development programme combining the Strategy update and the Board Assurance Framework to ensure all risks to the strategic objectives are appropriately aligned and informed.

To support delivery of the Trust Strategy, the trust had approved a Quality Strategy, Risk Management Strategy, Mental Health Strategy and Dementia and Delirium Strategy during the year. The Trust Board received a mid-year update on progress against the Trust Strategy Year 1 objectives at their meeting in September 2022. A further update will be provided to the Trust Board in March 2023 together with an outline on the Year 2 objectives for delivery in 2023/24.

The trust started developing a Quality Strategy in 2021 building on the established nursing quality improvement programmes and the Quality Account priorities. This included stakeholder engagement and a Board Development session in December 2021. The Strategy was approved in March 2022 and officially launched on the 1 June 2022. The Quality Committee has been overseeing the delivery of the strategy with good progress made in the first six months.

Most core services had a vision and strategy. Although, the health group with responsibility for the majority of surgical specialities, did not have an overarching strategy, but instead had developed an operational plan outlining key objectives and plan for 2022/2023. This plan required further embedding. The executives and non-executives were developing an approach of collaboration through partnership working. This was evident in the development of a Humber Acute Services reconfiguration programme with a neighbouring trust. It was also receiving mutual aid from other organisations as part of the elective recovery programme. This was a feature at a national, regional and local level. The trust's strategic plans were aligned with those of the integrated care system (ICS) and place-based partnerships (Place).

From our interviews with executives, non-executives and senior managers they could articulate what the priorities for the organisation were but there was more work to do to ensure actions were timely and reflected the priorities.

Culture

Staff did not always feel respected, supported and valued within some of the core services we inspected. They were not always consistently focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, but further work was required to improve experiences of Black, Asian and Minority Ethnic (BAME) staff. The trust was continuing to develop a more open culture where patients, their families and staff could raise concerns without fear but there was more work required to progress this and have an impact.

Senior leaders acknowledged that the service was on a journey of cultural improvement. The trust had developed clear strategies and programmes to address concerns highlighted in relation to the organisational culture, however the implementation, delivery and embedding of these workstreams and initiatives had been affected by the pandemic and had not yet been reflected in measures such as the most recent NHS staff survey.

The trust had completed some work regarding culture with an external company which had resulted in a report entitled "Evolution report 2017-2022". This report compared specific areas from 2017 to 2022. These areas included employee wellbeing, trust and engagement, direction and communication. The report highlighted that since 2017 there needs to be a greater focus on some areas particularly employee wellbeing, and trust and engagement. This work was being captured in specific programmes associated with organisational culture.

Non-executive directors demonstrated awareness of the challenges the organisation faced in terms of its culture. They reported they were involved in the undertaking ward visits and ensured visibility with staff across the organisation. Non-

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executive directors were also buddied with executive board members. However, in some areas staff reported limited visibility of senior leaders including board members.

In the 2021 NHS Staff Survey, scores for 'Staff Engagement' and 'Morale' were similar to the sector average but had significantly declined compared to the 2020 scores. Staff survey results from 2021 reported that morale and compassion and inclusivity within the service was beneath the trust average. The trust acknowledged that further work would be required in order to improve some of the metrics highlighted within the staff survey and had specifically ensured that when designing the cultural evolution programme, they paid particular focus to dealing with concerns around values, behaviours and relationships which impacted on performance.

There were some core services where staff did not always feel respected, supported and valued. In urgent and emergency care, staff survey results from 2021 reported that morale and compassion and inclusivity within the service was beneath the trust average. Responses regarding recognition and reward within the staff survey was also beneath the trust average.

Staff in urgent and emergency told us during inspection visits that there was an inconsistent approach to senior staff providing practical support and assistance during shifts. We were told that the level of support given was dependent on what senior staff were on duty at the time. We were also told that this had a direct impact on staff morale. Within surgery, staff morale and wellbeing varied, and some staff told us their morale was quite poor due to the staffing challenges.

An independent review of cardiology had also identified some cultural issues within this service previously. This had resulted in an action plan being produced and some key changes within senior clinical personnel. We were also aware of some cultural issues regarding pancreatic surgery services. The trust had delivered an action plan to address these issues.

The trust had a strategy in place in relation to Equality, Diversity and Inclusion at the time of our inspection. In relation to the Workforce, Race and Equality Standard, there were statistically significant differences in outcomes for black, Asian and minority ethnic (BAME) staff compared to white staff for the following indicators:

- Staff experiencing harassment, bullying or abuse from staff in the last 12 months. 31.3% of BAME staff experienced harassment, bullying or abuse from staff in the last 12 months which was significantly worse when compared to 26.0% of White staff.
- Staff believing that the trust provides equal opportunities for career progression or promotion. 44.8% of BAME staff believe that the trust provides equal opportunities for career progression or promotion compared to 58.7% of white staff.
- Staff experiencing discrimination from a colleague or manager in the past. 18.2% of BAME staff experienced discrimination from a colleague or manager in the past compared to 7.3% of white staff.

The trust had ensured that a staff network was in place for BAME colleagues within the organisation but acknowledged more work was needed to improve the experience for BAME colleagues working within the trust.

To support these improvements the Trust has completed extensive work to improve experiences of Black, Asian and Minority Ethnic (BAME). One key example is the creation of a Zero Tolerance to Racism Framework. This includes the Trust Anti-Racism Statement and clear expectations on behaviours expected of staff. This is supported by the Zero Tolerance to Racism Reporting tool which allows all staff to report racism (staff and patients) and is then reviewed by a circle group to determine action required.

Our findings

The trust has policies and processes which clearly detailed the role of the freedom to speak up guardian (FTSUG). The FTSUG had an established, embedded role within the trust. We spoke with the guardian who demonstrated a passion and drive to improve the culture of the organisation. Quarterly reports were provided to the Trust Board in the public board meeting. These reports detailed contacts received from members of staff, including number and themes of contacts, case studies, learning from contacts and future planned initiatives. This allowed for the identification of potential hotspots within the trust and appropriate interventions implemented where required.

The trust was better than the national average for the number of sick days for medical and dental staff, non-clinical staff and nursing and midwifery staff (Oct 2021 to Sept 2022). Hull University Teaching Hospitals NHS Trust has had the lowest sickness rate (for all staff) in the Humber, Coast and Vale ICS between July 2021 and July 2022. The sickness rate remained steady over this period, at around 4%, whereas other trusts in the ICS have had increases in sickness rates.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Ward to board governance and operational oversight was not always apparent or effective. Executives and corporate teams were clear about their roles and responsibilities. We found this to be variable at a Health Group and core service level where not all staff were clear about their roles and accountabilities.

The Trust has a Board Assurance Framework that is clearly linked to the Trust Strategy and Strategic Objectives. The template includes a link to risks on the corporate risk register that is simple to identify. Each risk has a lead Executive assigned and a Board Committee with responsibility for monitoring the delivery of actions associated with that risk. There is annual review of the Board Assurance Framework process. This includes the Chair of the Audit Committee attending the annual Board Development session for a review of the Strategy and progress against the strategic objectives and BAF development. There is an internal audit plan with clear alignment to the BAF, used as sources of assurance throughout the year. All internal audit reports are presented to the Audit Committee. there was an annual internal audit on the BAF and risk management arrangements each year as part of the internal audit plan. The output of the latest internal audit of the BAF concluded 'substantial assurance' with only one low level management action, which was implemented immediately.

Senior leaders had regular executive team meetings which did discuss operational risks and challenges and mitigating actions. However, as the non-executive directors did not attend this meeting, they did not have a clear line of sight on strategic risks or significant operational risks.

We also observed the BAF and corporate risk register did not have clear actions to mitigate the risks identified and that although we were told that some of the challenges faced by the trust were caused by failings in primary and adult social care, whilst the BAF reports and updates did detail actions taken by the trust in relation to these risks, they had not been effective in reducing the risk ratings.

In the core services we inspected each health group had their own risk registers. All were reviewed monthly through health group governance committees. In medicine, there were several risks and issues which had an impact on the health group which had been identified and not yet resolved or had not been actioned.

We identified some significant concerns regarding governance during our inspection of urgent and emergency care. There was no evidence found to support that senior leaders had a sufficient oversight and understanding of where the

Our findings

department was failing to meet standards in care. We saw staff failing to provide the required standard of care on multiple occasions. The same failings had been previously identified from locally completed audits, but we saw limited or no evidence that any action had been taken to address the repeated issues. As a result, we issued a section 31 letter of intent requesting urgent action to address these concerns. The trust provided an action plan to address these concerns. We returned to assess if the improvements detailed in the trust's action plan had been actioned. We found that despite assurances from the senior leadership, actions detailed in the plan had not been effective in demonstrating an improvement in patient care and experience nor had the trusts own systems identified the lack of progress. CQC had to escalate further concerns with the trust's executive team about patient safety and we asked the trust to make further urgent improvements and an additional action plan was submitted to manage the risks. CQC continues to monitor the progress the trust has made with these actions through engagement with the trust.

Senior leaders told us that the service review teams meet on a 6-weekly basis with attendance from all levels of staff; business manager, strategy planning manager, consultants, matrons, staff who want to be involved. We were also told of monthly clinical leads meetings. Governance leads and consultants are involved in making changes.

In addition to service level reviews, the trust holds a monthly performance and accountability review meeting with the Health Groups, chaired by the CEO.

The health groups met through governance committees to review standard agenda topics such as incidents, clinical harm, risk, pressure ulcers, falls and audit results. However, some minutes of these meetings, specifically surgery did not include detail sufficient for effective professional discussion. For example, this health group advised that there had been six serious incidents but there was no recorded discussion regarding the nature of the serious incidents, or the immediate actions taken to reduce future incidents. Audit delays were also outlined but there was no plan to drive improvement or action plans created to monitor audit findings. The lack of auditing suggested a lack of oversight of these concerns and the potential for risks not to be managed effectively.

The trust reported six surgery related never events between November 2021 and August 2022. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The never events varied in theme and were unconnected. The incident type included retained swab, medication, wrong implant and wrong site block. However, we found there was insufficient pace when sharing the learning from these incidents wider than the service involved, resulting in the potential further harm to patients from repeated incidents.

Also, within surgery, risks within theatres were not always recorded as part of the surgical safety checklist. We saw the trust had designed a checklist which only required one signature to confirm all aspects of the pause and check processes had been completed. This signature was made at the end of the surgical procedure by the lead clinician. The form did not provide an option to sign or evidence each aspect of the World Health Organisation (WHO) guidelines had been met. In day surgery at Hull Royal Infirmary (HRI) all the patient records reviewed had not had their surgical safety checklist signed by the lead clinician. Audits completed in August 2022 was shown to be incomplete with no preoperative checks completed.

As a result, we were concerned that ward to board governance and operational oversight was not always effective.

The trust had an incident reporting and investigation policy which detailed the appropriate information and action required for staff to follow. We reviewed six serious incidents investigations during the inspection, that included both initial reports (72-hour reviews) and completed investigations. The trust reported incidents on an electronic system and

Our findings

followed a root cause analysis (RCA) approach. In the sample we reviewed, we found the quality of reports was satisfactory and followed trust policy. They included detailed information and actions were identified. Duty of Candour was applied appropriately. However, in some of the incidents reviewed it was unclear whether these reports had been shared with the patients and relatives. There were also some missed opportunities to share learning.

As part of the Trust's incident and investigation processes, a Weekly Patient Safety Summit was held to review all incidents reported as moderate harm or above in the previous week. This summit was attended by multidisciplinary teams and promoted clinical engagement in the decision making for declaring serious incidents and undertaking immediate learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, they did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. There were significant challenges in some key areas that were not addressed timely and in a way that had the required impact on patient care.

The board received information through a performance and activity report, which provided detailed updates relating to access and flow including performance against the four-hour emergency standard, ambulance handover delays over sixty minutes, twelve-hour trolley waits, no criteria to reside, referral to treatment including 104 week waits and 62-day cancer performance. This was presented to the trust board to ensure members were sited on key risks. The reports highlighted significant challenges with performance and patient flow across the trust.

Within urgent and emergency care, ambulance staff consistently reported delays in handing over patients, we observed long delays in patients being assessed on arrival. In October 2022 it was reported that 252 patients had waited over 2 hours from arrival to being handed over to hospital staff. During inspection we saw multiple examples of patients waiting in excess of 10 hours before being seen by a doctor or other appropriate clinician. The number of patients waiting for admission more than four hours, but less than 12 hours had worsened. There were 3431 patients waiting more than 12 hours from decision to admit within the last 12 months. In October 2022 the number of patients waiting over 12 hours was 601. We observed patients that experienced long waits to be handed over from ambulance staff. We saw a number of examples of patients that needed escalation but were waiting in excess of six hours to be moved into the department. We noted in one case of a patient who had experienced a long wait that they had the highest NEWS score in the department and had started treatment on the back of the ambulance. We observed at the time whilst there were empty beds in the department they were not moved into the department and patients of a lower acuity were being admitted before them. We saw a number of other similar examples during our inspection.

Since January 2022, there had been a steady increase in the total number of patients on the trust's waiting list, this has been in line with the trend seen across the region and country (approximately 2% a month). As of August 2022, there were almost 72,000 patients on the waiting list which was 22% more than in August 2021 (just under 59,000). The three specialties with the highest waiting lists were general surgery, gynaecology and ear, nose and throat.

The number of patients treated increased by 33% during the 12 months to August 2022 (from just over 14,000 in August 2021 to almost 19,000 in August 2022).

The number of patients waiting over 52 weeks for treatment had reduced over the 12 months to August 2022, although there had been an upward trend in numbers since June 2022. The trust still had the highest number of patients waiting over 52 weeks in the region, with 7.5% of the waiting list waiting over 52 weeks compared to a regional average of 3.4%.

Our findings

The percentage of patients treated within 18 weeks had steadily declined since January 2022, in line with regional and national trends.

Within medicine, there were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be arranged. Patients were being moved sometimes multiple times in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment. Due to the complexities in assessing patients who needed onward care, and the lack of care packages available to be arranged by out of hospital services, there were long delays in discharging patient's home. Managers told us staffing shortages in adult social care had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care and domiciliary care, resulted in significant discharge delays. System partners and the trust had not implemented a discharge to assess (D2A) model, which had been implemented nationally during the Covid pandemic. We were also not assured that the trust was effectively managing their 'pathway 0' discharges and there was a lack of consistent and robust actions on a day to day basis.

We were concerned about the trust's pace of improvement across some services as these challenges remained. We were not assured that there was effective operational oversight and escalation across the trust and that issues would be appropriately escalated to the executive level of management. We were also not assured that trust assurances received regarding performance and other issues were correctly reported in enough depth and detail. For example, within surgery, it was not clear what scrutiny was applied to delays or general poor performance. There were 28 new clinical harm reports outlined within the same minutes, but no recorded discussion to address mitigation from further harm.

Workforce was a challenge and risk across the organisation, but in particularly within medical and surgery services. Although managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Within surgery and medicine, most wards did not have enough nursing and support staff to keep patients safe. Actual nurse staffing was consistently below planned establishment. Several wards we visited reported scenarios where only one registered nurse was left on the ward to manage a typical ward size of 27 patients. Staff told us where time allowed, an electronic alert was submitted for these incidents, due to staff feeling unsafe.

Following the inspection, the Trust provided us with information about the Safer Staffing process and reviews and demonstrated that the scenarios reported to us were not a frequent occurrence. There has been one incident in the last 12 months on one of the wards which was addressed during the same shift.

Staff told us they were frequently moved between wards to cover patient acuity, they further said that this compromised patient care through a lack of continuity of care. During the well-led inspection, we were told that nurse staffing vacancies were 2% which was significantly lower than most other NHS trust positions. However, we found that this reflected not only staff in post but also staff who had been offered a post but had not yet started. The reporting of the vacancy rate in this way meant that the true vacancy position was not visible to board members as it did not reflect the current vacancy position which was 7.5%. It also didn't correlate with the staffing challenges we found in clinical areas where shortfalls against planned numbers. Following inspection we were provided with daily worksheets which demonstrated that there were allocated staff to specific areas. On each inspection visit we were told by nurses in the main department that they were not allocated specific patients. This meant there was a fragmented approach to patient care with no clear oversight of who was responsible for each patient's needs, clinical oversight and escalation. This also impacted on staff's ability to provide individualised care and emotional support to patients.

Service and health group level risks were identified from governance meetings, incidents, serious incidents and audit. Once a risk was identified, the risk register template was populated and when completed was taken to the relevant

Our findings

health group governance meeting for their review and sign off. Once risks had been ratified, they were sent to the clinical governance meeting for final review and ratification. Each health group had their own risk register. Most, but not all, captured the relevant risks. For example, we were not assured that risk was prioritised as the surgery governance committee minutes were not sufficiently detailed to ensure robust discussions were held regarding clinical risk. We saw audit information was scant and incomplete and never events were not discussed fully. Also, within the emergency department not all risks we identified were on their risk register.

Financial management - the trust has a good track record of delivering capital development programmes that benefit patients. In 2022/23 alone the following programmes have been started or completed:

- New restaurant at HRI completed
- Paediatric ward H20 and H200 completed
- Main trauma theatre refurbishment completed
- Link Bridge completed
- CHH Allam
- Day Surgery Unit CHH underway
- Theatres 10 and 11

For 2021/2022 these programmes have been completed:

- STP Front Entrance
- Completion of Boiler Replacement HRI
- New PACU to HRI Theatres
- H39 Cardiology ward
- CHH CHP
- AMU reconfiguration
- Allam HRI
- Suite 36 relocation
- ANPR installation
- Replacement roof to boiler house
- Completion of ICU

The Trust continues to achieve its financial targets and was aware of the risk the underlying position deteriorating in the future.

Information Management

The service collected reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure.

Our findings

The trust had a Digital Strategy 2018-2023 which was to deliver the national policy for being paper free at the point of care. Discussion with senior staff indicated that there was an emerging structure of clinical, managerial and information technology in place. However, this strategy was not progressing in a timely way with some issues in terms of being paper free at operational level still to be resolved.

Within urgent and emergency care, although performance data was easily accessible, we did not see any examples of data being analysed to improve performance. Staff across all grades within the department struggled to access data when requested. Our inspection team were repeatedly told that the multiple computer systems were too complicated, took too long to use and that there was no consistent approach in the recording and storage of information which meant that staff could not always find what they were looking for.

There were similar issues within surgery and medicine. Some of the trust's systems and processes for recording were inconsistent, for example the lack of electronic recording systems in theatres. Consequently, ward staff spent time transferring paper-based information into the electronic recording systems which posed a risk of lost information during the transfer process. Within medicine clinician notes were still written and stored in paper format. We saw staff confidence using the electronic systems varied from ward to ward. All staff we asked to guide us through the electronic systems told us there were sections of the systems they had not accessed before.

Staff told us that not all staff could enter data into the electronic records. We saw examples of this when recently qualified nursing staff employed as band two staff in surgery were required to have patients' assessments signed off by a senior nurse before they could be added. Ward staff told us these created delays in recording patient observations, which often showed as not completed. We also found within urgent and emergency care (UEC) that healthcare assistants were not able to directly document patient care within the patient records. This information was passed to registered nursing staff to document. When we reviewed patient records, we found gaps in the recording of key elements of care the patient had received.

We saw internet dropouts on some of the wards we visited, and staff reported occasions when the electronic system failed completely, resulting in staff having to move to paper based systems. This created concerns in relation to medicines management. Some electronic systems were not being used to their full potential. For example, no electronic referral could be made to specialist staff such as palliative or pain teams. Ward staff were still required to make a manual referral. Patient records which were not stored securely on some of the wards we visited.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Whilst there was collaboration with partner organisations, relationships between organisations were not always effective to enable progress to be made to improve services for patients.

The trust's patient experience strategy was incorporated into their quality strategy. These were monitored and reviewed at patient experience groups, which fed into the quality committee. The patient experience team reported they had involved service users, staff members and external partners such as the clinical commissioners in the development of the patient experience strategy.

Our findings

The trust had numerous staff engagement strategies including the Moments of Magic, which was an established recognition scheme, which acknowledged staff who go above and beyond to provide great care to patients, staff and visitors. The trust reintroduced 'Greatix' to recognise staff idea and any learning. There had been 135 ideas received to date which the trust was reviewing for implementation. Patient, Public & Carer Councils had been established for Adult and Youth engagement as well as a patient forum used for feedback and discussion on their experiences.

The trust also had a People Recovery Plan following the pandemic, which was aimed at addressing health and wellbeing, developing inclusive teams and unlocking potential. We saw overarching plans to increase engagement with staff and aims to design a recovery plan for each health group.

The trust had completed comprehensive engagement with patients, staff and other stakeholders on the design of clinical services. This work was completed as part of the Humber Acute Service Review.

Senior leaders described an historically challenged system and relationships with some partner organisations, especially the relevant local authorities, however this was improving. There was a strong relationship with the Integrated Care Board (ICB), a neighbouring trust and local healthcare provider. However, we did find in some areas progress was slow such as discharges, actions taken did not always have the impact to make significant improvements and we were told relationships with partner organisations were not always effective and communication at times was difficult and challenging. Further work was needed by the trust, partner organisations and the system to work together in a collective and consistent way to improve services to the local population.

The senior leadership team reported close working relationships with Healthwatch and the local independent consumer champions for health and social care.

The trust had policies and procedures in place to support patients in line with the accessible information standards. These include access to interpreter and translation services, British sign language signers, using larger fonts for letters for visually impaired service users. The trust had applied "Browse Aloud" to its external web pages to enable the audio capabilities for people with visual impairments and also for language translation.

Learning, continuous improvement and innovation

Whilst staff were committed to continually learning and improving services, learning was not always shared wider within the trust. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust had an established continuous quality improvement (CQI) framework, with an associated training and development programme. Quality, Service, Improvement and Redesign (QSIR) was used by the trust to develop staff with the skills to undertake quality improvement projects. Regional partners supported the delivery of the five day NHSE QSIR practitioner training and supported 15 members of staff to undergo assessment to become trained associates. This resulted in the Trust becoming an accredited faculty to provide QSIR training to its own staff and others in May 2022. The trust held CQI celebration and learning events to share learning of improvements and best practices. Staff and senior leaders across the organisation demonstrated knowledge of improvement methods and the skills to use them.

There were examples of quality improvement initiatives in the services we inspected, including:

In urgent and emergency care, there was a project to improve access to specific primary and secondary care within the hospital setting which would have a positive effect on performance and patient care.

Our findings

With surgical services, Gastrointestinal (GI) Physiology at Hull University Teaching Hospitals NHS Trust was one (of only 4) accredited GI Physiology services in the UK that have (and continue) to be involved in the Improving Quality in Physiological Services (IQIPS) scheme.

The trust made use of internal and external reviews, and learning was shared at location level to make improvements. However, it was not clear that learning had always been shared across divisions with services and sites to improve patient care. An example of this was the pace of implementing actions following never event investigations and not addressing the wider safety issues identified.

A never event learning forum was held in both lecture theatres and virtually on the 12 August 2022. This included all clinicians involved in recent Never Events sharing the incidents, the clinical simulation findings and the actions taken in response. This was attended by over 180 staff, predominantly consultants with senior nurses, ODPs and executives also in attendance.

The Trust undertakes clinical simulation exercised to investigate Never Events and other appropriate serious incidents. This facilitates support and learning for those directly involved in the incident and helps identify actions for wider learning. The Chief Medical Officer leads all of these exercises supported by the Patient Safety Team.

The outputs of this go to a Never Events panel that includes a Non-Executive Director and Patient Representative ahead of going through the normal process for sign off at the Serious Incident Review and Oversight Group. However, it was not clear that learning from these types of events had been embedded as never events had continued to occur within the organisation.

The trust had a complaints policy and process which was supported by a centralised complaints and patient advice and liaison team who work with all health groups across the trust. The lead director for complaints is the Chief Nurse. The policy clearly identified the process to be followed for managing concerns and formal complaints, including offering resolution meetings to take place prior to sending out any final responses.

During the inspection, CQC reviewed six complaints. We found the overall quality of the complaint responses and the tone of the letters were appropriate. However, some response letters reviewed lacked compassion and empathy. Although the process was followed, at times, there was no thought as to how it could be perceived by the complainant. There was no evidence to demonstrate that resolution meetings have been offered when appropriate. The letters included advice on next steps and signposting both internally and externally, if not satisfied with the outcome or response provided.

At the time of the inspection, the trust had approximately 160 open complaints, with 96 of these being over the trust standard of 40 working days to response. The longest response times were within Surgery, Medicine and Family and Women's Health Groups, with the Emergency Medicine and Clinical Support Health Groups largely meeting response times. Senior staff told us this delay was due to a historic backlog, the complexity of complaints and the ongoing process of 'test and challenge' of complaints within the health groups. To mitigate against this backlog, the trust had implemented a complaints recovery plan which was monitored through the patient experience subcommittee and quality committee through to the board.

We interviewed a patient representative who confirmed patients, relatives and carers can raise issues and they are listened to by the trust. The trust has set up a patient council with volunteer representatives, particularly involving younger age and those interested in improving services. We were told the trust listened to issues and made changes where necessary. Further, the trust had set up patient user groups (for example, respiratory patients group) and

Our findings

included patient representatives on trust committees.

Since April 2017, the national 'learning from deaths' framework has stipulated that trusts must collect and publish, via quarterly public board papers, information related to deaths of patients

The trust had in place a learning from deaths process, Medical Examiner and Death Certification Process Policy dated November 2022. Deaths of patients with a learning disability were notified appropriately and families and carers were given the opportunity to be involved in the investigation process. The Trust's performance with learning from deaths was reported through health group mortality leads, health group governance committees up to the quality committee.

We undertook five mortality reviews as part of our inspection. All cases reviewed demonstrated an appropriate level of investigation and, in most cases, evidence of lessons being identified and learned being implemented.

There are two main measures used nationally; the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is similar to what would be expected. A higher score means more deaths; a lower score, means fewer. 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. The Trusts SHMI and HSMR have been higher than expected since January 2020 and October 2019 respectively. For the period April 2021 to 2022, the Trust's SHMI was much worse than expected with a value of 1.15, compared to the national rate of 1.0. The SHMI has been higher than expected since January 2020. For the period April 2021 and March 2022, the Trust's HSMR was worse than expected with a value of 114.11, compared to the national rate of 100. The HSMR has been higher than expected since October 2019. The HSMR for weekends was 121.7 and 111.2 for weekdays, which were also much worse when compared nationally (Apr 2021 to Mar 2022).

The trust delivered a broad research portfolio with 142 active and open portfolio studies, ranked 3rd highest in the region by National Institute for Health Research network.

In February 2022, the trust opened a diabetes centre which offered expanded accommodation for diabetes and endocrinology research and other research teams. There had been an increase in Trust-led research undertaken nationally, which has allowed the Trust to expand their research capability and capacity. A Molecular Imaging Research Centre (MIRC) is due to open early 2023 and will house the purchased state of the art medical Cyclotron to produce tracers for positron emission tomography (PET) scanning.

Within the health groups we inspected there were examples of innovation including:

A project had been completed on the reduction of the carbon footprint from the use of asthma inhalers. Short-acting beta agonist (SABA) inhalers account for 70 per cent of the total carbon footprint of all inhalers in the country and uncontrolled asthma has a higher carbon impact than controlled asthma. Collaboration between NHS providers, the University of Hull and a commercial pharmaceutical company used a co-designed intervention to identify and address SABA over-use to improve asthma outcomes and reduce asthma's environmental impact.

Our findings

Within the trust's colorectal service, robotic surgery had been introduced for patients undergoing major cancer surgery. The activity was currently being delivered by two consultants within the department, with a plan to train further consultants in the future. The service had also been able to secure funding from the Cancer Alliance to appoint a Band 4 Cancer Care Co-Ordinator. This post was pivotal in ensuring that patients can move along the cancer pathways in a timely fashion. They were also an additional point of contact for patients who have any concerns or queries.

On the day of our unannounced inspection senior leaders in the trust, including the CEO and Board members, were on a PSIRF oversight training course. We were told of the Trust's plan to aim for early transition to PSIRF as a result of all the preparation work that had been undertaken prior to the final publication in August 2022. All trusts are required to transition from the National Serious Incident Framework (2015) to PSIRF (2022) by September 2023. The trust was aiming to do this by April 2023. PSIRF investigator training also commenced in November 2022 in addition to triumvirates and deputy directors attending a 2-day Human Factors and Patient Safety for Senior Leaders course. The Trust had a multidisciplinary cohort going through a 6-day train the trainer course for Human Factors for Healthcare to support plans to launch its own training and Human Factors hub from April 2023.

The trust told us about its Zero30 plan. The plan sets out seven key areas to reduce its carbon footprint:

- In 2022 the trust opened a solar field, which made it the first hospital in Europe to be powered by solar energy.
- The trust had significantly reduced its use of Entonox in surgery.
- It had eliminated the use of desflurane in anaesthetics
- It had made its buildings more efficient in terms of energy use.
- The Trust engaged with staff to ask the how they will support the programme of work and over 100 individuals had pledged to do something different in support of our Zero30 objectives.
- In January 2022 the Trust joined 'Oh Yes! Net Zero', the Hull Net Zero Collaborative which seeks to deliver a low carbon economy with the support of local business, organisations and individuals.

The Trust told us about a number of achievements over the last twelve months. These included:

- International nurse of the year 2021
- Best UK nursing employer 2022 (Nursing Times)
- Zero tolerance framework, launch event and circle group
- Removal from Tier 1 as part of the elective recovery work.
- The Trust's Green Plan: Becoming Net Zero by 2030 was an ambitious aim. We saw outstanding practice in implementing this with the trust being the first hospital in Europe to be powered by solar energy via its solar field.
- The Trust's approach to research and innovation has resulted in the trust being ranked 3rd highest in the region by the National Institute for Health Research Network.
- The trust had an international partnership in place with a medical centre in Chennai to enable joint research and development opportunities and hosted a research conclave in Chennai which was attended by the British High Commissioner.
- The trust had undertaken significant preparation and accredited external training to support its preparedness for PSIRF. The ambition was to embrace the transformation this enables to improve patient safety.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↔ Mar 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hull Royal Infirmary	Inadequate ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↔ Mar 2023
Castle Hill Hospital	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Overall trust	Inadequate ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↔ Mar 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Hull Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Services for children & young people	Requires improvement Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Critical care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020
End of life care	Good Feb 2017					
Surgery	Inadequate ↓↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Urgent and emergency services	Inadequate ↓ Mar 2023	Inadequate ↓↓ Mar 2023	Requires Improvement ↓ Mar 2023	Inadequate ↓ Mar 2023	Inadequate ↓ Mar 2023	Inadequate ↓ Mar 2023
Maternity	Good Jun 2018					
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall	Inadequate ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↔ Mar 2023	Requires Improvement ↔ Mar 2023

Rating for Castle Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Critical care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020
End of life care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Inadequate ↓↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023
Outpatients	Good Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018
Overall	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Good ↔ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023	Requires Improvement ↓ Mar 2023

Hull Royal Infirmary

Anlaby Road
Hull
HU3 2JZ
Tel: 01482675783
www.hey.nhs.uk

Description of this hospital

Hull Royal Infirmary (HRI) provides a range of acute services to the residents of Hull and the East Riding of Yorkshire, as well as specialist services to North Yorkshire, North and North East Lincolnshire. The trust has approximately 1,160 inpatient beds across the two main hospitals and employs over 7,000 whole time equivalent staff to deliver its services. Hull Royal Infirmary is a major trauma centre for the region and provides care provision for Children and Young People including paediatric emergency care, critical care facilities, acute medical and surgery services as well as the Women and Children's Hospital and the Eye Hospital.

Urgent and emergency services

Inadequate ● ↓

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not ensure that everyone completed it.

All staff received but failed to keep up-to-date with their mandatory training. Mandatory training compliance provided following inspection demonstrated that medical staff achieved 88% compliance against the trust target of 90% and nursing staff achieved 86% compliance against the same target. We had concerns that resuscitation training compliance was only 76% for medical staff and 80% for nursing staff.

Whilst we were informed following inspection that there were processes in place to monitor mandatory training. We saw no evidence that managers monitored mandatory training nor were we told that they alerted staff when they needed to update their training.

The mandatory training programme was comprehensive and when completed met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse but they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was 76% for the completion of safeguarding children training and 79% for the completion of safeguarding adults training.

Medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training compliance was 91% for the completion of safeguarding children training and 76% for the completion of safeguarding adults training.

We requested safeguarding audits following inspection and found that where issues had been identified we saw no subsequent actions in place and no review for nine months. We were not assured that any issues highlighted from safeguarding audits would be actioned promptly following identification.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Urgent and emergency services

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw completed examples of safeguarding referrals during inspection and saw no errors or omissions.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff were inconsistent with the use of equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were not always visibly clean.

All areas were not always clean and the furnishings were not always clean and well-maintained. We saw damage to the floors in the majors area of the department which had not been repaired correctly and covered with tape. This would prevent the floors being cleaned effectively and potentially increase the risk of infection.

Local infection prevention and control (IPC) audits from May 2022 demonstrated omissions in the cleaning of the department. Cleaning records were not always up-to-date and nor did they demonstrate that all areas were cleaned regularly. We saw incomplete room cleaning checklists throughout all areas of the department, with the exception of paediatrics. We were told that cleaning records for the department were not in the department which meant that it was not easy to check when an area was last cleaned. Each patient room is required to be cleaned prior to the next patient being admitted. We observed one such clean, but we were not assured that this had been undertaken properly due to it being completed in less than five minutes. We saw no cleaning record checklist being completed.

Staff did not follow infection control principles including the use of personal protective equipment (PPE) or the principles of bare below elbow (BBE). We saw staff across all roles and grades not wearing facemasks correctly as was stipulated by the trust as a requirement at the time of inspection. We saw examples of staff wearing long sleeves, jewellery and nail varnish. Staff were noted to leave patient rooms without removing PPE. This had previously been highlighted as an issue following local IPC audits but we saw no evidence of any action following identification of the issue. Previous local IPC audits had also highlighted issues around handwashing compliance and a failure to complete required handwashing audits. During inspection we observed no member of staff undertake handwashing before or after patient contact.

Staff failed to demonstrate that they cleaned equipment after patient contact or labelled equipment to show when it was last cleaned. Local IPC audits from May 2022 demonstrated omissions in the cleaning of patient equipment such as commodes. We saw no cleaning of equipment between patient use nor the use of 'I am clean' stickers on any equipment to advise when it was last cleaned. We reviewed senior staff compliance checklists for the previous three months and found repeated omissions in relation to cleaning.

In line with national guidance from NHSE/I Estates, Patient Led Assessments of the Care Environment (PLACE) environmental audits were suspended for the last two years but had recommenced in September 2022, the results were not available at the time of inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff were trained to use them. Staff did not manage clinical waste well.

Urgent and emergency services

The mental health assessment/interview room was not compliant with guidance from the psychiatric liaison accreditation network (PLAN). We were told that there were two specific cubicles in the majors area that would be used for observation of patients with additional mental health needs, both cubicles were noted to have multiple ligature risks and contain equipment that could harm the patient or staff. We requested risk assessments for these cubicles following inspection. The risk assessments provided were dated after we had requested them, so we were not assured that any appropriate risk assessments had been in place when staff used these cubicles prior to inspection to manage patients in a mental health crisis.

We observed patients that had been waiting excessively long times in department being allocated rooms to wait in that were away from the main department with no clear oversight of who was responsible for monitoring that patient.

Staff did not always carry out daily safety checks of specialist equipment. We saw omissions in daily checklists in all areas of the department with the exception of paediatrics.

We reviewed senior staff compliance checklists for the previous three months and found repeated omissions especially in relation to cleaning records not being recorded.

Staff did not dispose of clinical waste safely. We saw multiple examples of sharps bins not being managed in line with guidance. We saw bins that were overfull which meant that the contents were not secure which posed a safety and infection risk. We saw clinical waste bags left of the floor whilst awaiting disposal. We did see that all clinical waste was appropriately colour coded

The design of the environment followed national guidance.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient swiftly. They did not remove or minimise risks nor update any assessments. Staff failed to identify or act quickly upon patients at risk of deterioration. Due to significant concerns in this area, we issued a section 31 letter of intent. We undertook a follow up visit in December 2022 to assess progress.

Staff used a nationally recognised tool to identify deteriorating patients but failed to recognise and escalate them appropriately. During inspection we reviewed five patients who required escalation due to deterioration but found no evidence of escalation in all five patient records. At our follow up visit we reviewed an additional 21 sets of patient records and found escalation warning scores recorded in nine records reviewed but only evidence of appropriate escalation in two records.

Staff could not evidence that they completed risk assessments for each patient on admission or arrival, using a recognised tool, nor that they reviewed this regularly, including after any incident. During inspection we reviewed five patients who had been in the department for times that ranged from 19 hours to 24 hours. None of the five patients had any completed risk assessments available for review, therefore we were not assured that these patients had been adequately risk assessed since their arrival in department. At our follow up visit we reviewed an additional 21 sets of patient records and found no completed risk assessments in 12 patient records.

Urgent and emergency services

Staff knew about but could not evidence how they dealt with any specific risk issues. We reviewed one patient who had been in department in excess of 24 hours, we noted that staff had recognised that the patient was at risk of pressure area damage but no treatment plan, interventions or any use of pressure relieving care were documented. We also did not observe any nursing interventions and we also noted that they were on a standard hospital trolley rather than pressure relieving equipment or a standard hospital bed. At our follow up visit we reviewed an additional 21 sets of patient records and found omitted pressure area risk assessments in 12 patient records. We also noted that intentional rounding was only documented in nine patient records.

We were told that all patients would be assessed at the point of arrival for sepsis. We saw no completed risk assessments for sepsis in any of the 30 records that we reviewed. Following inspection, we requested any sepsis recognition, escalation and treatment audit results but none were provided. We were told that following the first inspection visit that staff would be undertaking sepsis competency training, we requested training compliance figures and no information was provided. At our follow up visit we reviewed an additional 21 sets of patient records and found one completed sepsis screening tool and two screening tools that had been commenced but not completed accurately.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We reviewed two patients who had presented with mental health needs and found no mental health risk assessment in either case. At our follow up visit we reviewed six patients who due to presentation or past medical history would require mental health risk assessment. We found six incomplete or omitted mental health risk assessments. We observed one patient who had been risk assessed as 'high risk' due to active suicidal ideation but none of the required actions to maintain their safety had been taken. The patient was in a non observable cubicle, the cubicle had not been risk assessed as appropriate for a mental health patient in crisis, no equipment had been removed so there were multiple ligature risks and equipment to cause potential harm to self and others. This was escalated to senior staff who addressed the issue immediately but had not been aware of the patient.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). We were told that the mental health team were easy to contact and would attend if required. Following inspection, we were provided with information that documented 24 incidents in the previous 12 months where the mental health team did not attend or were delayed in attending, and patients subsequently experienced long waits for assessment.

We observed examples of patients waiting excessively long times for assessment and patients of a lesser acuity being seen first which meant we were not assured that staff were escalating patients appropriately according to clinical need.

Following inspection we were provided with daily worksheets which demonstrated that there were allocated staff to specific areas. On each inspection visit we were told by nurses in the main department that they were not allocated specific patients. This meant there was a fragmented approach to patient care with no clear oversight of who was responsible for each patient's needs, clinical oversight and escalation.

We reviewed senior staff compliance checklists for the previous three months and found repeated omissions especially in relation to 'safe care'. Prior to our follow up visit we were told that senior nursing staff were now completing audits to ensure oversight of the department and to provide assurance that risk was being managed appropriately. We requested copies of the audit results during the inspection visit and we were told that they weren't available at that time. We requested the information after the inspection visit and no information was provided.

Urgent and emergency services

Staff shared key information to keep patients safe when handing over their care to others. Since the last inspection the service had introduced regular board rounds where all patients would be discussed and any issues raised. We observed these several times during inspection and all relevant information was shared

Shift changes and handovers included all necessary key information to keep patients safe. We observed staff using situation, background, assessment and recommendation (SBAR).

Staffing

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The paediatric department was partially compliant with the 'facing the future' standard of two registered sick children's nurses per shift. They had insufficient numbers to cover unplanned absence, sickness or annual leave but had mitigation of being able to use general trained nurses from the main department who had undertaken and achieved additional paediatric competencies.

The department manager could adjust staffing levels daily according to the needs of patients. We saw discussions during matron level bed meetings regarding the reallocation of staff to meet patient acuity.

The number of nurses and healthcare assistants did not always match the planned numbers. We saw discrepancies between the planned numbers of staff per shift and the actual numbers of staff working on each day of the inspection visit.

The service had low vacancy rates in all nursing grades except band five where the vacancy rate was 7%.

The service had low turnover rates from November 2021 to October 2022 of 3%.

The service had sickness rates of 8%.

The service had increasing rates of bank and agency nurses increasing from 7% in November 2021 to 20% in October 2022.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with bank staff and they all reported that they had a full induction on their first shift in the department.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

Urgent and emergency services

The service had enough medical staff to keep patients safe. Consultant cover met national standards for a department of this size. We saw and we were also told of the ongoing recruitment programme to ensure that consultant cover met and exceeded national requirements.

The medical staff matched the planned number. All junior staff reported that they had enough staff per shift. We saw the daily allocation board for medical staff and noted no gaps in the rota.

The service had low vacancy rates for medical staff.

The service had reducing turnover rates for medical staff.

Sickness rates for medical staff were low at 4% for October 2022 which was an increase of 1% since April 2022

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We saw good examples of skill mix on every shift we observed during inspection.

The service always had a consultant on call during evenings and weekends. We saw that consultant cover met national guidance for overnight and weekend cover.

The service had low rates of bank and locum staff from November 2021 to October 2022.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. Staff found it difficult to access all records when providing care.

We reviewed 30 patient notes and found most to contain errors or omissions. Patient notes were found to be missing key information such as risk assessments and evidence of nursing care. We observed staff across all grades struggle to access all relevant information and would routinely need to access three different computer systems when reviewing patients which meant that we were not assured that all staff could access patient records easily.

We observed during both inspection visits that staff were undertaking patient care but on review this care was not recorded with the patient's records therefore, if the care had not been directly observed we would not have assurance that it had been undertaken

When reviewing data submitted by the trust following inspection, we saw confidential patient details written on daily compliance checklists such as name, date of birth and test results.

When patients transferred to a new team, there were no delays in staff accessing their records, but we were not assured that all relevant information was included.

Records were stored securely. We saw all computers locked which required individual swipe cards or passwords to access.

Urgent and emergency services

Medicines

The service used systems and processes to safely prescribe and administer medicines but we identified issues in the recording and storage of medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. We saw evidence in clinical governance meetings that safety alerts had been received and acted upon.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff did not always store and manage all medicines and prescribing documents safely. We saw six examples of intravenous medicines that had not been identified as out of date. This was highlighted to senior staff and was immediately rectified. We reviewed the controlled drugs administration log and found examples of alterations to stock levels which did not meet best practice guidance, this was also escalated to senior staff at the time of inspection.

Incidents

Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated reported incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff reported that they were encouraged to report incidents and that it was a culture of no blame and that incident reporting was integral to learning.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had reported no never events in the department for the last 12 months.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed clinical governance meeting minutes for the last three months and saw that duty of candour was a fixed agenda point, we also noted an average compliance for duty of candour requirements of 93%.

Staff received feedback from investigation of incidents, both internal and external to the service.

Urgent and emergency services

Staff met to discuss the feedback and look at improvements to patient care. Senior staff gave us examples of newsletters and emails to ensure all staff could access learning from incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed clinical governance meeting minutes for the last three months and saw that incidents were a fixed agenda point.

Managers debriefed and supported staff after any serious incident.

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Inadequate ● ↓↓

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, we saw no evidence of how managers checked to ensure that staff followed guidance. For example, we saw omitted capacity assessments and incomplete risk assessments.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We observed effective conversations between staff regarding the mental health act which demonstrated a good level of understanding.

Nutrition and hydration

Staff did not give patients enough food and drink to meet their needs and improve their health. We saw no examples of staff using special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We reviewed one diabetic patient who waited 16 hours before receiving any nutrition or hydration.

Staff did not fully and accurately complete patients' fluid and nutrition charts where needed. We reviewed five patients who had been in the department between 17 and 24 hours and saw no completed fluid and nutrition charts in all five.

Staff did not complete a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed 30 patients care records and did not see a completed nutrition risk assessment in any of their records.

Urgent and emergency services

Pain relief

Staff did not consistently assess or monitor patients regularly to see if they were in pain. We saw no examples of how they supported those unable to communicate using suitable assessment tools nor give additional pain relief to ease pain.

Staff did not consistently assess patients' pain using a recognised tool nor were they able to give examples of different assessment tools for patients with additional communication needs.

Patients did not always receive pain relief soon after it was identified that they needed it, or they requested it. We reviewed one patient who reported high levels of pain but had not received adequate pain relief in a timely manner.

We spoke with specialist staff who reported that they would regularly attend to patients who had not received appropriate pain relief prior to assessment.

Once pain relief medication was prescribed, staff, administered and recorded pain relief accurately. We saw no errors or omissions in any medicine charts that we reviewed.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment. They did not demonstrate that they used the findings to make improvements or to achieve good outcomes for patients.

We were told that the service was not currently submitting data towards national clinical audits but it was unclear why participation had been suspended. We saw records of participation in relevant national clinical audits in 2021. We reviewed the service audit plan and saw that participation was planned for April 2023.

We saw no evidence that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed locally, completed audits following inspection and saw limited evidence that managers and staff used the results of audits to improve patients' outcomes.

We saw limited evidence that managers used information from the audits to improve care and treatment.

There was limited evidence to demonstrate that managers shared and made sure staff understood information from the audits.

The service had a better than the England average of expected risk of re-attendance of 2% from November 2021 to October 2022.

Competent staff

The service did not always ensure staff were competent for their roles. Managers did not always appraise staff's work performance nor hold supervision meetings with them to provide support and development.

Staff did not always have opportunities to discuss training needs with their line manager and were not always supported to develop their skills and knowledge.

Managers did not consistently support nursing staff to develop through regular, constructive clinical supervision of their work. Appraisal completion rate was 74% which did not meet trust target of 90%. Paediatric nurse appraisal rate was noted to be 100%.

Urgent and emergency services

Managers did not consistently support medical staff to develop through regular, constructive clinical supervision of their work. Appraisal completion rate was 73% which did not meet trust target of 90%.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers recruited, trained and supported volunteers to support patients in the service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed the newly introduced board round meetings that were held throughout each shift. We saw examples of good communication across the multidisciplinary team.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were told that the department had good links with external teams such as the mental health team.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Health Promotion

Staff could give examples of how they could give patients practical support and advice to lead healthier lives.

We saw no evidence that staff assessed each patient's health when admitted nor provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not always follow national guidance to gain patients' consent. Staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff did not always agree personalised measures that limit patients' liberty.

Staff did not evidence how they understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw three examples of patients who potentially had reduced capacity to consent but on review of their records found no completed capacity assessments. We saw one completed capacity assessment during inspection for a patient experiencing an acute mental health crisis, but the assessment had multiple omissions. We raised this during inspection with senior staff and noted that they raised it with the staff concerned but on further review the capacity assessment had still not been completed fully.

Urgent and emergency services

When patients could not give consent, we were not assured that staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw no examples of best interest decisions being recorded in any patient notes that we reviewed.

Nursing staff received but did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards Training compliance was 84% and 82% respectively against a trust target of 90%.

Clinical staff received but did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training compliance was 87% and 86% respectively against a trust target of 90%.

Senior staff in the paediatric department told us that there had been occasions where security staff had been required to restrain paediatric patients in mental health crisis. Following inspection, we requested paediatric restraint training compliance data for security staff. The trust told us that security staff would not restrain paediatric patients and as such did not receive paediatric restraint training. We were not assured that there was sufficient oversight regarding this issue and that there was increased risk that patients were receiving inappropriate care.

We saw no evidence that managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

We saw no evidence that managers monitored how well the service followed the Mental Capacity Act and how they would make changes to practice when necessary.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

All paediatric staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Is the service caring?

Requires Improvement  

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

Compassionate care

Staff always treated patients with compassion and kindness. However, due to the demands and pressures of the department they did not always respect their privacy and dignity and take account of their individual needs.

Staff did not follow policy to keep patient care and treatment confidential. We observed staff entering patients' cubicles without knocking or requesting permission.

Urgent and emergency services

We observed that curtains for patient rooms were not always of a length to ensure that privacy and dignity could be maintained. We observed shorter than standard curtains in the resuscitation area which did not protect the patient's privacy and dignity when closed. We saw examples of the shorter curtains not protecting the patients' dignity whilst receiving personal care.

Staff demonstrated how they understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to give examples of how they would apply additional needs to a patient's care.

Staff did not always document how met a patient's individual need. We saw no examples in 30 patient notes that included how staff had met the personal, cultural, social and religious needs of patients.

We saw examples of not all patients having a call bell to hand. We also observed patients having long waits to have call bells answered.

Emotional support

Staff were not observed to provide emotional support to patients, families and carers to minimise their distress but were able to give examples of how they did this. They understood but did not document patients' personal, cultural and religious needs.

We saw no examples of staff giving patients and those close to them help, emotional support and advice when they needed it. Staff were able to describe how they had previously given emotional support and advice.

We saw no examples of staff supporting patients who became distressed in an open environment or how they helped them maintain their privacy and dignity. Staff were able to describe how they had previously supported distressed patients.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

We saw and we were told on both inspection visits that nurses in the main department were not allocated specific patients, this meant there was a fragmented approach to patient care with no clear oversight of who was responsible for each patient's needs, clinical oversight and escalation.

We saw one example of a family member who was the designated advocate for the patient have their concerns for the patient and the care being received being dismissed without due consideration.

We saw no information on display in the department advising how patients and their families could give feedback on the service and their treatment. We saw no examples of staff supporting patients to enable them to do this.

We saw no evidence of staff supporting patients or ensuring those close to them understood their care and treatment.

Urgent and emergency services

We saw no evidence of staff supporting patients to make advanced decisions about their care.

We saw no evidence of staff supporting patients to make informed decisions about their care.

The feedback from the friends and family survey from May 2022 to October 2022 was 64% positive. We did not see that any work had been undertaken to understand or to improve upon this feedback.

Is the service responsive?

Inadequate ● ↓

Service delivery to meet the needs of local people

The service planned and attempted to provide care in a way that met the needs of local people and the communities served. It also attempted to work with others in the wider system and local organisations to plan care.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. We reviewed 24 incident reports from the past 12 months in which patients had waited a long time for an assessment under the Mental Health Act.

Managers planned and organised services so they met the needs of the local population.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was not always inclusive and could not demonstrate how it took account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

The department had not been designed to meet the needs of patients living with dementia and no adjustments for patients with dementia were apparent. The department covered a large footprint and signage was not clear.

We saw and we were told on each inspection visit that nurses in the main department were not allocated specific patients, this meant there was a fragmented approach to patient care with no clear oversight of who was responsible for each patient's needs, clinical oversight and escalation.

We saw missed opportunities during the admission process to identify additional needs, we saw nursing assessments consistently not completed across all patient care that we reviewed.

We saw no evidence and staff did not tell us about processes to support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff were not able to articulate the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Urgent and emergency services

We saw no evidence and staff did not tell us about patients being given a choice of food and drink to meet their cultural and religious preferences.

Staff told us that they did not have access to communication aids to help patients become partners in their care and treatment.

The service had patient information available in the department but did not have other languages other than English on display. Staff told us they could source alternative languages but could not say where they could get alternative formats.

Interpreters and signers were available; however, staff did not give us any examples of needing to use this service.

Access and flow

People could not always access the service when they needed it and but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times but were not always able to ensure that patients could access emergency services when needed and that they received treatment within agreed timeframes and national targets.

We spoke with ambulance staff who consistently reported delays in handing over patients, we observed long delays in patients being assessed on arrival. In October 2022 it was reported that 252 patients had waited over 2 hours from arrival to being handed over to hospital staff.

The average wait time following initial assessment to first contact with a clinician was 122 minutes in November 2021 but was reported as 169 minutes in October 2022.

The average waiting time to see a clinician was 169 minutes. During inspection we saw multiple examples of patients waiting in excess of 10 hours before being seen by a doctor or other appropriate clinician.

The total time spent in department had increased, the department's average time in department was 405 minutes.

The number of patients waiting for admission more than four hours, but less than 12 hours had worsened. The national average was 26% and the department's average was 21%.

There were 3431 patients waiting more than 12 hours from decision to admit within the last 12 months. In October 2022 the number of patients waiting over 12 hours was 601.

The number of patients leaving the service before being seen by a clinician was 6%.

We observed patients that experienced long waits to be handed over from ambulance staff. We saw examples of patients that needed escalation but were waiting in excess of six hours. We noted one case of a patient who had experienced a long wait whilst there were empty beds in the department and patients of a lower acuity being admitted before them.

During the first day of inspection we observed 16 ambulances waiting to hand over patients to hospital staff, we also noted that there were empty beds within the department but we were given no clear rationale to why the patients were being allowed to wait in the corridor. We escalated this with senior leaders and on the second day we saw that this had improved.

Urgent and emergency services

Managers and staff did not always work to make sure that they started discharge planning as early as possible. During our inspection visit we saw limited discharge planning in any of the notes that we reviewed. Audit data provided following our inspection visit demonstrated that only 30% of patient notes reviewed had any form of discharge planning documented.

We saw specialist staff that planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Staff understood the policy on complaints and knew how to handle them. We reviewed examples complaints and saw them managed in line with trust policy.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed examples of complaints and saw that patients received comprehensive feedback.

Managers shared feedback from complaints with staff and but we were given no examples of how any learning was used to improve the service.

We reviewed clinical governance meeting minutes for the last three months and saw that complaints were not a fixed agenda point but following inspection we saw that there were other forums where complaints would be addressed.

The service did not have clearly displayed information about how to raise a concern in all patient areas.

Not all staff could give examples of how they used patient feedback to improve daily practice.

Patients, relatives and carers did not always know how to complain or raise concerns.

Is the service well-led?

Inadequate  

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Urgent and emergency services

All senior leaders were able to describe their role and how their skills and abilities enabled them to run the service at a local level.

All senior leaders could articulate the priorities and issues that the service faced, they acknowledged previous inspection findings and could describe how they wanted the service to improve.

All staff reported that senior leaders were a visible presence within the department and that they were always approachable.

Some staff reported that there was support at all levels to develop their skills and take on senior roles. We were given examples of clear succession planning which led to all grades being able to progress professionally.

Whilst senior operational leaders could articulate the priorities and issues the service faced, we saw little evidence of senior operational leaders making contributions to either improving patient care or managing patient improvements.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

All senior leaders could articulate the vision and strategy for the service detailed within the trust Strategy 2022-25 which detailed the vision for - Great Staff; Great Care; Great Future. They could describe quality improvement plans that had been undertaken, work that was planned and they could also demonstrate actions that had been previously taken that contributed to the services development.

Staff could describe what the vision and strategy was for the service and they articulated how their role contributed to the strategy.

Culture

Staff did not always feel respected, supported and valued. They were not consistently focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work or provide opportunities for career development. The service did not always evidence that it was an open culture where patients, their families and staff could raise concerns without fear.

Staff survey results from 2021 reported that morale and compassion and inclusivity within the service was beneath the trust average. There was acknowledgement from senior managers regarding the negative responses in the staff survey and that the issues were being addressed.

Staff told us that they didn't feel valued and as such were seeking alternative employment. Responses regarding recognition and reward within the staff survey was also beneath the trust average.

Staff told us during both inspection visits that there was an inconsistent approach to senior staff providing practical support and assistance during shifts. We were told that the level of support given was dependent on what senior staff were on duty at the time. We were told that this had a direct impact on staff morale.

Urgent and emergency services

Following inspection we were provided with daily worksheets which demonstrated that there were allocated staff to specific areas. On each inspection visit we were told by nurses in the main department that they were not allocated specific patients. This meant there was a fragmented approach to patient care with no clear oversight of who was responsible for each patient's needs, clinical oversight and escalation.

We were given examples of individual members of staff being encouraged and supported to develop within their careers. Staff told us that managers were always prepared to help with development.

Staff were able and encouraged to report incidents and make suggestions. They all reported being taken seriously and that their views were considered as valid as more senior staff.

All staff felt confident to raise concerns or to report incidents as they felt that it was not a punitive process and that incident reporting was used as a tool for learning.

Governance

Leaders could not evidence that they operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was no evidence found to support that senior leaders had a sufficient oversight and understanding of where the department was failing to meet standards in care. We saw staff failing to provide the required standard of care on multiple occasions, the same failings had been previously identified from locally completed audits, but we saw limited or no evidence that any action had been taken to address the repeated issues.

We were not assured that there was effective escalation outside of the department and that issues would be appropriately escalated to the executive level of management. We were not assured that managers and senior managers identified, escalated and acted to mitigate risks and poor performance. Managers did not check to ensure remedial actions were completed to address identified risks.

We saw evidence of regular governance meetings held across all grades and roles. These meetings were minuted and then disseminated by email to ensure that all staff had access to them.

Management of risk, issues and performance

Leaders and teams did not effectively use systems to manage performance. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Due to significant concerns in this area, we issued a section 31 letter of intent. We undertook a follow up visit in December 2022 to assess progress.

Prior to our second inspection visit the trust provided a series of actions that it would introduce to address the issues that we had escalated following the first visit. During our second inspection visit we saw limited action taken, we saw work that had either not been undertaken or had been undertaken but with errors, omissions and with no evidence that any identified issues had been acted on.

We were not assured that there were effective systems to manage performance. We saw incomplete or omitted risk assessments in all patient records that we reviewed. Senior leaders had access to systems designed to give oversight and assurance but none of the senior leaders were aware of the scale of the issue when it was raised during inspection.

Urgent and emergency services

We saw examples of when systems had identified in real time that risk assessments had not been completed but when this was raised during inspection, senior staff were unable to describe how they would address this with staff.

We saw multiple examples of staff failing to escalate risk and issues, especially with deteriorating patients. We were told that systems had been implemented to address this but were not yet fully embedded. Following our first inspection visit, we were told that there would be a series of audits undertaken by senior management to provide assurance that all risk was being suitably managed within the department. We requested copies of the completed audits and we found that whilst the audits had been completed and issues had been identified, we saw a very limited response that did not provide assurance that risk was managed appropriately nor that the information was being used to drive improvement.

We were not assured that senior leaders had sufficient oversight of performance targets, there were significant issues especially around total time in department, time to initial assessment and time from decision to admit. Senior leaders were aware of performance targets but whilst there were long term plans to improve performance, we saw no immediate action plans to address performance issues.

We were told that security staff had been used to restrain paediatric patients in mental health crisis. We requested training data following inspection, but we were told that security staff were not trained as they did not fulfil this role. We were not assured that senior leaders had sufficient oversight.

All senior leaders were sighted on the corporate and clinical risk register. They told us about risks being allocated, reviewed and with mitigation being in place.

We were given examples of the service using systems to reduce and share risk throughout all services within the hospital.

Senior leaders and staff were able to give examples of when they had to cope with unexpected events.

Information Management

We were not assured that the service collected reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, nor did they use it to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We were told and we saw that performance data was easily accessible, but we did not see any examples of data being analysed to improve performance.

Staff across all grades struggled to access data when requested. We were repeatedly told that the multiple computer systems were too complicated, took too long to use and that there was no consistent approach in the recording and storage of information which meant that staff could not always find what they were looking for.

We saw locally completed audits that had identified issues such as safeguarding audits but no actions had been taken to use that information to make improvements.

Engagement

Leaders and staff actively and openly engaged with staff but could not demonstrate how they engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Urgent and emergency services

Staff reported that engagement with senior leaders had started to improve following staff survey results regarding engagement that were beneath the trust average.

Senior leaders were able to articulate how they had improved engagement with staff and we saw evidence within the department that demonstrated engagement was ongoing.

We were not given any examples nor did we see any engagement with patients or other groups.

We were told how the service collaborated with partner organisations such as the local NHS ambulance trust but staff were not aware nor could they articulate how this manifested.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All senior leaders were able to articulate the need for continuous innovation and improvement as well as understanding of quality improvement methods and the skills to use them. Examples given included improving access to specific primary and secondary care within the hospital setting which would have a positive effect on performance and patient care.

Medical care (including older people's care)

Requires Improvement ● ↓

Is the service safe?

Requires Improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills but did not make sure all staff completed it.

Nursing and medical staff did not always receive or keep up-to-date with their mandatory training. We reviewed training compliance figures across all wards we visited and saw that at the time of inspection compliance rates were below the trust's 90% target. Evidence provided showed that 80.4% of all staff within the health group had completed their mandatory training.

Although the previous inspection of the service in 2020 identified the need for all medical staff to receive and keep up-to-date with their mandatory training, this was not achieved for either medical or nursing staff, 74.4% for medical staff and 85.2% for nursing staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The completion of Mental Capacity Act (MCA) training was below trust target for both medical staff (70.9%) and nursing staff (84.7%). The completion of Deprivation of Liberty Safeguards (DoLS) training was also below trust target for medical staff (71.3%) and nursing staff (83.2%).

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was monitored within the health group and discussed at regular performance review meetings. Ward managers told us they monitored mandatory training and alerted staff when they needed to update their training. We were told high patient acuity, staff sickness, isolation due to COVID, and operational pressures had impacted on staff maintaining their mandatory training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however not all staff had completed the training in line with trust guidance.

Staff received training specific for their role on how to recognise and report abuse. The trust provided training data which evidenced that at the time of inspection both nursing and medical staff did not meet the trust target of 90% for safeguarding training modules. Safeguarding adults level two training showed a compliance rate 81.8% and safeguarding children level two showed a compliance rate of 80.7% which did not meet the trust target. There were plans in place to improve compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding risks were discussed during patient handovers, ward and board rounds and staff huddles.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust informed us that Patient Led Assessments of the Care Environment (PLACE) visits did not take place in 2021, nor 2022 due to the pandemic, the last reported visit was in 2019. Although we did see PLACE visits during our inspection, assessments were not expected until early 2023.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were supplies of hand gel and PPE in all areas we visited and prompts for their use were visible at all ward entrances to inform staff and visitors of hygiene requirements. We saw staff wore face masks correctly in clinical areas in line with guidance and all clinical staff were bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All wards visited had designated isolation rooms for patients with COVID symptoms or those known to be positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed.

Wards visited reported low or no cases of clostridium difficile (C.diff) and methicillin resistant staphylococcus aureus (MRSA). Staff worked with the trust's infection prevention control team on a programme of quality improvement at ward level. Trust infection rates for the twelve months before inspection showed 21 incidences of clostridium difficile across the health group and 2 incidences of MRSA bacteraemia at the hospital.

The trust carried out enhanced infection prevention and control audits identifying compliance with hand hygiene, PPE, environment and equipment cleaning. These showed between 88.6% and 93.5% compliance across the health group.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). This stipulates patients presenting with one or more high risk criteria should receive antibiotics within an hour of being identified. However, the audit showed a pass rate of 60% for the management and treatment of infection and sepsis and resulted in recommendations for improvement.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

Medical care (including older people's care)

The design of the environment followed national guidance. At ward entrances, face masks and hand gel were readily available. Wards we visited had boards to display information about staff on the ward, visiting times, who was in charge, and other useful information, such as falls and numbers of incidences of infections.

Staff carried out daily safety checks of specialist equipment. Equipment including emergency resuscitation equipment was subject to routine planned preventative maintenance and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers.

The service had suitable facilities to meet the needs of patients' families. Each ward visited had a specific room set aside for families, patients and also for the use of staff to discuss issues with patients and families.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) alert system was used and provided an ongoing oversight of patients which helped staff to identify and escalate deterioration in a patient's condition. We saw appropriate completion of NEWS2 documentation and appropriate escalation of patients within patient records.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. Risk assessments were completed on admission and transfer for falls, nutrition and hydration, pressure area care, dementia and moving and handling. We reviewed completed risk assessments and saw these were used to plan care and treatment pathways for each patient.

Some patients required one to one observation but, due to staffing pressures, this was not always possible. Staff told us they would try to cohort patients at risk in the same bay.

An audit to '...measure compliance with, and knowledge of National guidelines and Local Policy for sepsis within Hull University Teaching Hospitals' was completed in March 2022. This showed a 60% pass rate for the management and treatment of infection and sepsis, and resulted in recommendations to:

- Escalate patients with a National Early Warning Score (NEWS2) of 5-6 with urgency to the nurse-in-charge and doctor for urgent review within 30 mins;
- Escalate patients with a NEWS2 score of 7+ as an emergency, to the nurse-in-charge and senior doctor to review immediately (within 15 mins) and inform outreach teams;
- Ensure all patients with a NEWS2 score of 5 or more, commence the trust 'Sepsis Screening Tool'.

A referral to the critical care outreach team was made by anyone involved in caring for patients acutely ill or deteriorating causing concern, or those meeting the trust's escalation criteria.

Medical care (including older people's care)

Following review there were 59 pressure ulcer incidents reported in August 2022 across the health group; these were reported as category 2 pressure damage (38) and deep tissue injury (21). There were 14 hospital acquired pressure ulcers reported and validated in September 2022, the ward with the highest number was Ward 110 Stroke Unit.

In response, the tissue viability team continued with fundamental standard audits, structured and intensive ward and board rounds, leg ulcer training, a quarterly newsletter, and a tissue and viability task and finish group had been established to help reduce these numbers.

However, the numbers of pressure ulcer incidents had not yet started to decrease, averaging 48 each month over the four months from May to August 2022. To further address this, link nurse sessions had commenced, and the tissue viability team were undertaking leg ulcer training in line with the 'National Wound Care Strategy Programme'.

The annual report of the falls prevention committee showed the trust recorded an overall increase in the number of inpatient falls reported between 2020/2021 and 2021/2022, from 2370 to 2825 (18.7% increase). However this was a decrease in the number of falls measured by falls for each 1000 beds days. The ward with the highest number of falls (September 2022) was ward 10 endocrinology with 18 recorded.

Initiatives taken to reduce the number of falls included an updated patient and relative information leaflet, e-learning packages for all staff, and agreement that falls prevention training should become mandatory for all registered and non-registered nurses with the exception of midwives and paediatric nurses. Further, a falls educator had been allocated for a one-year secondment, this role commenced in February 2022 and helped develop a multi-disciplinary team approach to falls prevention and a network of falls champions for each ward. We saw a specific falls bundle had been designed and was completed as part of the electronic nursing documentation.

The service had 24-hour access to mental health liaison and specialist mental health support.

Shift changes and handovers included all necessary key information to keep patients safe. We found handovers on all wards discussed key risks and risk mitigation. Wards held safety huddles as part of the daily handover process where patient risks were discussed including staffing, numbers of patients, risk of falls, enhanced care patients and escalation, end of life, cannula care, pressure ulcers, infections and infection control, and do not attempt cardiopulmonary resuscitation (DNACPR) orders.

Nurse staffing

Senior leaders within the health group acknowledged the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although staffing levels and skill mix were regularly reviewed, this did not always provide established safe levels of staffing.

The service did not always have enough nursing and support staff to keep patients safe. Due to national shortages and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. Staff told us they were frequently moved between wards to cover patient acuity, they further said that this compromised patient care through a lack of continuity of care. We were informed by patients and receiving services before inspection of delayed and unsafe discharges from medical wards.

Although ward managers told us they were allocated dedicated managerial hours, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care.

Medical care (including older people's care)

Managers reviewed staffing levels throughout the day and moved staff across the hospital when needed based on acuity, enhanced patient needs and staff availability. Electronic systems were used to identify and support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks.

'Care hours per patient day' (CHPPD) detail staffing levels in relation to inpatient numbers on an inpatient ward. Overall trust CHPPD remained between 6.5 and 7.0 hours in the 12 months to May 2022, although there was variance in wards in the hospital, for example 4.01 hours (H9, geriatric medicine) and 8.74 hours (H36, general medicine).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a 'red flag' system to identify staff shortfalls on individual wards. This identified when there were less than 2 registered nurses on a ward, the shortfall in registered nurse time (hours) and the inability to give 1:1 care and support on the ward. There had been 455 red flags identified in October 2022; the highest being the shortfall in registered nurse time (214 hours total).

Meetings and 'huddles' were held throughout the day including matrons and shift leads to highlight concerns in the red flag system, dependency, acuity and staffing levels. This enabled an early response and support by the health group. An overview of staffing and potential operational risks was also shared at trust operational meetings held three times daily. Matrons and site duty managers liaised across health groups and sites to ensure mitigating actions were taken.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Nursing staff vacancies at the time of inspection showed a whole-time equivalent shortfall of 223 hours across the hospital. Sickness rates for nursing staff at the time of inspection showed a sickness rate of 5.41%.

The health group had undertaken international recruitment and worked with the local university to attract nurses to the trust. Further the trust was developing currently employed staff through apprenticeships, nurse associate training and a hybrid role of auxiliary nurse and therapist to address staff shortfalls.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. The medical staff did not match the planned number. Patients were reviewed by consultants depending on their care pathway.

However, we were not assured there was sufficient consultant cover in the evenings and at weekends to ensure timely and effective decision making and discharge. In the twelve months before inspection internal locums provided 14.3 whole time equivalent staff and external bank and locums provided 6.7 whole time equivalent staff.

To address this, weekly meetings were held with medical staffing teams to gain assurance that cover for all shifts for the coming seven days was in place. A health group patient flow meeting was held which reviewed overnight staffing so that plans for cover were identified.

Medical care (including older people's care)

Since August 2022, the trust had changed the management of rotas to try to help minimise gaps. There are now regular meetings between the clinical director, rota co-ordinator and human resources and the rota was issued in four-month blocks. This enabled specialist registrars (StRs) to move between rotas to ensure the residential medical officer (RMO) slots were always filled and helped to co-ordinate when StRs came off the RMO rota, such as for acting up as a consultant. Gaps in the rota had been reduced as a result.

Medical staff vacancies at the time of inspection showed a whole-time equivalent shortfall of 221.6 hours across the hospital. Sickness rates for medical staff at the time of inspection showed a sickness rate of 2.43%.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were recorded on handheld electronic devices and terminals located on wards. The electronic system had all relevant risk assessments, protocols and pathways available for staff to access. Although nursing documentation had been migrated to the electronic system, some medical notes were still in paper format.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record system automatically allowed hospital staff to access the record.

Records were stored securely. All terminals and handheld electronic devices had secure log-in access to the device and patient care records.

Electronic whiteboards were used on wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations. We saw handovers where the information on whiteboards was used to update patient assessments and care plans immediately.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We observed nursing staff administer safely, in a timely way and with a caring attitude. Small amounts of stock medications were held on wards, patients were discharged with 14 days' supply provided. A pharmacy technician was allocated to each ward, and they checked patients had a sufficient supply of medicines, undertake reconciliation in line with the immediate discharge letter (IDL) if the patient had transferred on to the ward quickly; the IDL was clinically checked by a pharmacist.

Medical care (including older people's care)

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Paper copies of the discharge summary, including discharge medicines were given to the patient, and discharge letters contained details of medicines started, stopped and to be continued. Discharge medicines were all clearly labelled, and patients were counselled about their medicines by the pharmacy technician.

The nurse in the discharge lounge did not have access to electronic Prescribing and Medicines Administration (ePMA) records and was reliant on paper handover sheets that wards send with the patient for any critical information about medicines (for example if the patient has diabetes). There was no system in place for keeping medicine administration records in the discharge lounge.

Staff completed medicines records accurately and kept them up-to-date. We reviewed 22 electronic Prescribing and Medicines Administration (ePMA) records and found these were completed appropriately.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff were confident they knew which incidents to report in line with trust policy. They told us they received feedback from incidents reported through team meetings and where appropriate learning was shared directly by their ward manager.

Patient safety alerts (PSA) were cascaded throughout the health group to relevant staff and compliance with alerts was monitored through the health group monthly governance briefing report. At the time of inspection two PSA showed as compliant and had been closed, one (risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis from a particular insulin pump) was due for compliance and closure in November 2022), and the other was awaiting confirmation of compliance before closure on schedule.

Managers shared learning about never events with their staff and across the trust. We discussed a serious incident which had happened in February 2022 with managers and staff. This had involved the placing of an antimicrobial skin cleanser within reach of a patient. This had been investigated, new procedures developed, and staff across the health group confirmed they had been made aware of the incident and the procedures put in place to prevent repetition.

Staff reported serious incidents clearly and in line with trust policy. From October 2021 to September 2022, there had been 28 incidents reported to the Strategic Executive Information System (StEIS) under the medical speciality. The highest number of incidents were reported in December 2021 and the most common incident type was 'Slips/trips/falls meeting SI criteria'.

Medical care (including older people's care)

A total of 5,071 incidents were reported to the National Reporting and Learning System (NRLS) under 'medical specialties' from February to September 2022. Of these, 3005 were related to 'patient accident' or 'implementation of care and ongoing/monitoring review'.

The majority of all medicine's incidents were reported as 'low' or 'no harm'. The health group reported 468 incidents in September 2022, a decrease compared to the previous month (503) and the overdue and breached incidents (not completed within 28 days) decreased from 240 to 228. Of these, 9 major and 17 moderate harms were recorded.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the last five serious incident investigation reports for the hospital. These showed staff understood and applied duty of candour (DoC). They were open and transparent and gave patients and families a full explanation when things had gone wrong. Ward managers and most of the staff we spoke to knew of the DoC requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families.

The trust had carried out a 'Falls Serious Incidents Thematic Review' in June 2022. The review identified the patients' medical condition on admission, an overview of the incident, further comments and root cause and contributory factors to the fall.

Contributory factors to these incidents were identified as the accurate assessment of patient falls risk both on admission and throughout their care and acuity pressures on ward staff contributing to the missed reassessment of falls risks. An action plan had been developed to address these and was being taken forward by the trust 'Falls Prevention' committee.

Managers debriefed and supported staff after any serious incident. Investigations identified care and service delivery problems where appropriate, recommendations, action plans and key lessons learnt for debrief to staff.

Is the service effective?

Requires Improvement  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. However, the majority of procedural documents were past their review dates.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Handheld devices contained current care pathways and plans, flow charts and policies for risk assessments, patient care and treatment. The trust had systems and processes in place to ensure that care was given in line with national guidance, such as that issued by the National Institute for Health and Care Excellence (NICE).

Medical care (including older people's care)

An audit (June 2022) of the use of direct oral anticoagulants (DOACs) in the treatment of venous thromboembolism (VTE) showed 99% compliance with VTE diagnosis documented on the patient's discharge letter, 81% compliance with therapy duration documented, 64% compliance with the dose of DOAC adjusted to the patient's renal function, and 100% compliance with no contraindication (for example mechanical heart valve) to DOAC therapy.

The trust had a guideline (August 2022) in place for the management of infection and sepsis screening. This identified the appropriate triggers for the use of 'The Infection and Sepsis Screening and Management Pathway', the expected timeframe for assessment and the minimum investigations to identify hidden potential infection. Sepsis training provided by the sepsis team was currently not mandatory and was paused during the COVID pandemic, but was included in the initial junior doctor training programme.

Trust policies reviewed after inspection were comprehensive, in date and version controlled. However, the 'Medicine health group governance briefing report' (October 2022) showed 66% of procedural documents were overdue for review. These included the Nutrition and Hydration Policy (review date November 2020), Stroke Unit Operational Policy (November 2020), Delirium Policy (March 2021), Insertion and Maintenance of Naso-Oro Gastric Tubes (April 2022). In addition, 23 guidelines were also overdue for review, for example oxygen guidelines, hypertension and chronic heart failure. In total, these were 66% of procedural documents specific to the health group.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw staff at handover meetings referred to the psychological and emotional needs of patients, their relatives, and carers and referred patients to the psychiatric liaison team when needed.

The endoscopy unit did not have Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards. However, the service was working towards this and had produced a comprehensive action plan covering, for example, leadership, safety, quality patient involvement and teamwork.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Signage was in place on wards to make it clear which patients had modified diets or were nil by mouth.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw the screening tool was fully completed. Red trays and jugs were in use for patients identified as at risk and those needing assistance at mealtimes. We observed mealtimes on different wards and saw that all patients were served food and assistance was given to those who needed it. Staff were careful to note which patients were nil by mouth. Patients' relatives were encouraged to assist with mealtimes if they wished.

On some wards a caterer undertook a refreshment round twice a day offering patients tea, coffee or a cold drink. Snacks were also available. Caterers knew which patient required a special diet, whiteboards in kitchen areas indicated dietary requirements. Water jugs or beakers of water were at each patient's bedside and these were replenished throughout the day. One patient said that they had a restricted diet for medical reasons but even though their options were limited on the regular menu, caterers went out of their way to accommodate her dietary choices when able.

Medical care (including older people's care)

The trust had a commitment to protected mealtimes. To ensure patients received appropriate nutritional uptake and assistance at mealtimes, tasks such as cleaning were not permitted in patient areas.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it and patients requiring this were frequently reviewed. In addition, each ward had a member of nursing staff who was a nutrition champion. One ward had three nutrition champions (Ward 5).

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain-scoring tool to assess a patient's level of pain. All staff we spoke with knew about pain assessments and how to score patients level of pain. We did not observe staff using communication aids to support patients unable to communicate or for those with specific needs, for example dementia or learning difficulties.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Additional pain relief was requested from medical staff, if required. Some staff told us that some pain medications were given late due to requests for prescribing being delayed due to ward pressures. However, patients we spoke with told us staff managed their pain in a timely way.

A trust audit (December 2021 to January 2022) highlighted discrepancies between the timeliness and accuracy of prescriptions written by pain nurse prescribers in comparison to junior doctors following pain team recommendations. This supported a business case to support pain nurse development and completion of non-medical prescribing, resulting in an established substantive post, and plans for the further development of pain nurses to undertake non-medical prescribing.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Due to the COVID pandemic there have been delays to the publication of national audits, for example the National Lung Cancer Audit, National Heart Failure Audit, National Diabetes Inpatient Audit and the National Audit of Inpatient Falls.

However the National Audit of Inpatient Falls issued in November 2021 and covering the year up to December 2021 resulted in actions, some ongoing, to add completion of training for reporting of falls for all nurses, the introduction of yellow bracelets for patients at risk of falls, and the review of incidents reported within the health group.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. Trust data showed that no medical ward met the trust target (95%) for testing patients for venous

Medical care (including older people's care)

thromboembolism (VTE) risk within 24 hours of admission, in the twelve months before inspection. Across the health group 82.3% of patients were tested for venous thromboembolism (VTE) risk within 24 hours of admission, in the twelve months before inspection. The National Institute of Clinical Excellence (NICE) states ‘...all patients should receive a VTE risk assessment as soon as possible after admission to hospital or by the time of first consult review by a medic’.

The hospital had a lower than expected risk of readmission for elective care than the England average. From January 2021 to December 2021, patients at the hospital had a lower than expected risk of readmission for elective admissions when compared to the England average. Of the top three specialties by count of admission, gastroenterology and endocrinology had a lower than expected risk of readmission and nephrology had a higher than expected risk of readmission when compared to the England average.

The hospital had a similar to the expected risk of readmission for non-elective care than the England average. From January 2021 to December 2021, patients at the hospital had a similar to the expected risk of readmission for non-elective admissions when compared to the England average. Of the top three specialties by count of admission, general medicine and acute internal medicine had a similar to the expected risk of readmission to the England average and geriatric medicine had a lower than expected risk of readmission when compared to the England average.

Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. The health group had identified actions to improve outcomes from previous national and local audits, for example to hold a falls prevention week (September 2022) and education sessions with general practitioners (inflammatory arthritis). Initiatives to reduce falls within the trust had resulted in a reduction of falls for each thousand bed days to an average of 7.7%, a 0.6% decrease from the previous year.

There were medical patients outlying on non-medical wards on the day of inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses and internationally recruited nurses with a full induction and preceptorship.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust provided information which showed that the health group compliance with nurse appraisal completion was 72.1%, this did not meet the trust target. Ward managers had plans in place to complete appraisals, but told us operational challenges continued to affect the ability of staff to undertake appraisal.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The appraisal completion rate for medical staff within the health group was 91.4%, above the trust target of 90%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role. On most wards we found link nurses were in place for falls, dementia and tissue viability. These members of staff had received training from specialist teams within the trust.

Medical care (including older people's care)

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We found there were daily multidisciplinary team (MDT) meetings on each ward. These were attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. Each patient was discussed, and their changing needs and care plans updated as well as discharge planning.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The health group had access to teams for ongoing assessments of mental health, alcohol and psychiatric liaison. Although these were available 24 hours a day, we were told there were long waits at busy times. Initial assessments were carried out by consultants and registrars, and junior doctors had input if any patient concerns were identified.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Although, key services were available seven days a week to support timely patient care, we were not assured there was sufficient consultant cover in the evenings and at weekends.

Consultants led daily ward rounds on all wards. Patients are reviewed by consultants depending on the care pathway. A review of patient notes showed they were clinically assessed by a consultant within 12 hours of admission.

However, we were not assured there was sufficient consultant cover in the evenings and at weekends. In the twelve months before inspection internal locums provided 14.3 whole time equivalent staff (29,842 hours) and external bank and locums provided 6.7 whole time equivalent staff (13,894 hours).

To address this, weekly meetings were held with medical staffing teams to gain assurance that cover for all shifts for the coming seven days was in place. A health group patient flow meeting was held which reviewed overnight staffing so that plans for cover were identified and actioned.

An operational support manager had been employed to provide daily oversight of all rotas, liaising with the deputy director of operations and health group general managers to support the filling of rota gaps by internal and external locums. Plans were communicated with on-call teams, residential medical officers and on-call consultants daily, and updates given to the site operational bed meetings.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Staff told us there was good access to diagnostic services.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Medical care (including older people's care)

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw information promoting healthy lifestyles and support on all wards and units visited.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were screened on admission for smoking and alcohol intake as part of the admission pathway and offered appropriate advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent and support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed ten patient records, and these showed staff formally assessed patient's capacity and ensured care and treatment was appropriate and safe. Patient care records reflected day to day decision making in respect to patient care and documentation of capacity for example receiving personal care.

A trust audit of Deprivation of Liberty Safeguards (DoLS) applications carried out between April and September 2022 raised a number of concerns, as follows:

- *The over propensity for nurses to complete the process;*
- *Patients may be illegally detained as the quality of the mental capacity assessments do not meet the legal requirements in line with the MCA 2005;*
- *Poor completion delays the process and the subsequent submission to the LA's which may lead to an illegal detention;*
- *Poor application of the fundamental capacity assessment leading to delays in the process;*
- *Poor compliance to the DATIX procedure to register restrictive process;*
- *Current paper-based process is time consuming and does not promote quality of completion.*

In response the trust decided to continue monthly audit, review fundamental Mental Capacity Act training, review existing documentation and pursue an information technology in preparation for the change to Liberty Protection Safeguards.

When patients could not give consent, staff made decisions but did not always document the best interest process. We reviewed do not attempt cardio-pulmonary resuscitation (DNACPR) forms and found that none of those that identified the patient as lacking capacity had evidence of best interest decision making processes (ward 5). Staff told us this would usually be done by a doctor and they would document on the form that a discussion with the patient's family had taken place. This was not documented.

A trust 'Audit of Mental Capacity Act (2005) Compliance and consent 4 process' also found variable results, for example, evidence of a best interest decision, completion of a best interest discussion at the same time as a mental capacity assessment and evidence of family involvement.

Medical care (including older people's care)

The hospital made 28 DoLS applications in the three months before inspection. Four of these were still open and awaiting decision from the local authority. The remaining 24 were either cancelled after sent to the local authority due to the patient being discharged or a change in needs (9), or cancelled before sent due to the patient being discharged or change in needs (15).

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information supplied by the trust showed that 70.9% of medical staff and 84.7% of nursing staff had received Mental Capacity Act training at the time of inspection. Further, 71.3% of medical staff and 83.2% of nursing staff had received Deprivation of Liberty Safeguards training. These completion rates did not meet trust compliance targets of 90%.

Is the service caring?

Good   

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff interact with patients in a way that ensured patients maintained their dignity throughout their care. We observed staff assisting patients with personal care in private, maintaining the dignity of the patient. We saw positive interactions between staff and patients. Staff introduced themselves to patients before providing care and included patients in discussions about their care. Staff communicated in a positive manner with patients whilst undertaking routine observations, assisting patients to eat and drink and assisting them with their care.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. All patients told us staff treated them well, with kindness and respect; all patients we spoke with praised staff and the total experience with the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. Bed curtains were drawn when providing care and treatment and we saw nursing and medical staff spoke with patients in private to maintain confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients said staff treated them well and with kindness.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We found patients were given emotional support when needed, and staff showed caring and empathy. Wards had designated family rooms to enable support to be given to patients by family and friends, and these were also used for discussions between staff and family members.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. One patient told us that all the staff had been brilliant and that they had been kept well informed about treatment options needed for their condition. They said that everyone smiled when passing their room and everyone knew their name.

The health group had electronic devices available for patients to contact family and friends. Patients could see and talk with their loved ones using remote technology.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff spending time with patients, their families and carers when discussing their discharge plan. Patients told us staff were knowledgeable and provided good care.

Staff talked with patients, families and carers in a way they could understand. Patients told us that the staff were always busy and working hard, but felt this did not compromise care. Patients who had raised concerns about their health were reassured by staff who took time to explain investigations and discharge plans to them and their families, and carers.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were able to give informal feedback on each ward, but were also able to complete the 'Friends and Family Test'; the health group had a 90.75% positive rating.

Staff supported patients to make advanced decisions about their care. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) which supports conversations about care in a future emergency, was in place. It was designed to allow patients greater influence on what happens to them, and that their wishes are carried out appropriately, should they ever find themselves in an emergency situation where they are not able to express their wants and/or needs. We reviewed ten ReSPECT care records had found these had been completed appropriately and 82% of medical staff had completed ReSPECT training.

Patients gave positive feedback about the service. We received positive comments from all patients spoken with, this was complemented by positive comments from family members and carers.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement  

Our rating of responsive stayed the same. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust confirmed there had been no mixed sex accommodation breaches in the last twelve months.

Facilities and premises were appropriate for the services being delivered. We found all wards to be well organised, clean and suitable for their use for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health issues, learning disabilities and dementia. The trust had a dementia and delirium strategy in place which aimed to provide high quality dementia care and focused on improving compliance with dementia through delirium and depression triple screening on admission, completion of the dementia and delirium digitalisation plan, and investigation of potential themes relating to inequality in care (for example, length of stay, patient harms, safeguarding concerns).

The strategy had resulted in the appointment of a clinical educator to provide additional training and education support in dementia and learning disability, patient name boards had been improved to enable staff to easily identify patients' communication needs (for example, glasses, hearing aids) and harm risks (falls, pressure ulcers, nutrition), and dementia activity and companion volunteer roles had been developed.

Managers ensured that patients who did not attend appointments were contacted.

The service had systems to help care for patients in need of additional support or specialist intervention. The health group had access to teams for ongoing support to patients with issues around mental health, alcohol dependency and psychiatric needs.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards were designed to meet the needs of patients living with dementia. The trust 'Dementia and Delirium Strategy 2022-2027) set out the trust's plan to deliver safe, high quality care and services to patients and their families living with dementia and/or experiencing delirium and established the dementia and delirium steering group.

Medical care (including older people's care)

The strategy aimed to place the person living with dementia and/or experiencing delirium, including their families/carers, at the forefront of the trust strategy by:

- developing and supporting local and national initiatives to reduce the risks of developing dementia;
- supporting regional dementia pathways to improve diagnosis rates;
- supporting delivery of patient engagement and experience initiatives;
- creating communications systems that actively seek to gain patient and essential care givers feedback;
- embedding digital systems that provide ongoing quality data to guide targeted quality improvement projects such as length of stay, falls and pressure ulcer prevention;
- ensuring current dementia friendly environments are maintained, ongoing projects completed, and all new builds/improvement projects adhere to Kings Fund principles; and
- establishing and promoting individualised spiritual care.

We found wards were dementia friendly, and staff supported patients living with dementia. Wards used the 'butterfly scheme' to identify patients living with dementia; a butterfly shaded in blue meant the patients had a confirmed diagnosis, an outline meant the patient could be suffering with delirium and might need reassessment. The butterfly was displayed above a patient's bed, on the name board and the patient's identity bracelet. This meant staff could easily see if a patient might need additional assistance in a discreet way.

The health group cared for patients with mobility difficulties and the ward environment had been designed to help those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request.

Although staff understood the policy on meeting the information and communication needs of patients with a disability or sensory loss, we did not observe this being applied.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We reviewed morbidity and mortality cases discussed in the three months before inspection and the minutes of the emergency medicine/acute medicine joint morbidity and mortality meeting. These showed a structured review of the patient journey within the hospital, patient outcomes, good practice and learning outcomes.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Some patients needed longer stays while they awaited treatment and discharge.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Medical care (including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. From February 2021 to January 2022 the average length of stay for medical elective patients at the trust was 5.1 days, which was lower than the England average of 6.4 days. For medical non-elective patients, the average length of stay was 6.8 days, which was higher than the England average of 6.0 days.

From February 2021 to January 2022 the average length of stay for medical elective patients at Hull Royal Infirmary was 6.2 days, which was about the same as the England average of 6.4 days. Of the top three specialities, by count of admission, average length of stay for elective patients in nephrology and respiratory medicine was about the same as the England average; gastroenterology was higher than the England average.

For medical non-elective patients, the average length of stay was 7.3 days, which was higher than the England average of 6.0 days. Of the top three specialities, by count of admission, average length of stay for non-elective patients in general medicine and acute internal medicine was higher than the England average; geriatric medicine was lower than the England average.

Since January 2022, there had been a steady increase in the total number of patients on the waiting list, this has been in line with the trend seen across the region and country (approx. 2% a month). As of August 2022, there were almost 72,000 patients on the waiting list which was 22% more than in August 2021 (just under 59,000). The three specialities with the highest waiting lists were general surgery, 'other' and ear, nose and throat.

The number of patients treated increased by 33% during the 12 months to August 2022 (from just over 14,000 in August 2021 to almost 19,000 in August 2022).

The number of patients waiting over 52 weeks for treatment had reduced over the 12 months to August 2022, although there had been an upward trend in numbers since June 2022. The trust still had the highest number of patients waiting over 52 weeks in the region, with 7.5% of the waiting list waiting over 52 weeks compared to a regional average of 3.4%.

The percentage of patients treated within 18 weeks had steadily declined since January 2022, in line with regional and national trends.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The trust had a 'Non-criteria to Reside Patient Wards' standard operating procedure in place (June 2022). The Trust recognised there were patients with no criteria to reside who cannot be discharged due to lack of capacity and resource within social care. In response, the trust had established 'No Criteria to Reside Wards'. The aim was to ensure appropriate levels of care, effective deployment of resource and increase patient flow through the hospital.

The procedure identified that a delegated consultant will provide two weekly board rounds and a weekly virtual board round. Between rounds, advice is available by telephone from the named consultant for the ward. The health group ensured junior doctor cover was available for a minimum of one doctor working 9 a.m. to 9 p.m. daily (7 days a week) and after 9 p.m. cover was met by the on-call team.

Escalation of issues were made to the appropriate speciality and ward moves minimised as far as possible. If a patient did require an escalation to an acute ward, they would be transferred directly to a base ward covered by the appropriate speciality or named consultant. In exceptional circumstances (for example, when the patient needs urgent transfer and a bed on the base ward is not readily available), patients were readmitted to either the acute medical assessment unit or elderly assessment unit. All efforts were made not to transfer the patient back to the emergency department.

Medical care (including older people's care)

In the six months prior to inspection (May to October 2022) the hospital had 5925 admissions of patients identified as 'non-criteria to reside' on to wards and assessment units, during our inspection there was an average of 131 'non-criteria to reside' patients across the two hospitals. Staff told us there were difficulties in accessing timely and appropriate care packages for patients on these wards. We were told that some patients stayed on no criteria to reside wards for a significant length of time awaiting social care packages; this meant some patients had to return to acute medical wards to receive more appropriate care.

The service moved patients only when there was a clear medical reason or in their best interest. Although, staff tried not to move patients between wards at night this did happen when there was a clear medical reason or in the best interest of the patient. The trust provided data which showed in the three months before inspection (August to September 2022) there were 126 bed moves at night (10 p.m. to 8 a.m.).

Managers and staff started planning each patient's discharge as early as possible. Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. There had been a steady increase in the percentage of patients delayed at discharge since July 2022. As of September 2022, 85% of patients were delayed at discharge, this was the highest in the local integrated care system (ICS) and almost 10% more than the regional average (76%).

For half of patients at the trust (55%) the main reason for being delayed was due to waiting for availability of beds or resource assessment in adult social care settings. This was similar to the regional and national figures.

Patients with a documented discharge plan within 24 hours of admission were not admitted to a no criteria to reside ward unless necessary, due to bed availability pressures, and discharged directly from the admitting ward. The trust began the discharge process for all 'pathway 0' patients (patients whose needs can be met through normal ward care) on admission leading to patients being identified for discharge as soon as practicable. However, there were often delays in discharge due to the timing of the decision to discharge, for example in the afternoon, and the availability of social care beds and packages of care.

The trust had not developed other initiatives to ensure the discharge of patients as soon and as safely as practical ensuring patients' care was optimised. For example, the trust had not instigated a 'discharge to assess' process such as the 'Hospital Discharge Service Guidance' (March 2020) which sets out how trusts and local authorities can plan and deliver hospital discharge and recovery services from acute hospital settings.

There were 22,053 'pathway 0' patients discharged in the six months before inspection; 3676 'pathway 0' patients discharged in the month before inspection (October 2022).

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Complaints information was available online and displayed on wards. However, we received comments before inspection that the distinction between raising a concern with the Patient Advice and Liaison Service (PALS) and making a formal complaint was not clear.

Medical care (including older people's care)

The average turnaround time for complaints to be resolved or closed in the last 12 months was 76 days, this is above the trust target of 40 days. During interview the head of patient experience told us this delay was due to a historic backlog, the complexity of complaints and the ongoing process of 'test and challenge' of complaints within the health group.

In the three months before inspection, there were 33 complaints received by the health group, and at the time of the inspection there were around 160 open complaints across the trust.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The main themes of complaints were around inappropriate discharge, co-ordination of medical treatment and lack of explanation of care. The health group leadership team had initiated increased discharge planning on wards through the appointment of co-ordinators on each medical ward.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed six responses to formal complaints to the trust. We found these were not always written as sensitively as possible and needed improvement and contained medical terminology without explanation. The head of patient experience acknowledged that these findings were accurate and that they worked with individual specialities to improve the tone and sensitivity.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, we were told staff identified patients with communication needs were identified as soon as possible and interpreters and translation services accessed.

Is the service well-led?

Requires Improvement ● ↓

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

Leadership

Leaders had the skills and abilities to run the service. Although, they understood the priorities and issues the service faced, they had not always fully addressed these. They were visible and approachable in the service for patients and staff.

The medicine health group was led by a triumvirate of a medical director, an interim nurse director and a director of operations. The current make-up of the team had been formed in the last twelve months, had a variety of complementary experience and worked constructively.

The team had developed and was maintaining the group strategy, and operational plans for general medicine, specialist medicine, frailty and acute medicine, and cardiology. We were told that there was a positive reporting culture of incidents within the group, and the team was able to confirm the top risks, for example nurse staffing, non-criteria to reside patients, medical vacancies and impact on seven-day services.

Medical care (including older people's care)

The team was also working on improving patient discharges through in-reach to the emergency department and surgical wards to assess patients, improvements to the DoLS process and the digitalisation of medical records.

However, there were issues the leadership team had identified but had not yet fully addressed, for example non-criteria to reside patients, seven-day services, both nursing and medical recruitment, unsafe discharges and delayed discharges.

We found visible leadership on wards by matrons and ward managers. Staff told us they felt supported by matrons and senior nurses.

Vision and Strategy

The service had a vision for what it wanted to achieve and operational plans to turn it into action, developed with all relevant stakeholders.

The vision of the health group was to aim for excellence without exception, continue to put patients first, and to be a great place to work and a great place to receive care.

The medicine health group had operational plans in place for general medicine, specialist medicine, frailty and acute medicine, and cardiology. These allowed the health group to identify aims and key challenges for each service, for example performance, backlog, recovery, finance, capacity and workforce.

Regional issues such as ongoing reconfiguration of services to community-based provision, social and residential care availability, sustainability, pace of change within primary care and lack of GPs, were also identified.

Culture

Staff felt respected, supported and valued and were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers. However, some staff members expressed frustration at their having to change wards due to short staffing across the health group. Staff told us that staff shortages impacted on patient care as gaps in staffing were not always filled.

The most recent NHS Staff Survey showed the health group scored better than the trust average for 'we are always learning' (5.3, trust 5.2), the same as the trust for 'we are a team' (6.4) and 'staff engagement' (6.7), and within 0.2 of the trust average for the other metrics except 'we are safe and healthy' (5.4, trust 5.8).

In response a series of virtual executive led focus groups and manager briefings were held, the survey results were presented at health group business meetings, a bi-monthly staff forum was instigated, and a values survey were held.

The health group worked closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff had every opportunity to share feedback and were signposted to appropriate support where necessary.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however these were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Medical care (including older people's care)

We reviewed the minutes of governance meetings held within the health group. These showed ongoing actions, updates from specialities, incidents, risks, audits, complaints, performance and feedback from committees (falls, nutrition, information governance) were discussed.

The monthly governance report (October 2022) reported on the following, for example:

- number of incidents, the number of 'moderate harm and above' incidents, serious incidents;
- number of falls reported per 1000 bed days;
- hospital acquired pressure ulcers;
- clinical harm reviews;
- compliance with guidelines and quality standards;
- high-priority audits;
- mortality and morbidity meetings;
- 'Learning from Death' quarterly report; and
- complaints and PALS.

A monthly health group governance meeting and each speciality held their own governance meetings which fed into the health group governance meeting and then to the trust quality committees.

However, during our inspection we also found governance arrangements did not ensure robust compliance with all MCA and DoLS requirements, and all health group procedural documents had been appropriately reviewed.

Management of risk, issues and performance

Although, leaders and teams used systems to manage performance, they did not always identify and escalate relevant risks and issues, and did not identify actions to reduce their impact.

The health group had identified a number of high and moderate risks, these were included on the corporate risk register and local risk register.

Those identified as high risk were:

- the 'lack of adequate substantive consultant workforce in acute medicine'. This had been on the risk register since March 2021 and was mitigated through locum cover (long term and short term);
- the 'lack of suitably trained staff to perform cardiac stress testing'. This had been on the risk register since January 2022 and was mitigated by two staff members covering the service and restricted to one staff member allowed off at any one time. Additionally a business case for additional support to preform cardiac stress testing had been drafted, and was awaiting approval; and
- multiple junior doctor vacancies - risk to patient safety and care'. This had been on the risk register since January 2022 and was mitigated by advanced clinical practitioners, reviews of weekly rotas, rota gaps reviewed with medical staffing and clinical leads, re-deployment of existing staff to cover shortfalls and the authorisation of locum and agency staff.

Medical care (including older people's care)

In addition, there were eight identified moderate risks, for example the risk to patient safety due to same day emergency care (SDEC) beds used overnight for acute medical unit patients due to lack of capacity, and the inability to provide timely medical care to stroke patients. All moderate risks had mitigation in place.

However, there were a number of risks and issues which had an impact on the health group which had been identified and not yet resolved, or had not been actioned. For example:

- the health group had shortages in the established numbers of medical and nursing staff;
- staff training did not meet trust targets;
- the majority of procedural documents within the health group were overdue for review;
- the health group did not meet the trust target for completing a VTE risk assessment within 24 hours of patient admission;
- staff did not always follow national guidance to gain patients' consent and support patients who lacked capacity to make their own decisions; and
- there were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

We found information systems were integrated and secure, to prevent unauthorised access of information. Systems were used to record and share patient sensitive data and there were clear processes to ensure compliance with access protocols.

However, although plans were in place to migrate all patient information to the electronic system, this had not yet happened, and clinician notes were still written and stored in paper format. This caused staff some difficulty in aligning patient progress across the two formats.

Managers understood performance targets including quality and data from clinical and internal audits. The trust participated in national clinical audit projects and clinical outcome quality indicators.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust has developed networks for staff, for example within black, Asian and minority ethnic groups (BAME), lesbian, gay, bisexual, transgender, queer (LGBTQ+) and disability.

We interviewed a patient representative who confirmed patients, relatives and carers can raise issues and they are listened to by the trust. The trust has set up a patient council with volunteer representatives, particularly involving younger age and those interested in improving services. We were told the trust listened to issues and made changes where necessary. Further, the trust had set up patient user groups (for example, respiratory patients group) and included patient representatives on trust committees.

Medical care (including older people's care)

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust participated in the Friends and Family Test (FFT) which showed that 90% of respondents gave a positive rating for the trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The health group provided examples of innovative practice.

For example, a project had been completed on the reduction of the carbon footprint from the use of asthma inhalers. Short-acting beta agonist (SABA) inhalers account for 70 per cent of the total carbon footprint of all inhalers in the country and uncontrolled asthma has a higher carbon impact than controlled asthma.

Frequent SABA use is a feature of uncontrolled asthma and is associated with increased risk of asthma attacks. Reducing SABA over-use can achieve important outcomes for both patients and the environment. Collaboration between NHS providers, the University of Hull and a commercial pharmaceutical company used a co-designed intervention to identify and address SABA over-use to improve asthma outcomes and reduce asthma's environmental impact.

The health group also prepared for and proactively managed patients during the COVID-19 pandemic. Learning from what was happening elsewhere across the continent, the health group proactively increased the ability to provide non-invasive ventilatory support on the respiratory ward, in advance of admissions with respiratory failure. Of 24 beds on the respiratory ward the group was able to provide this facility for up to 16 patients. Outcome data was prospectively collected. This initiative was recognised at the 'HullLive' Health & Care Awards 2021 with "Team of the Year" and "Nurse of the Year" awards.

Surgery

Requires Improvement  

Is the service safe?

Inadequate   

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it.

Training was offered as either face to face or through an electronic learning portal. Staff told us they were offered time to complete the course when they could.

Nursing and medical staff did not always receive or keep up to date with their mandatory training. We reviewed training compliance figures across all the wards we visited and saw that the compliance rates were below the trusts 90% target. We requested the mandatory training data for the surgical health group overall and saw nursing staff mandatory training compliance was slightly below the trust target of 88% and medical staff compliance was 72%.

The mandatory training was comprehensive; however, it did not always meet the needs of patients and staff. We reviewed resuscitation training rates across the wards we visited and saw it was significantly below the trust target. On some wards compliance was as low as 52%. Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. These courses were not part of the mandatory training list. Staff told us they could access electronic training modules if they requested it.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance figures were collated through the human resources monthly reports and sent to senior ward staff who told us that they had difficulty accessing certain courses such as the resuscitation training, as it was constantly oversubscribed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse. The safeguard lead for the health group, had not completed the appropriate level of safeguarding training.

We reviewed the mandatory training compliance figures and saw that 84% of staff within the health group had completed level 2 adults safeguarding training and 86% had completed level 2 children's safeguarding training. These figures fell slightly below the trusts target of 90%. However, the data did not include the completion of level 4 adults safeguarding lead. Following inspection the provider confirmed that the level 4 training is a requirement for the corporate safeguarding team who have named leads consistent with the NHS accountability framework.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff knew who to contact and where safeguarding policies were for support. Staff were able to articulate examples of recent safeguarding alerts made and understood those patients who were most vulnerable and required safeguarding input. They used online

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forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern and liaise with the social work team who were based within the trust. Staff described multi-disciplinary team working to ensure patients were protected. Staff could also add any safeguarding issues to the electronic recording system.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the most recent safeguarding alerts submitted by the trust and saw that patients were referred to the local authority safeguarding team as appropriate. Staff told us they received feedback following submission of these alerts where possible.

Staff told us the onsite social work team were extremely supportive and provided ongoing guidance regarding complex safeguarding matters.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service did not always use systems to identify and prevent surgical site infections. Staff used equipment to protect patients, themselves and others from infection. However, control measures were not always in place.

Most ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We reviewed equipment with 'I am clean stickers' which were generally in date. However, we saw two portable diagnostic machines were out of date on ward 6 at Hull Royal Infirmary (HRI). The provider told us they carried out monthly infection prevention and control (IPC) assurance visits across all wards. We reviewed the data submitted by the service; however, this did not cover all surgical wards, and did not provide clear overall compliance data for the service. For example, we saw audits appeared to be completed inconsistently and we did not receive any action plans to address low scores. We saw audits were completely inconsistently. Therefore, we were not assured that robust IPC monitoring was in place.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We requested hand hygiene audits for the surgical health group and saw compliance was recorded as 100% in the most recent audit dated 1st April 2022 to the 30th of October 2022. However, staff did not always observe the Standard Infection Prevention and Control Precautions policy, as they were not always bare below the elbow and did not always wear surgical masks. We saw examples of this on ward 6, however, during the inspection, we observed that most staff were compliant with hand hygiene policies.

Sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE) and we observed staff using gloves and aprons appropriately.

There was no patient led assessment of the care environment (PLACE) audit data as this was suspended nationally in response to the COVID19 pandemic and had only just recommenced. We did not see any evidence of recent audit results specific to IPC displayed on the wards that's we visited.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always store clinical waste safely

The service did not always have suitable facilities to meet the needs of patients' families.

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We reviewed the day surgery unit at HRI and saw the room utilised for children and adults coming into the department, was cold dark and we saw evidence of water leaking through into the waiting room at the doorway. We reviewed the storage facilities in the day surgery unit at HRI and saw several boxes of equipment stored inappropriately on the floor of the storerooms and clutter partially blocking the theatre exit corridors. We reviewed the audit completed for this unit and saw that storage was not included as part of the audit and therefore this issue was not identified or managed, as part of the trust's auditing programme.

The service had sufficient suitable equipment to help them to safely care for patients. All staff told us they had sufficient equipment to safely care for patients. However, on ward 6 at Hull Royal Infirmary, staff told us that they had insufficient electronic recording handsets in which to record patient information. Following inspection, the trust provided us with information which demonstrated that staff had allocated devices and that devices were replaced as required. This resulted in a potential delay in the recording of vital patient information such as blood pressure monitoring, national early warning score (NEWS) and care assessments.

We visited several wards with out of date or blank information boards and panels. On other wards we saw that information that was displayed did not always match what staff told us. Staff told us this was due to staff shortages and the movement of staff throughout the day.

We found no medical gas signs on the storeroom doors of all wards we visited. These rooms stored Entonox and oxygen inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward.

Staff did not dispose of clinical waste safely. Sluice room doors were also unlocked in some areas. For example, day surgery at HRI. We also saw chemicals were left on the cleaning trolley in patient areas. This meant anyone could enter and gain access to harmful COSHH chemicals. We brought this to the immediate attention of staff, due to the possibility of children and vulnerable adults accessing this area.

Resuscitation trollies we reviewed were checked daily and checks were documented. Defibrillators had also been checked and serviced in the previous year. Records were clear and provided guidance and clarity to staff on what to check and how to record it accurately.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimised risks. Staff identified but did not always act upon quickly, patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS). We reviewed 15 patients records and found that all had a completed NEWS score recorded within the electronic database system. All staff told us that an escalated NEWS score would automatically trigger a medical review. However, we reviewed a serious incident report dated June 2022 and saw a patient found to have a news score of eight, was not escalated and subsequently died. We requested audit data regarding NEWS, but this was not provided.

Staff completed an initial assessment for each patient upon admission/arrival, using a series of systematic question and answer stages to determine the frequency of subsequent assessments. The individual assessments then flagged as a colour, with red indicating patients who were at particular high risk such as falls. Staff told us they completed these

Surgery

assessments for each patient and included pressure ulcer risk assessments and venous thromboembolism assessments where appropriate. We saw pre-determined assessments were not personalised to the patient and did not clearly define how risks would be managed. We saw some evidence of personalised risk management by staff adding narrative into the free text nursing update section, but this was not consistently completed.

Senior ward staff told us they had oversight of these assessments and demonstrated the ward overview screens on the electronic recording systems. We saw some assessments were displaying as red indicating assessments were overdue. In most cases we saw they were just recently over their due time. For example, within the hour. The electronic recording system was not utilised by all departments, for example theatres. Patient observations including NEWS was recorded on a paper-based system by recovery staff, which was then handed to the ward when patients transferred across. However, systems were not cohesive and the transfer of paper to electronic records resulted in some observations and assessments missed, for example pain scoring. In addition, staff told us that the process of transferring information to the electronic system was time consuming and took away the time spent delivering care. Staff told us there was also a risk that not all information would be transferred accurately. We received concerns prior to inspection as part of our planning, that this was a specific concern. We requested the most recent audits of the electronic recording system, but they were not provided.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff told us that risk was always discussed at handover. However, we observed ward handovers and saw risk was not discussed for each patient. Risk within theatres should be recorded as part of the surgical safety checklist. However, we saw three examples of patients with known risks such as allergies and confusion and the checklists were not completed. We reviewed 15 paper records and saw none of them outlined risk such as falls, delirium or tissue viability issues. We spoke with senior managers who told us that risk was not recorded on the paper-based system but would be shared verbally at handover.

We reviewed the completion of surgical safety checklists in all of the theatres we visited. We saw the trust had designed a checklist which only required one signature to confirm all aspects of the pause and check processes had been completed. This signature was made at the end of the surgical procedure by the lead clinician. The form did not provide an option to evidence that all aspects of the pause and check process had been completed.

We also saw examples where the same checklist had not been completed to show allergies and special assistance needs, despite patients having allergies recorded within their medical records. In day surgery at HRI 100% of the patient records we reviewed, had not had their surgical safety checklist signed by the lead clinician. We asked to speak to this member of staff, but we were told they had left for the day.

Staff told us that these checklists were regularly audited. We requested the most recent audits and saw the last completed audit was August 2022 and was shown to be incomplete with no pre-operative checks carried out.

Therefore, we were not assured that risk and safety management processes were robust and did not always protect patients from possible harm.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. However, bank and agency staff were not given a full induction.

Surgery

The service did not have enough nursing and support staff to keep patients safe. On all wards we visited with the exception of ward 12, we saw actual nurse staffing was consistently below planned establishment. For example, during our inspection, we reviewed the staffing numbers on ward 6 and saw 28 shifts across a four-week period had below the planned number of registered nurse numbers.

Several wards we visited reported scenarios where only one registered nurse was left on the ward to manage a typical ward size of 27 patients. Staff told us where time allowed, an electronic alert was submitted for these incidents, due to staff feeling unsafe. Again, we saw five occasions of this, on ward 6. Following the inspection, the Trust provided us with information about the Safer Staffing process and reviews and demonstrated that the scenarios reported to us were not a frequent occurrence. There has been one incident in the last 12 months on one of the wards which was addressed during the same shift.

We requested the electronic incident data from the trust in relation to concerns of unsafe staffing levels and saw 354 incidents were reported by staff on the wards trust wide in the last twelve months.

We reviewed trust sickness levels and saw Nursing and Midwifery staff which reported a 4.3% sickness rate. In addition, the trust wide vacancy rate for October 2022 was 6.2%. Staff told us recruitment was ongoing and there had been several nursing appointments which was encouraging. None of the wards we visited had a full complement of staff, at the time of inspection.

Not all wards displayed planned and actual staffing numbers. Staff told us this was because staff were moved around constantly to meet the needs of the busiest wards and departments. However senior ward staff confirmed the recent recruitment success and were able to make several new nursing appointments on most of the wards we visited. These newly registered nurses were either waiting for essential recruitment checks to be processed or were approaching their actual start date, at the time of inspection. Staff saw this as hugely positive and a boost to the staff's morale. Some wards had newly qualified nurses working in a supernumerary basis whilst awaiting confirmation of their RGN PIN.

Ward staff told us there were two-night practitioners onsite to support all departments, across the two sites. However due to specific ward pressures, these staff were unable to support all wards. Senior leaders told us they had recently introduced a pastoral matron who was available up to 10p.m Monday to Friday, with a specific remit to support staff morale during particularly challenging staffing situations.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior lead nurses held daily beds management meetings across all health groups. This included oversight of staffing numbers, access and flow with cross-divisional matrons reviewing pressures across each site. We observed a beds management meeting which was held four times each day and was attended by matrons from each health group, the enhanced care team and the bed management matron. They discussed expected admissions and discharges, wards with challenges such as high acuity patients and increased admission numbers. We observed proactive discussion between the staff who prioritised the demand across the various health groups and considered appropriate staffing levels. Recently senior leaders had introduced band 6 staff to observe these meetings, so that they had a greater understanding of the trust pressures. In addition to the patient placement meetings, the Trust held separate Safe Care meetings. These were held 4 times per day to respond in a timely way to any staffing challenges.

Surgery

Managers limited their use of agency staff and requested staff familiar with the service. For example, internal bank staff. Senior ward staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. We observed this during the bed management meeting. We requested induction checklists for bank staff whom had recently worked on the wards we visited. Senior ward staff told us some induction information was given, but this was not recorded.

Due to the consistently low staffing numbers, the electronic incident concerns raised by staff and the lack of formal recorded bank staff induction, we were not assured that staffing levels kept patients safe.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. In the last twelve months reviewed the proportion of consultants and junior doctors reported to be working at the trust were higher than the England averages.

We saw the percentage of consultants at this trust were 55% when compared to 50% as the England average.

We saw the percentage of junior doctors at this trust were 15% when compared to 11% as the England average.

In the same reporting period, we saw the following grades reported to be working at the trust were lower than the England averages.

We saw the percentage of middle career doctors at this trust were 6% when compared to 11% as the England average.

We saw the percentage of Registrar doctors at this trust were 24% when compared to 28% as the England average.

Junior doctors at HRI told us that they felt the workload was unmanageable at times and expressed concerns as to how 'stretched' they felt. Staff described specific pressures whilst working nightshift and told us there were too many wards to cover. The trust recognised difficulties regarding the rostering of junior doctors and the ongoing pressures. The current junior doctor fill rate trust wide was at 96% and work was ongoing with internationally to recruit new doctors.

We reviewed ward 39 at HRI and saw there was no allocated consultant or registrar cover in place for these patients. We brought this to the providers immediate attention and steps were taken to address this.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always kept up to date. Records were easily available to all staff providing care but not always stored securely.

The service used both electronic and paper-based records in which to record nursing and medical information for patients. The use of the electronic recording system was inconsistent across the trust as it was being phased in gradually by the trust.

The ability to navigate the electronic system varied according to the time they had used it and staff were open in relation to their own competencies using the system.

Surgery

Not all staff had access to the electronic recording database. Senior ward staff told us that band 2 staff were unable to add or review nursing assessments as this had been blocked by the trust. This caused frustration amongst staff as many band 2 staff were student nurses who had completed their training but were waiting for PIN and registration. These staff were unable to add any documentation. One student told us they had worked on the ward for a month and had not documented anything anywhere.

Medical and therapy staff completed paper record reviews. However, nurses told us they rarely, if ever, reviewed patients' paper notes. Some nursing records were paper based such as those completed by theatre staff.

We found confidential patient records unattended on ward 6 at HRI, which were in a main thoroughfare. We reviewed these records and saw that they were not filed in date order. Loose documents were placed randomly within patient files, and we did not see any locked notes trolleys on this ward. Therefore, we were not assured patient paper records were managed safely and securely.

Most of the senior ward staff told us that the electronic recording system did not offer real time monitoring. For example, we reviewed the dashboard which showed the nurse in charge which assessments were due. Many assessments showed as red, meaning overdue. However, some assessments were completed but were not showing on the dashboard. We were able to corroborate this on several wards we visited.

Patient notes were not always comprehensive or up to date. We reviewed five patient records, all of whom had a diagnosis of dementia. Despite there being a flag on the electronic recording system to show the patient had a diagnosis of dementia there was no further support outlined within the system, such as communication tools, visual and nutritional aids. We requested paper records for these patients and saw there was no further information regarding the care and management of these patients.

We reviewed 15 surgical safety checklists and saw that only one was signed to confirm that all aspects of the pause and check processes were carried out. This indicated that the appropriate checks in accordance with WHO guidance was not completed. This meant that patients were not appropriately protected from the potential of harm due to the absence of mandatory record keeping. Therefore, we were not assured that individual care records including clinical data, written, stored and managed, kept people safe.

We saw some Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents in use. ReSPECT is a process (endorsed by the Resuscitation Council) that creates personalised recommendation for a person's clinical care in a future emergency, in which the patient is unable to make or express choices; and it includes advance decision making around resuscitation.

We reviewed a serious incident investigation report dated June 2022 relating to ward 6 at HRI. The report found that the completion of the ReSPECT forms was not clear in regard to the levels of escalation and should be reviewed through audit.

We requested audit data in relation to ReSPECT forms, however the provider submitted data for only ward 10 at HRI, information which showed poor document compliance. Following inspection the provider submitted annual audit data which showed variable compliance across the trust. We did not see any further action plans in which to address and improve document completion and we were not assured that the use of this document was consistent across all wards we visited.

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Medicines

Ward staff used systems and processes to safely, administer, record and store medicines. However, theatre staff did not always administer controlled drugs safely.

The hospital used an electronic system to prescribe medicines for patients. However, staff used a paper-based system within theatres, as the electronic system had not been introduced yet.

Ward staff completed medicines records accurately. However, theatre staff did not always follow safe practice or the trust's procedure when completing records of the administration of controlled drugs.

We reviewed the controlled drugs records in theatre one at HRI and saw two anaesthetist's signatures were missing on the 30th of September and the 5th of October. We attempted to contact the staff member concerned to address this issue, but they did not respond. This practice is not in line with NICE guidance 'Controlled drugs: safe use and management' guidance or the Royal Pharmaceutical Society 'Professional Standards for Hospital and Pharmacy Services' guidance.

In theatre eight we saw ODP's had signed as witnessing the administration of a controlled drug but had not actually witnessed the drug being given. This was not in line with the trusts own standard operating procedure (1.4, 5.1) or the above guidance.

We reviewed the emergency drugs both used by all theatres at HRI and saw that the tamper proof seal was not in place suggesting that the contents may have been opened. Checklists reviewed with theatre showed that pharmacy had been contacted to report this, but no action had been taken at the time of inspection.

However, we reviewed controlled drug management across several wards we visited including ward 60 and saw that best practice was being followed and the controlled drugs count were correct.

Staff did not always review patients' medicines regularly and provided specific advice to patients and carers about their medicines. We spoke with pharmacy staff who told us they were not sure when audits were last undertaken. Senior managers confirmed that there were plans to audit medicines in theatre, but currently none were undertaken.

The fridges we reviewed were within their required temperature range. However, we found staff personal food items in one fridge at HRI.

The service did not always have systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We talked to several members of staff, but their responses were varied in how safety alerts and incidents were discussed.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents although they did not always share lessons learned, with the whole team.

Surgery

Staff knew what incidents to report but did not always report them. The service reported four surgery related never events between November 2021 and August 2022. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The never events varied in theme and were unconnected. The incident type included retained swab, medication, wrong implant and wrong site block.

Managers did not always investigate incidents thoroughly. We saw insufficient pace when sharing the learning, resulting in potential subsequent harm to patients. We reviewed all four reports relating to these incidents and saw delays in the time taken to fully investigate them. For example, we saw three reports that did not have a sign off date to conclude the investigation. These incidents occurred in June, July and August 2022. In the same incident reports, we saw that actions to be taken following the incident, were still ongoing at the time of inspection.

We reviewed the trust's policy in relation to incident reporting which included a pathway outlining the process, however timescales for completion of the full investigation were not defined.

In the never event report relating to medication dated June 2022, we saw an action was required, to complete a training needs analysis for medicines management and development of clear objectives competencies for operating department practitioners (ODPs). These and four other actions were not completed at the time of inspection. We found concerns with medicine management as part of our inspection and saw further poor practice. We also intervened to prevent a patient receiving medications in error.

In the never event report relating to the retained swab, we saw within the findings that staff had omitted to sign some surgical safety checklist documents. During inspection we saw 14 of the 15 surgical safety checklists that we reviewed, had not been signed.

We reviewed a series of recent serious incidents and saw further delays in both the completion and roll out of learning following the incident.

In the serious incident report relating to the wrong site block dated July 2022 we saw within the report findings that there was no 'pause and check process' or 'stop before you block'. In the 14 records we reviewed we saw no evidence to confirm these processes had been completed. Staff told us it was done but it was not recorded.

In the serious incident report relating to sub optimal care dated June 2022 we saw that all actions following the incident, were not complete at the time of inspection.

Most ward staff we asked could not give us recent examples of any shared learning from incidents. They could not list the top three incident-related risks on their ward or department beyond broad categories such as falls. However, theatre staff at both sites told us they had received information regarding the most recent Never Events and told us these were discussed at staff meetings, safety bulletins and safety huddles. However, we saw poor medicines management was still an issue in theatres, due to the lack of robust and timely incident management processes.

We also reviewed safety bulletins displayed on ward notice boards which were recently dated but did not include information regarding never events.

Surgery

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they reported patient incidents quickly and with confidence. Some staff were confident to report staffing concerns, but others said staffing concerns using the electronic incident reporting system were rarely resolved, and they had stopped using the system. Some medical staff also told us it was pointless reporting incidents and concerns because nobody listened anymore.

Therefore, we are not assured that patients are protected from the potential of harm due to the ongoing potential risk.

Is the service effective?

Requires Improvement ● ↓

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. However, staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff told us that policies were regularly reviewed and updated in accordance with national guidance and best practice.

We requested a copy of the trust policy in relation to the frequency of policy review and saw clear processes for the development and review of all policies in line with national guidance and best practice, across the trust.

Staff knew where to access policies and guidance on the intranet.

Staff did not always follow up-to-date policies to plan or deliver high quality care according to best practice and national guidance. We reviewed the Local Safety Standards in relation to invasive procedures policy which is used in conjunction with the WHO safety check audits and saw again that it was not dated as current, did not have a review date and was not shown to have been ratified. Providers are required to demonstrate that policies are regularly reviewed and updated to ensure staff follow the most up to date national guidance or current best practice.

The trust provided data in relation to the review of current policies. This data showed that 64% of policies were currently in date in November 2022, meaning 36% were out of date or overdue. The provider told us they had developed a procedural document improvement plan to address this backlog and have added this to their risk register. The surgical health group specific policies showed that 17% were out of date and 83% compliant.

Staff did not always protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed three patients' records, all of whom were recorded as being confused and may lack capacity. We saw capacity assessments were not completed and we did not see any evidence of best interest decision making processes. This is not in line with the Mental Capacity Act 2005.

Therefore, we were not assured that policies were always developed and reviewed in accordance with best practice and national guidance.

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Nutrition and hydration

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts and nutritional intake records. As with other patient records, recovery staff used paper records and consistently recorded fluid intake and output. These stopped once the patient reached the ward and electronic records were completed instead. Fluid balance intake was recorded on both paper and electronic systems depending on which wards has access to the electronic systems. We reviewed 13 fluid balance records and saw that they were fully completed.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw nutritional risk assessments were carried out on all inpatients. Staff explained those at risk such as patients with frailty had dietician input. We saw evidence of dietician involvement in the records that we reviewed.

Specialist support from staff such as dietitians and speech and language therapists were available for those patients who required them. We also saw a nutritional assistant on one ward who told us they provided additional support to patients across the ward with needs such as diabetes, post-surgical calorie monitoring and physical dietary support, such as those who were frail or those who struggled to feed themselves. Ward staff found the additional support to be invaluable but there were only two nutritional assistants in post at the time of inspection. We did not see any volunteers on the wards that we visited.

Patients waiting to have surgery were not left nil by mouth for long periods. We requested fasting audit data from the trust, but this was not provided.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. However, they did not always give pain relief in a timely way or support those unable to communicate using suitable assessment tools.

Staff did not assess patients' pain using a recognised tool; however pain relief was given in line with individual needs and best practice on most wards that we reviewed.

We saw patients receiving care in theatre following surgery were assessed using a pain score. Numerical scores were recorded on the paper documents that we reviewed. However, these scores were not continued once the patients transferred to the wards. None of the wards we visited had a recognised pain scoring tool and although the electronic recording system had capacity to record pain, staff were not using it. We asked ward staff on each ward we visited what pain scoring tool was being used and all staff told us there was none in use. Ward staff told us that they would ask patients to describe their pain but there was no tool to support patients who were unable to communicate or for those with specific needs such as dementia or learning difficulties. Some staff told us that the electronic recording system could be used to record pain but none of the staff we spoke with knew how to do this.

Ward staff told us they could refer patients to a specialist pain team and we saw evidence of involvement within the records we reviewed.

Some patients on ward six told us that they waited long periods for pain relief to be administered and staff told us that when nursing staff numbers were reduced on the ward there were delays in the administration of controlled drugs which required two staff signatures to administer. However, we reviewed six electronic prescribing and administering records and saw medication was given as appropriate.

Surgery

We requested pain audit data from the trust, but this was not provided.

Patient outcomes

Staff monitored the effectiveness of some care and treatment. They used the findings to make improvements and achieve good outcomes for patients.

The service participated in national audits. We reviewed the National Hip Fracture database and saw it was last published in August 2021 using data from January to December 2019). Hull Royal Infirmary had one indicator that was the 'same' compared to other hospitals but one that was worse and one that was much worse. Castle Hill Hospital had three that were the same but also one that was worse and one that was much worse.

The indicators that were worse and much worse were the same for both hospitals were the risk adjusted 5-year hip revision ratio and the number of patients consented to have personal details included in the National Joint Registry.

We also reviewed the National Emergency Laparotomy Audit and saw it was last published in January 2022 using data from December 2018 to November 2019.

Due the pandemic there have been delays to the publication of some audits. Data in the latest publications was at least two years old or data was not available at trust level.

The National Bowel Cancer Audit last reported in 2020 with incomplete data showing for the trust. However, a report published post inspection in December 2022, demonstrated a report was submitted with completed data.

The National Oesophago-gastric Cancer Audit was last published in August 2021 using data from April 2017 to March 2019.

The National Ophthalmology Database Audit was last published in January 2021 and the trust did not sign up to this audit or declined to participate.

The National Prostate Cancer Audit was last published in March 2021 using data from April 2018 to March 2019 and The National Cardiac Audit Programme – Adult Cardiac Surgery was last published in March 2019 using data from April 2014 to March 2017.

We asked senior managers what plans were in place to recommence data submission into these national audits. We were told that the health group conducted internal reviews with the data collected through their own internal governance processes, but we were not assured that this internal data was used to bench mark the trusts own performance against similar sized trusts nationally.

Outcomes for patients were mixed, and inconsistent when compared to the England average.

For all specialties overall at trust and hospital level and also for elective and non-elective patients, the trust had longer average stays than the national average between February 2021 and January 2022. Specialties with the most notable differences compared to the England average were Colorectal Surgery with patients having longer lengths of stay on average than the national average.

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The Cancelled Elective Operations collection was paused in April 2020 due to the pandemic. For the quarters for which we have data, the trust was cancelling a similar number of operations each quarter. The percentage of the cancellations that weren't treated within 28 days was higher than pre-pandemic however, figures were below the national average.

All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average. Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Vascular Surgery patients at Hull Royal Infirmary had a higher than expected risk of readmission for elective admissions when compared to the England average.

For patients having elective Neurosurgery at the trust the average length of stay was 4.2 days. The average for England was 5.4 days.

The average length of stay for patients having non-elective Colorectal Surgery at Hull Royal Infirmary was 5.1 days. The average for England was 3.4 days.

Both SHMI and HSMR show mortality to be higher than expected from January 2020 to March 2022. In-hospital mortality following admission with a primary diagnosis of Septicaemia (except in labour) was higher than expected from January 2021 to December 2021.

Managers and staff carried out some audits to check improvement over time. We requested the trusts recent audit data in relation to pain and preoperative fasting. We did not receive any audit data in relation to pain. We did not receive any preoperative fasting audits.

We saw the trust had a Commissioning for Quality and Innovation (CQUIN) framework in place 'Supporting patients to drink, eat and mobilise after surgery' with the aim to ensure surgical patients are supported to eat, drink and mobilise within 24 hours of surgery ending. We saw no data was submitted for this in quarter one.

PROMS data was incomplete at the time of inspection. The PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. These areas are nationally selected procedures.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance. Staff induction was not always recorded, and link nurse training had not been renewed.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke with several staff working in newly appointed senior nursing roles. Many of whom had been in their current role for less than 12 months but were supported by matrons and colleagues working at a similar grade.

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction booklets were tailored to the staff specific role to ensure training was appropriate.

We asked to review bank staff induction checklists, to ensure staff working on these wards were provided with a basic overview of the operational aspects of the ward such as patient escalation processes. All staff told us induction was not recorded and information was given verbally.

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Managers did not always make sure staff received specialist training for their role. The provider told us that link nurses were in place across all wards and departments and had specialist training in areas such as tissue viability, dementia, and falls. The use of nurse link roles also varied between wards. On some wards the link roles had gone when staff left and on other wards there were clear link roles and responsibilities for all members of the ward team, and those with special interests were encouraged to develop. We requested to speak with link nurses on the wards that we visited, but staff told us link nurse's arrangements had not been updated since the pandemic and training had lapsed.

The clinical educators supported the learning and development needs of staff. Senior ward staff told us that newly qualified nurses were provided with ongoing support through their preceptorship period. All staff we spoke with told us that the support received was invaluable.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us meeting notes were emailed to all staff by ward managers and we found printed copies were displayed on staff noticeboards.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Trust wide staff appraisal data was submitted by the provider for the health group. We saw that the overall appraisal compliance figures for surgery was 69%, which was lower than the trust target of 90%. However, general theatres at HRI scored 100%. Medical staff appraisal rates were submitted separately but did not include junior doctor compliance rates and therefore an overall compliance rate cannot be determined.

Some managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. However, other ward managers and staff told us there was no time or money for development. Following the inspection, the Trust provided us with information about the training days allocated to staff to reflect the training required and CPD monies which is available for all staff to apply for academic qualifications.

Senior staff told us the trust and directorate encouraged staff to undertake extended roles and to develop professionally with advanced nurse practitioner and apprentice nurse posts. They completed specific training and competence checks before taking on additional specialist patient care tasks.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Ward staff told us that managers ensured time was made available where possible to complete training and share courses which were available throughout the trust.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers described the support they offered to staff and actions taken when improvements were required. We saw additional support was offered to all staff during the peak of the pandemic, alongside additional training updates such as IPC.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We reviewed ward rounds which were conducted several times and saw patient information exchanged using the electronic recording system.

We saw consultants and allied health professionals arriving to the wards at various points of the day, which impacted on the senior sister or nurse in charge having to repeat essential handover information. Handovers were not co-ordinated

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to ensure all members of the multi-disciplinary team were present. We did not see robust handovers for staff who had been absent for several days and therefore needed additional information regarding the patients receiving care. Senior ward staff told us that handovers were printed off, so that the exchange of information was standardised, however these documents were shredded at the end of each day. We reviewed these documents and saw risk was again not always identified.

We observed the locum doctor covering ward 39 at HRI, was not positively supported by senior medical staff when requesting medical review and advice. We observed a reluctance to review some patients on this ward at the time of inspection.

All wards in the Surgery Health group have a discharge assistant. However, we spoke with ward clerks who liaised with families, social workers, and care home managers, and booked district nurse and GP practice nurse appointments to ensure patient discharges went as smoothly as possible.

Trauma staff told us there were additional ward pressures at the weekend. This was due to the theatre staff not collecting patients from the wards to transfer to theatre, which only happened Monday to Friday.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but tried to ensure meeting minutes were read by all staff where possible.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Ward staff told us consultants led daily ward rounds on all wards and staff told us patients were reviewed daily by consultants depending on their health group or speciality. However, patients residing on ward 39 at HRI were not reviewed by any of the consultants as they were deemed to be medically fit and required no further intervention. However, we spoke with staff on this ward who told us that patients did require medical review, as patients were not always medically fit when transferred. We observed staff during our inspection experiencing difficulties trying to access consultants on call for advice. We observed a reluctance to review these patients despite the requests by the locum doctor. In addition, we were given examples of patients who had been transferred to this ward with active intervention in situ such as nasogastric tubes, despite the criteria for the ward being that patients were ready for discharge. We reviewed one particular patient who was transferred across to ward 39 as they were deemed to be medically fit. Staff on the ward told us when this patient deteriorated the specialist ward had refused to accept this patient, despite the urgent request. We brought this to the immediate attention of the trust who took steps to review all of the current patients on ward 39 and improve the current processes for escalation, clarify the acceptance criteria and improve the medical review of unwell patients. The trust also told us that in this instance additional staff were provided to support the care of this patient on ward 39, however ward staff told us this support was delayed.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The service offered seven day 24-hour discharge and the pharmacy was open seven days a week at HRI.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

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The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Wards we visited had lots of information available for patients on leaflet racks. However, we did not see any staff giving patients leaflets post-procedure or before discharge. We did not see any evidence of health promotion during ward rounds or handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Managers did not always monitor the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. All staff we spoke with understood when to apply Deprivation of Liberty Safeguards and we saw two recorded applications which were completed and documented appropriately. Training for staff was provided by the trust as part of the Mental Capacity Act module. However, we requested training compliance figures from the provider and saw 82% of nursing staff within the health group had completed mental capacity training compared to 70% of medical staff, which was significantly below the trust's internal 90% target.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the Mental Capacity Act 2005. We reviewed the records of three patients recorded as having dementia or confusion as part of the initial assessment process. None of the three patients had a mental capacity assessment undertaken. We saw medical staff proceeded to complete a consent 4 form for all three patients to consent for surgical procedures. This consent 4 form is used when patients are deemed to lack capacity. These consent forms were not appropriate as mental capacity had not been formally assessed first. We also saw that the four-stage pillar process for assessing capacity as defined within the legislation had not been followed.

We saw in two of the patient files consent for care and treatment was only obtained through discussion with families. Staff we spoke with told us this was usual practice. We did not see any evidence of consent for care and treatment in one of the other files we reviewed.

We reviewed the trusts policy in relation to mental capacity assessments and saw the policy clearly states that the person who has overall responsibility for the patient's care must undertake a formal mental capacity assessment using the four-stage pillars process.

The trust undertook an audit of Mental Capacity Act (2005) compliance in January 2022 following a serious case review. The audit identified several failings in relation to the lack of best interest decision making, failure to complete the four-stage capacity assessment and poor recording of discussion in relation to decision making. The audit was due to be repeated in April 2022, but this was not completed.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. We saw an example of a junior member of the medical team sign for a major surgical operation which carried significant risks. The consent form had not been countersigned by a senior clinician to evidence that all risks had been discussed with the patient. This posed a risk to the patient who may not have been fully advised and therefore not informed of all risks associated with this surgery.

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When patients could not give consent, staff did not always make decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not see evidence of best interest decision making documents, in any of the files we reviewed.

Therefore, we are not assured that consent is always obtained or recorded in line with relevant guidance and legislation. There is a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation.

Is the service caring?

Good   

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

Compassionate care

Staff treated patients with compassion and kindness, however respecting privacy and dignity was not always maintained in some of the areas we visited.

Staff followed policy to try to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff holding sensitive conversations respectfully.

Side rooms were available on all the wards we visited and were utilised where possible, for those patients particularly in need, such as end of life or those requiring isolation.

Patients said staff treated them well and with kindness. Patients at Hull Royal Infirmary told us "all the staff are great, they make sure we get everything we need", "they're very kind and care about us all". When we asked patients about privacy and dignity, they told us "staff always draw the curtains and give me time to wash myself, it's good to have some dignity". However, one patient said, "The staff all work so hard, but they can't always get to you straight away".

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff did not always provide emotional support to patients to minimise their distress. They did not always understand patients' personal, cultural, or religious needs.

Staff told us that additional care was always provided, for example, additional observations known as 'Spaces', but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support. We also reviewed on three of the wards we visited that these checks were not completed in a timely way and were showing as red on the electronic screen meaning overdue. Senior ward staff told us that that this screen is often incorrect, as checks may have been carried out but not logged into the system.

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Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and we saw staff working together to ensure patients received the optimum level of care with the staffing resources that they had.

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. However, we did not observe this support on any of the wards we visited.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients to understand their condition and make decisions about their care and treatment.

Staff did not always make sure patients understood their care and treatment. We reviewed the records of five patients and saw clear communication recording between medical staff, allied health care professionals such as speech and language services and patients' families.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff interaction with families and patients' carers and saw information was provided in a way that was easily understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this and gave positive feedback about the service. However, we saw within the last patient survey report, that patients felt that staff did not always provide communication around expectations following surgery. Patients said that further communication was needed so that they know what to expect before and after surgery. Feedback during the inspection however was positive.

Is the service responsive?

Requires Improvement ● ↓

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met some of the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. Service staff told us they had good access to the trust's own social work team, specialist palliative care and mental health teams. The electronic system however did not support staff to refer to these services as it did not have the functionality to raise an automatic referral. Manual contact was required to access supporting services, which added to the existing workload of staff.

The service relieved pressure on other departments when they could treat patients in a day. We reviewed the beds management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients. The demands on the beds however meant some patients operations were cancelled on the same day.

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We saw examples of this during the inspection resulting in frustration and distress for some patients. We reviewed the number of same-day cancelled operations within the health group and saw 1445 were cancelled in the last 12 months. The highest number of cancelled operations was due to emergency cases requiring theatre space, followed by the lack of critical care beds.

The recent creation of ward 39 at HRI was seen by managers, as a positive step to manage patients deemed to be ready for discharge. Staff at both sites were aware of this ward and the ability to transfer patients to relieve some of the specific ward pressures.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had. Day surgery however on both sites did not provide separate areas for male and female patients.

We asked several staff what provision was in place to support transgender individuals who were transitioning. Staff were not aware of any specific support for patients undergoing surgery.

The upper GI service has established a STT two week wait referral pathway for patients referred in from GPs with suspected Oesophagogastric cancer. All patients that meet the referral criteria go straight to endoscopy and are scoped in the main by a consultant Upper GI Surgeon. All patients are now dated within 2 weeks of referral and the majority discharged at this appointment. The new pathway is in line with national guidance, has improved patient experience, and significantly reduced the time patients wait for a diagnosis (and treatment). The service has received positive patient and GP feedback following the introduction of the new pathway. During the past 12 months Upper GI Service has been successful in securing funding for a 3rd Clinical Nurse Specialist (CNS). This now enables the Upper GI CNS service to support patients in oncology clinics, not just surgical clinics – offering support to the patient on the whole of the pathway from pre-diagnosis to end of treatment rather than just focussing on the surgical element of the pathway. Managers told us the change has been well received by patients and the feedback has been positive.

The service had some systems to help care for patients in need of additional support or specialist intervention. We saw specialist teams such as pain and dietary service staff involved in the care and treatment of the patients we reviewed.

We spoke with staff regarding specialist provision for bariatric patients, however we were told that day surgery was not an option as these patients would be admitted for specialist surgical support. The service has developed a patient information video for patients to view at their first outpatient appointment outlining the bariatric pathway and surgery types.

The use of volunteers had been paused during the pandemic. Following inspection, the trust told us there were 53 active volunteers within the surgery health group.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.

We saw patient records at Hull Royal Infirmary showed liaison with the local homelessness team. There were entries in paper records with contact details, positive and negative involvement by patients, and continuing support throughout inpatient stays. There was similar documentation regarding drug and alcohol misuse with support and signposting clearly written in patient notes.

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Wards were not always designed to meet the needs of patients living with dementia. We did not see any evidence of adaptation for patients with a dementia such as appropriately coloured bays or specifically designed signage. Several senior ward staff told us they would include discussion around the needs of specific patients with dementia as part of the safety huddle, but we did not see records relating to specialist intervention or support. In addition, we did not see any equipment provided such as brightly coloured drinking cups and plates in use on the wards we visited.

We saw the day surgery room used for children and adults, had some stencilled images on the wall, however there were no additional additions to identify this area as an appropriate and welcoming area for children.

We saw in day surgery at HRI, men and women were managed together. We saw the provider had added a plastic screen in-between the bays, however as there was a curtain on only one side of the plastic screen, we were not assured that privacy and dignity was maintained across day surgery, at both hospital sites.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw examples of the documents in use on some of the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Two patients we spoke with could understand English but had been offered access to information in their first language if they needed it.

Managers did not always make sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could access language support when required however we reviewed a patient who did not speak English. Consent had been obtained despite staff not utilising any translation support. This meant there was a potential risk that the patient did not fully understand the surgical procedure they were undertaking.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw only two employed nutritional assistants within the health group, despite all staff recognising the support and the benefits to patients that these additional posts provided.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards

Managers monitored waiting times but did not always make sure patients could access services when needed or receive treatment within agreed timeframes and national targets.

Managers reported growing waiting lists which they said was worrying but they said this was in line with national direction. Additional theatre lists were introduced to address some of the most significant waits such as urology, and mutual aid was provided by a neighbouring trust to support with backlogs. The trust told us a significant elective recovery programme is in place and the core capacity is supported by a comprehensive range of insourcing, outsourcing, internal waiting list initiatives and additional clinics with mutual aid (both within the ICS and wider for regional

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services). The elective recovery programme is supported by a financial plan, effective performance monitoring/management and a Patient Access and Concierge Team who support conversations with patients to ensure that they are treated as soon as possible. The Trust told us they continue to prioritise all patients in terms of their clinical priority – to ensure that those patients with the highest clinical priority are treated soonest.

Health group staff met to discuss key deliverable target measures. Managers said staff understood and contributed to good recovery action plans.

Managers monitored waiting times and made sure patients could access emergency services when needed. Medical staff we spoke with said their elective procedure waiting lists were growing and plans were in place to tackle the waiting lists. However, there were no weekend or waiting list initiative work planned to help clear the backlog.

Most specialties at the trust had readmission rates that were below or similar to the England average from January to December 2021. The notable exceptions are elective vascular surgery patients at Hull Royal Infirmary.

For all specialties overall at trust and therefore location level, and for elective and non-elective patients – the trust had longer average stays than the national average between February 2021 and January 2022. Specialties with the most notable differences compared to the England average were Colorectal Surgery with patients having longer lengths of stay on average than the national average.

The Cancelled Elective Operations collection was paused in April 2020 due to the pandemic. For the quarters for which we have data, the trust was cancelling a similar number of operations per quarter. The percentage of the cancellations that weren't treated within 28 days was higher than pre-pandemic however, figures were below the national average.

We reviewed cancer waiting times and saw the current national standard for being seen within two weeks of referral is 93%, from the trust's data provided, this was met in July and August 2022.

The national standard for being treated within 62 days of a decision to treat is 85%, this was not met by the trust in any month from September 2021 to August 2022 based on the data provided.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust reported significant numbers 'no criteria to reside' patients who were ready for discharge but were unable to do so due to external factors. We reviewed trust figures and saw that they ranged from 150 to 180 at any one time. Work was ongoing with the wider system to try to address the issues.

Managers monitored patient transfers and followed national standards. We observed patients transferred to other wards where it was deemed safe and appropriate to do so, to free up capacity for elective surgical patients or urgent admissions.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

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The service displayed information about how to raise a concern in some patient areas. We saw some PALS information displayed on wards we visited but this was not consistent. Wards we visited did not have friends and family test feedback boxes and display boards were out of date and did not show current feedback. However, patients, relatives and carers knew how to complain or raise concerns. A patient we asked, said they would feel confident asking ward staff how to raise a complaint or concern.

The trust supplied a log of complaints for the surgical health care group that showed 120 complaints had been received from patients and relatives, in the last twelve months. The highest number of complaints related to treatment and the second highest communication.

Matrons told us they investigated complaints and identified themes on behalf of other wards to retain an independent view, investigation and any identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers told us they shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints. We saw examples of concerns raised by patients in staff communication files on some of the wards we visited.

Staff could give examples of how they used patient feedback to improve daily practice. This included access for ward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Is the service well-led?

Requires Improvement ● ↓

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

Leadership

Leaders understood the challenges the service faced; however, intervention or remedial action was not always timely or effective. Senior leaders were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Clinical specialities across the trust were defined as divisional health groups. Each health group was led by a Medical director, Nurse Director and Director of Operations. Within the health group of surgery also sat surgical speciality, trauma, theatres, anaesthetic and critical care and digestive diseases. A Clinical Director was appointed for each of the subgroups. Deputy Directors had also been recently introduced as part of the overall succession planning.

Senior matrons provided oversight of ward and theatre management and governance support arrangements in conjunction with business managers. Matrons provided line manager support to staff across the health group across all wards and theatres.

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New objectives for the surgical health group were set out in April 2022 which include new elective recovery working patterns, with a defined service and quality improvement focus.

Local leaders we spoke with understood the new direction for leadership and spoke with passion regarding the services that they represent.

Senior ward staff told us they felt supported by their matrons and sought daily support through visible engagement. Staff told us they were able to escalate issues to their senior managers and felt issues were addressed where it was possible to do so. However, staff told us they did not see senior members of the health group and attendance on the wards was rare.

Vision and Strategy

The service had a vision for what it wanted to achieve but did not have a health group specific strategy to turn it into action. The vision and operational plan did not always focus on sustainability of services and aligned to local plans within the wider health economy. Leaders did not always understand or know how to apply them and monitor progress.

We reviewed the trust Strategy 2019-24 which detailed the vision for - Great Staff; Great Care; Great Future. The health group did not have an overarching strategy due to its recent development but instead had developed an operational plan outlining key objectives and plan for 2022/2023. The document listed demand and capacity, quality, finance, workforce and infrastructure and equipment as the domains in which to define the objectives.

Key areas for recovery included orthopaedics, urology and oral surgery. Increasing theatre and cancer treatment capacity was also outlined. Several objectives including the retention of staff and the recruitment of new staff were also listed.

The document also outlined a number of key priorities which linked to the trust's quality and clinical strategies. These included; consistent and sustained planned activity and income targets, delivery of agreed performance thresholds and trajectories partnership working and delivery leadership and organisational capacity.

We saw an operational plan was also developed for each of the subgroups within the health group. Target periods for achieving objectives were shown, however they were not detailed.

We also reviewed the theatre transformation strategy which outlined key objectives to improve theatre utilisation with the development of a day surgery pathway, day surgery ward and the provision of dedicated day surgery teams. The trust outlined plans to introduce a demand and capacity model across all theatres to ensure efficiencies through effective access and flow processes.

We reviewed the overarching plans including the benefits for patients and the reduction of long waits; however, we did not see timescales for this strategy or when the phased approach would commence. Following inspection, the trust submitted a theatre strategy update report dated September 2022 which showed only one activity as completed.

We also saw a theatre utilisation plan was in progress at the time of inspection, but there were no timescales aligned to the plan and we were not provided with an update to show the plan was being implemented. The project end date was shown to be March 2023.

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Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff morale and wellbeing varied, and a few staff told us their morale was quite poor due to the staffing challenges. However, nursing staff generally felt well supported by their local managers and matrons and several staff told us that they felt managers were doing 'all that they can to support them'.

However, one staff nurse felt the duty matrons were not approachable and did not listen when they tried to raise overnight staffing issues which they felt were unsafe. Staff told us they understood the staffing challenges whilst trying to maintain staff morale and provide support.

We reviewed the NHS Staff survey results 2021 and saw theatre and surgical staff scored lower across all responses when compared to colleagues from other departments. Questions included how valued staff felt and how safe and how healthy they felt they were. We did not see an action plan to address these low scores or any developments to specifically address how valued staff felt.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

The health group met through a governance committee to review standard agenda topics such as incidents, clinical harm, risk, pressure ulcers, falls and audit results.

We reviewed the governance committee meeting minutes dated August 2022 and saw all areas were discussed but the minutes did not include detail sufficient for effective professional discussion. For example, the health group advised that there had been six serious incidents but there was no recorded discussion in regard to the nature of the serious incidents or the immediate actions taken to reduce future incidents.

We also saw two never events were recorded within the same minutes but there was no further recorded discussion.

Audit delays were outlined also but there was no plan to drive improvement or action plan created to monitor audit findings.

It was not clear what scrutiny was applied to delays or general poor performance. For example, there were 28 new clinical harm reports outlined within the same minutes, but no recorded discussion to address mitigation from further harm.

We spoke with senior leaders in regard to the apparent lack of learning in regard to the reported never events. Leaders told us learning and the roll out of actions takes time. We again reviewed the August governance committee meeting minutes and saw that learning following serious incident was shown as 'no data available'. The minutes referred to a possible lack of staff within this department.

Senior leaders told us that the service review team meet on a 6-weekly basis with attendance from all levels of staff; DGMs business manager, strategy planning manager, consultants, matrons, staff who want to be involved. We were also told of monthly clinical leads meetings. Governance leads and consultants are involved in making changes.

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The lack of auditing of the electronic system by the provider, suggested a lack of oversight of these concerns and the potential for ongoing unmanaged risk. Due to the lack of scrutiny, insufficient information and lack of oversight in regard to risk we were not assured that robust governance processes were in place. We were also not assured that poor performance was fully sighted by the board, due to the lack of pace to drive improvement.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance effectively. They did not always identify and escalated relevant risks and issues and did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders within the health group told us that elective recovery was their biggest challenge with no single solution to address this, thus requiring a multifaceted long-term plan incorporating more staff, more theatres, investment new builds and facilities. We saw plans to address this within the day surgery development strategy.

The current focus was to efficiently manage the delivering of services whilst reducing long waits and backlogs. Managers told us this involved all staff working collaboratively together to meet the complex needs of patients and changing ways of working to get 'most good' for patients. This involved any aspect of problem solving by working together.

Senior leaders told us there were 35 risks identified within the health group risk register, seven of which were rated as high risks. These included general capacity, theatre, beds, nurse staffing and ICU capacity. Managers told us they had rated 22 moderate risks specific to workforce issues, for example consultant shortages. Each register was reviewed monthly and managed, to achieve the lowest level of risk.

Most backlogs developed during COVID-19 and were rated high risk. Measures were taken to mitigate with enhanced IPC measures and were then downgraded to moderate. Staffing numbers across certain areas such as ICU, anaesthetics, ODPs, remain a challenge. Capacity difficulties within orthopaedics and trauma in both ward and theatres were recently downgraded.

Major trauma centre including arthroplasty remains high risk but managing better and expect to downgrade.

We saw three risk registers were reviewed every month. This included the corporate, COVID-19 and high operational registers. We reviewed the surgery governance committee minutes and saw that these were standard agenda items.

However, we were not assured that risk was prioritised as the minutes were not sufficiently detailed to ensure robust discussions were held in regard to clinical risk. We saw audit information was scant and incomplete and never events were not discussed fully.

For example, we reviewed the August 2022 minutes and saw key information was missing for several agenda items. This included mortality and morbidity learning, serious incident learning, incident and duration and medication incident reports. As such, learning from these incidents was not discussed.

None of the audits discussed at this meeting led to any action plan being developed to ensure improvement was made.

We spoke with senior managers regarding concerns we saw within theatres and specifically in regard to controlled drugs. Managers were not aware of the current practice undertaken by some staff, as recent internal audits undertaken

Surgery

by the trust had not identified these issues. We spoke with pharmacy staff in regard to the recent audit findings within theatres, however they were unsure when audits were last completed in regard to medication. The auditing of medication in theatres was an internal action following a never event. We saw this was not completed at the time of inspection.

We also raised the concerns we saw regarding the inappropriate example of consent forms. We asked when consent was audited but we were told it used to be mandatory but was not audited currently.

Leaders were disappointed to learn that we had found concerns when reviewing the surgical safety checklists. We saw within the safe September performance report that the frequency of WHO audits had been doubled but results were not available at the time of inspection.

We asked senior managers about the learning following the recent numbers of never events within the health group and were told that there had been six never events to date, but the majority of them had not caused patient harm. Managers told us all incidents are discussed at team meetings and lessons learnt discussed to prevent happening again, for example informing the GP in a more timely fashion if a procedure has been cancelled due to high blood pressure - to prompt them to treat it quickly and inform the team when safe to scope the patient.

A consultant learning event had been organised to share their experiences and this had been successful with 180 people attending. The new Patient Safety Incident Reporting Framework, improvement month and Surgery Safer September were all new initiatives to ensure learning was captured and rapidly embedded. Managers told us Patient Safety Incident Investigation (PSII) Training is planned in November to drive a systems approach to investigations and improvement, alongside Human Factors & Patient Safety for Senior Leaders.

Information Management

The service collected some reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure.

We found some of the trust's systems and processes for recording inconsistent, for example the lack of electronic recording systems in theatres. Consequently, ward staff spent time transferring paper-based information into the electronic recording systems which posed a risk of lost information during the transfer process. We saw staff confidence using the electronic systems varied from ward to ward. All staff we asked to guide us through the electronic systems told us there were sections of the systems they had not accessed before.

Staff told us that not all staff could enter data into the electronic records. We saw examples of this when recently qualified nursing staff employed as band two staff were required to have patients' assessments signed off by a senior nurse before they could be added. Ward staff told us these created delays in recording patient observations, which often showed as not completed.

We saw internet dropouts on some of the wards we visited, and staff reported occasions when the electronic system failed completely, resulting in staff having to move to paper based systems. This created concerns in relation to medicines management.

We found some electronic systems were not being used to their full potential. For example, no electronic referral could be made to specialist staff such as palliative or pain teams. Ward staff were still required to make a manual referral.

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We saw patient records which were not stored securely on some of the wards we visited.

We saw a large percentage of trust policies were overdue and 43 patient information leaflets were out of date, posing a risk that both staff and patients were not following up to date guidance and advice.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the last NHS staff survey was conducted in 2021. We saw the trust had developed overarching objectives in which to support staff. These included improving staff engagement, raise awareness of staff survey plans, ensure wellbeing was embedded in everything, development of managers abilities to have supportive and compassionate conversations with staff and support improvement. We saw these objectives were an outline of proposed plans but did not have sufficient detail including timescales and clear actions to be undertaken.

The trust reintroduced 'Greatix' to recognise staff idea and any learning. There had been 135 ideas received to date which the trust was reviewing for implementation.

The trust submitted examples of benefits for staff such as wellbeing days and the introduction of a tuck shop.

We saw plans for a People Recovery plan which was aimed to address health and wellbeing, develop inclusive teams and unlocking potential. We saw overarching plans to increase engagement with staff and aims to design a recovery plan for each health group. However, we did not see any updates regarding the progress of this roll out.

A senior manager and a team of staff had visited Liverpool to review their SHMI and their approach to the management of Sepsis.

The bowel screening service was working with organisations across the region to develop a health inequalities strategy to increase participation in bowel screening in areas of low uptake.

The trust told us some alcohol dependent service users were not engaging with community support providers. As such, the trust employed an expert by experience charitable volunteer who provided an alternative peer support. This was met with positive feedback from the patients and the Alcohol Liaison team.

The trust told us stoma patients were routinely being contacted for regular follow-ups and community visits, however, through the use of a patient feedback survey, the trust found that not all users wanted these appointments. Therefore, the trust had set up a patient helpline and provided patients options for their pathway preference. The majority of patients after the first 6 months were happy to be put onto Patient Initiated Follow Up access plans with access to the helpline in the meantime should they require any urgent assistance.

The bariatric service had updated post-discharge bariatric Information leaflets for General Practitioners and patients. This is sent to the patient and their GP on discharge outlining all of the post-operative requirements, including what bloods are required and what multivitamins and supplements. It includes the Top 10 tips for General Practitioners post bariatric surgery.

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We saw the last family and friends survey carried out by the trust and saw that HRI received a 88% positive response rate and Castle Hill received 92% positive response rate.

We requested examples of recent public engagement, but this was not provided.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The bowel screening service offered 'attend anywhere' appointments for patients, so that they can have a virtual face-to-face appointment rather than a telephone appointment, reducing the need for patients to travel in. The screening programme have also gone 'paper lite' to make sure all the patient documentation was visible to all staff no matter where they were working within the region.

Over the past 12 months, the colorectal service had introduced robotic surgery for patients undergoing major cancer surgery. The activity was currently being delivered by two consultants within the department, with a plan to train further consultants in the future. The service had also been able to secure funding from the Cancer Alliance to appoint a Band 4 Cancer Care Co-Ordinator. The trust told us the post was pivotal in ensuring that patients were able to move along the cancer pathways in a timely fashion. They also provided an additional point of contact for patients who had any concerns or queries.

GI Physiology at Hull University Teaching Hospitals NHS Trust was one (of only 4) accredited GI Physiology services in the UK that have (and continue) to be involved in the Improving Quality in Physiological Services (IQIPS) scheme.

The Upper GI service had also begun to implement the use of robotic surgery, in the first instance for patients diagnosed with Oesophagogastric cancer. The service was planning to focus on 'robotic-assisted minimally invasive oesophagectomy (RAMIE)' in the first instance, with the process bringing improvements/reductions in length of stay and post-surgical morbidity amongst other benefits. The trust advised the aim would be then for the Hepatobiliary service to introduce the robot for pancreatic cancer resections.

Castle Hill Hospital

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Description of this hospital

Castle Hill Hospital (CHH) provides a range of acute services to the residents of Hull and the East Riding of Yorkshire, as well as specialist services to North Yorkshire, North and North East Lincolnshire. The trust has approximately 1,160 inpatient beds across the two main hospitals and employs over 7,000 whole time equivalent staff to deliver its services. Castle Hill Hospital has the regional Queen's Centre for oncology and haematology and provides cardiac and elective surgery facilities, medical research teaching and day surgery facilities in the Daisy Building.

Medical care (including older people's care)

Requires Improvement ● ↓

Is the service safe?

Requires Improvement ● ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills but did not make sure all staff completed it.

Nursing and medical staff did not always receive or keep up-to-date with their mandatory training. We reviewed training compliance figures across all of the wards we visited and saw that at the time of inspection compliance rates were below the trust's 90% target. Evidence provided showed that 80.4% of all staff within the health group had completed their mandatory training.

Although the previous inspection of the service in 2020 identified the need for all medical staff to receive and keep up-to-date with their mandatory training, this was not achieved for either medical or nursing staff, 74.4% for medical staff and 85.2% for nursing staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The completion of Mental Capacity Act (MCA) training was below trust target for both medical staff (70.9%) and nursing staff (84.7%). The completion of Deprivation of Liberty Safeguards (DoLS) training was also below trust target for medical staff (71.3%) and nursing staff (83.2%).

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was monitored health group ally and discussed at regular performance review meetings. Ward managers told us they monitored mandatory training and alerted staff when they needed to update their training. We were told high patient acuity, staff sickness, isolation due to COVID, and operational pressures had impacted on staff maintaining their mandatory training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however not all staff had completed the training in line with trust guidance.

Staff received training specific for their role on how to recognise and report abuse. The trust provided training data which evidenced that at the time of inspection both nursing and medical staff did not meet the trust target of 90% for safeguarding training modules. Safeguarding adults level two training showed a compliance rate 81.8% and safeguarding children level two showed a compliance rate of 80.7% which did not meet the trust target. There were plans in place to improve compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Safeguarding risks were discussed during patient handovers, ward and board rounds and staff huddles.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The trust informed us that Patient Led Assessments of the Care Environment (PLACE) visits did not take place in 2021, nor 2022 due to the pandemic, the last reported visit was in 2019.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were supplies of hand gel and PPE in all areas we visited and prompts for their use were visible at all ward entrances to inform staff and visitors of hygiene requirements. We saw staff wore face masks correctly in clinical areas in line with guidance and all clinical staff were bare below the elbow.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All wards visited had designated isolation rooms for patients with COVID symptoms or those known to be positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed.

Wards visited reported low or no cases of clostridium difficile (C.diff) and methicillin resistant staphylococcus aureus (MRSA). Staff worked with the trust's infection prevention control team on a programme of quality improvement at ward level. Trust infection rates for the twelve months before inspection showed 21 incidences of clostridium difficile across the health group and one incidence of MRSA bacteraemia at the hospital.

The trust carried out enhanced infection prevention and control audits identifying compliance with hand hygiene, PPE, environment and equipment cleaning. These showed between 88.6% and 93.5% compliance across the health group.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). This stipulates patients presenting with one or more high risk criteria should receive antibiotics within an hour of being identified. However, the audit showed a pass rate of 60% for the management and treatment of infection and sepsis and resulted in recommendations for improvement.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. At ward entrances face masks and hand gel were readily available. Wards we visited had boards to display information about staff on the ward, visiting times, who was in charge, and other useful information, such as falls and numbers of incidences of infections.

Medical care (including older people's care)

Staff carried out daily safety checks of specialist equipment. Equipment including emergency resuscitation equipment was subject to routine planned preventative maintenance and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers.

The service had suitable facilities to meet the needs of patients' families. Each ward visited had a specific room set aside for families, patients and also for the use of staff to discuss issues with patients and families.

The service had enough suitable equipment to help them to safely care for patients. We were told by staff on ward 20 (general medicine, no criteria to reside) that equipment was not always readily available on the ward and had to be 'borrowed' from other wards. However, we were later told specific equipment was available for 'signing out' at the hospital reception.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) alert system was used and provided an ongoing oversight of patients which helped staff to identify and escalate deterioration in a patient's condition. We saw appropriate completion of NEWS2 documentation and appropriate escalation of patients within patient records.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. Risk assessments were completed on admission and transfer for falls, nutrition and hydration, pressure area care, dementia and moving and handling. We reviewed completed risk assessments and saw these were used to plan care and treatment pathways for each patient.

Some patients required one to one observation but, due to staffing pressures, this was not always possible. Staff told us they would try to cohort patients at risk in the same bay.

An audit to '...measure compliance with, and knowledge of National guidelines and Local Policy for sepsis within Hull University Teaching Hospitals' was completed in March 2022. This showed a 60% pass rate for the management and treatment of infection and sepsis, and resulted in recommendations to:

- Escalate patients with a National Early Warning Score (NEWS2) of 5-6 with urgency to the nurse-in-charge and doctor for urgent review within 30 mins;
- Escalate patients with a NEWS2 score of 7+ as an emergency, to the nurse-in-charge and senior doctor to review immediately (within 15 mins) and inform outreach teams;
- Ensure all patients with a NEWS2 score of 5 or more, commence the trust 'Sepsis Screening Tool'.

A referral to the critical care outreach team was made by anyone involved in caring for patients acutely ill or deteriorating causing concern or those meeting the trust's escalation criteria.

Medical care (including older people's care)

Following review there were 59 pressure ulcer incidents reported in August 2022 across the health group; these were reported as category 2 pressure damage (38) and deep tissue injury (21).

In response, the tissue viability team continued with fundamental standard audits, structured and intensive ward and board rounds, leg ulcer training, a quarterly newsletter, and a tissue and viability task and finish group had been established to help reduce these numbers.

However, the numbers of pressure ulcer incidents had not yet started to decrease, averaging 48 each month over the four months from May to August 2022. To further address this, link nurse sessions had commenced, and the tissue viability team were undertaking leg ulcer training in line with the 'National Wound Care Strategy Programme'.

The annual report of the falls prevention committee showed the trust recorded an overall increase in the number of inpatient falls reported between 2020/2021 and 2021/2022, from 2370 to 2825 (18.7% increase). However this was a decrease in the number of falls measured by falls for each 1000 beds days. The ward with the highest number of falls (September 2022) was ward 28/cardiology medical unit with 8 recorded.

Initiatives taken to reduce the number of falls included an updated patient and relative information leaflet, e-learning packages for all staff, agreement that falls prevention training should become mandatory for all registered and non-registered nurses with the exception of midwives and paediatric nurses. Further, a falls educator has been allocated for a one-year secondment, this role commenced in February 2022 and will help develop a multi-disciplinary team approach to falls prevention and a network of falls champions for each ward. We saw a specific falls bundle had been designed and was completed as part of the electronic nursing documentation.

The service had 24-hour access to mental health liaison and specialist mental health support.

Shift changes and handovers included all necessary key information to keep patients safe. We found handovers on all wards discussed key risks and risk mitigation. Wards held safety huddles as part of the daily handover process where patient risks were discussed including staffing, numbers of patients, risk of falls, enhanced care patients and escalation, end of life, cannula care, pressure ulcers, infections and infection control and do not attempt cardiopulmonary resuscitation (DNACPR) orders.

Nurse staffing

Senior leaders within the health group acknowledged the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Although staffing levels and skill mix were regularly reviewed, this did not always provide established safe levels of staffing.

The service did not always have enough nursing and support staff to keep patients safe. Due to national shortages and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. Staff told us they were frequently moved between wards to cover patient acuity, they further said that this compromised patient care through a lack of continuity of care. We were informed by patients and receiving services before inspection of delayed and unsafe discharges from medical wards.

Although ward managers told us they were allocated dedicated managerial hours, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care.

Medical care (including older people's care)

Managers reviewed staffing levels throughout the day and moved staff across the hospital when needed based on acuity, enhanced patient needs and staff availability. Electronic systems were used to identify and support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks.

'Care hours per patient day' (CHPPD) detail staffing levels in relation to inpatient numbers on an inpatient ward. Overall trust CHPPD remained between 6.5 and 7.0 hours in the 12 months to May 2022, although there was variance in wards in the hospital, for example 5.12 hours (C26, cardiology) and 10.27 hours (C01A, rehabilitation).

Nursing staff vacancies in September 2022 showed a vacancy rate of 2.19%. Trust wide sickness rates for nursing staff in the six months before inspection showed a sickness rate of 5%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust used a 'red flag' system to identify staff shortfalls on individual wards. This identified when there were less than 2 registered nurses on a ward, the shortfall in registered nurse time (hours) and the inability to give 1:1 care and support on the ward. There had been 455 red flags identified in October 2022; the highest being the shortfall in registered nurse time (214 hours total).

Meetings and 'huddles' were held throughout the day including matrons and shift leads to highlight concerns in the red flag system, dependency, acuity and staffing levels. This enabled an early response and support by the health group. An overview of staffing and potential operational risks was also shared at trust operational meetings held three times daily. Matrons and site duty managers liaised across health groups and sites to ensure mitigating actions were taken.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Nursing staff vacancies at the time of inspection showed a whole-time equivalent shortfall of 12.8 hours across the hospital. Sickness rates for nursing staff at the time of inspection showed a sickness rate of 5.41% across the trust.

The health group had undertaken international recruitment and worked with the local university to attract nurses to the trust. Further the trust was developing currently employed staff through apprenticeships, nurse associate training and a hybrid role of auxiliary nurse and therapist to address staff shortfalls.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. The medical staff did not match the planned number. Patients were reviewed by consultants depending on their care pathway.

However, we were not assured there was sufficient consultant cover in the evenings and at weekends to ensure timely and effective decision making and discharge. In the twelve months before inspection internal locums provided 0.8 whole time equivalent staff and external bank and locums provided 2.1 whole time equivalent staff.

To address this, weekly meetings were held with medical staffing teams to gain assurance that cover for all shifts for the coming seven days was in place. A health group patient flow meeting was held which reviewed overnight staffing so that plans for cover were identified.

Medical care (including older people's care)

Since August 2022, the trust had changed the management of rotas to try to help minimise gaps. There are now regular meetings between the clinical director, rota co-ordinator and human resources and the rota was issued in four-month blocks. This enabled specialist registrars (StRs) to move between rotas to ensure the residential medical officer (RMO) slots were always filled and helped to co-ordinate when StRs came off the RMO rota, such as for acting up as a consultant. Gaps in the rota had been reduced as a result.

Medical staff vacancies at the time of inspection showed a whole-time equivalent shortfall of 42.96 hours across the hospital. Trust wide sickness rates for medical and dental staff in the six months before inspection showed a sickness rate of 2.43%.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Patient notes were recorded on handheld electronic devices and terminals located on wards. The electronic system had all relevant risk assessments, protocols and pathways available for staff to access. Although nursing documentation had been migrated to the electronic system, some medical notes were still in paper format.

When patients transferred to a new team, there were no delays in staff accessing their records. The electronic patient record system automatically allowed hospital staff to access the record.

Records were stored securely. All terminals and handheld electronic devices had secure log-in access to the device and patient care records.

Whiteboards were used on wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations. We saw handovers where the information on whiteboards was used to update patient assessments and care plans immediately.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We observed nursing staff administer safely, in a timely way and with a caring attitude. Small amounts of stock medications were held on wards, patients were discharged with 14 days supply provided. A pharmacy technician was allocated to each ward, and checked patients had a sufficient supply of medicines, undertake reconciliation in line with the immediate discharge letter (IDL) if the patient had transferred on to the ward quickly; the IDL was clinically checked by a pharmacist.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Paper copies of the discharge summary, including discharge medicines were given to the patient, and discharge letters contained details of medicines started, stopped and to be continued. Discharge medicines were all clearly labelled, and patients were counselled about their medicines by the pharmacy technician.

Medical care (including older people's care)

Staff completed medicines records accurately and kept them up-to-date. We reviewed 22 electronic Prescribing and Medicines Administration (ePMA) records and found these were completed appropriately. Access to electronic medicine records was restricted to authorised clinical staff. Medicines that are controlled drugs were managed safely.

Staff stored and managed all medicines and prescribing documents safely. We found some medication stored in the medication fridge was out of date (Ward C01).

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. We observed medicines administration and saw that medicines were administered safely and followed national guidance.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff were confident they knew which incidents to report in line with trust policy. They told us they received feedback from incidents reported through team meetings and where appropriate learning was shared directly by their ward manager.

Patient safety alerts (PSA) were cascaded throughout the health group to relevant staff and compliance with alerts was monitored through the health group monthly governance briefing report. At the time of inspection two PSA showed as compliant and had been closed, one (risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis from a particular insulin pump) was due for compliance and closure in November 2022), and the other was awaiting confirmation of compliance before closure on schedule.

Managers shared learning about never events with their staff and across the trust. We discussed a serious incident which had happened in February 2022 with managers and staff. This had been investigated, new procedures developed, and staff across the health group confirmed they had been made aware of the incident and the procedures put in place to prevent repetition.

Staff reported serious incidents clearly and in line with trust policy. From October 2021 to September 2022, there had been 28 incidents reported to the Strategic Executive Information System (StEIS) under the medical speciality. The highest number of incidents were reported in December 2021 and the most common incident type was 'Slips/trips/falls meeting SI criteria'.

A total of 5,071 incidents were reported to the National Reporting and Learning System (NRLS) under 'medical specialties' from February to September 2022. Of these, 3005 were related to 'patient accident' or 'implementation of care and ongoing/monitoring review'.

Medical care (including older people's care)

The majority of all medicine's incidents were reported as 'low' or 'no harm'. The health group reported 468 incidents in September 2022, a decrease compared to the previous month (503) and the overdue and breached incidents (not completed within 28 days) decreased from 240 to 228. Of these, 9 major and 17 moderate harms were recorded.

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Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed the last five serious incident investigation reports for the hospital. These showed staff understood and applied duty of candour (DoC). They were open and transparent and gave patients and families a full explanation when things had gone wrong. Ward managers and most of the staff we spoke to knew of the DoC requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families.

The trust had carried out a 'Falls Serious Incidents Thematic Review' in June 2022. The review identified the patients' medical condition on admission, an overview of the incident, further comments and root cause and contributory factors to the fall.

Contributory factors to these incidents were identified as the accurate assessment of patient falls risk both on admission and throughout their care and acuity pressures on ward staff contributing to the missed reassessment of falls risks. An action plan had been developed to address these and was being taken forward by the trust 'Falls Prevention' committee.

Managers debriefed and supported staff after any serious incident. Investigations identified care and service delivery problems where appropriate, recommendations, action plans and key lessons learnt for debrief to staff.

Is the service effective?

Requires Improvement  

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983. However, the majority of procedural documents were past their review dates.

Medical care (including older people's care)

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. Handheld devices contained current care pathways and plans, flow charts and policies for risk assessments, patient care and treatment. The trust had systems and processes in place to ensure that care was given in line with national guidance, such as that issued by the National Institute for Health and Care Excellence (NICE).

An audit (June 2022) of the use of direct oral anticoagulants (DOACs) in the treatment of venous thromboembolism (VTE) showed 99% compliance with VTE diagnosis documented on the patient's discharge letter, 81% compliance with therapy duration documented, 64% compliance with the dose of DOAC adjusted to the patient's renal function, and 100% compliance with no contraindication (for example mechanical heart valve) to DOAC therapy.

The trust had a guideline (August 2022) in place for the management of infection and sepsis screening. This identified the appropriate triggers for the use of 'The Infection and Sepsis Screening and Management Pathway', the expected timeframe for assessment and the minimum investigations to identify hidden potential infection. Sepsis training provided by the sepsis team was currently not mandatory and was paused during the COVID pandemic, but was included in the initial junior doctor training programme.

Trust policies reviewed after inspection were comprehensive, in date and version controlled. However, the 'Medicine health group governance briefing report' (October 2022) showed 66% of procedural documents were overdue for review. These included the Nutrition and Hydration Policy (review date November 2020), Stroke Unit Operational Policy (November 2020), Delirium Policy (March 2021), Insertion and Maintenance of Naso-Oro Gastric Tubes (April 2022). In addition, 23 guidelines were also overdue for review, for example oxygen guidelines, hypertension and chronic heart failure. In total, these were 66% of procedural documents specific to the health group.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw staff at handover meetings referred to the psychological and emotional needs of patients, their relatives, and carers and referred patients to the psychiatric liaison team when needed.

The endoscopy unit did not have Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards. However, the service was working towards this and had produced a comprehensive action plan covering, for example, leadership, safety, quality patient involvement and teamwork.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw a screening tool was fully completed to identify patients who are malnourished, at risk of malnutrition (undernutrition), or obese. Red trays and jugs were in use for patients identified as at risk and those needing assistance at mealtimes. We observed mealtimes on different wards and saw that all patients were served food and assistance was given to those who needed it. Staff were careful to note which patients were 'nil by mouth'. Patients' relatives were encouraged to assist with mealtimes if they wished.

Medical care (including older people's care)

On some wards a caterer undertook a refreshment round twice a day offering patients tea, coffee or a cold drink. Snacks were also available. Caterers knew which patient required a special diet, whiteboards in kitchen areas indicated dietary requirements. Water jugs or beakers of water were at each patient's bedside and these were replenished throughout the day.

The trust had a commitment to protected mealtimes. To ensure patients received appropriate nutritional uptake and assistance at mealtimes, tasks such as cleaning were not permitted in patient areas.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it and patients requiring this were frequently reviewed. In addition, each ward had a member of nursing staff who was a nutrition champion.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain-scoring tool to assess a patient's level of pain. All staff we spoke with knew about pain assessments and how to score patients level of pain. We did not observe staff using communication aids to support patients unable to communicate or for those with specific needs, for example dementia or learning difficulties.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Additional pain relief was requested from medical staff, if required. Some staff told us that some pain medications were given late due to requests for prescribing being delayed due to ward pressures. However, patients we spoke with told us staff managed their pain in a timely way.

A trust audit (December 2021 to January 2022) highlighted discrepancies between the timeliness and accuracy of prescriptions written by pain nurse prescribers in comparison to junior doctors following pain team recommendations. This supported a business case to support pain nurse development and completion of non-medical prescribing, resulting in an established substantive post and plans for the further development of pain nurses to undertake non-medical prescribing.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Due to the COVID pandemic there have been delays to the publication of national audits, for example the National Lung Cancer Audit, National Heart Failure Audit, National Diabetes Inpatient Audit and the National Audit of Inpatient Falls.

However the National Audit of Inpatient Falls issued in November 2021 and covering the year up to December 2021 resulted in actions, some ongoing, to add completion of training for reporting of falls for all nurses, the introduction of yellow bracelets for patients at risk of falls, and the review of incidents reported within the health group.

Medical care (including older people's care)

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. Trust data showed that no medical ward met the trust target (95%) for testing patients for venous thromboembolism (VTE) risk within 24 hours of admission, in the twelve months before inspection. Across the health group 82.3% of patients were tested for venous thromboembolism (VTE) risk within 24 hours of admission, in the twelve months before inspection. The National Institute of Clinical Excellence (NICE) states ‘...all patients should receive a VTE risk assessment as soon as possible after admission to hospital or by the time of first consult review by a medic’.

The service had a higher than expected risk of readmission for elective care than the England average. From January 2021 to December 2021, patients at the hospital had a higher than expected risk of readmission for elective admissions when compared to the England average. Of the top three specialties (medical oncology, clinical oncology and clinical haematology), by count of admission, all three had a higher than expected risk of readmission when compared to the England average.

The service had a higher than expected risk of readmission for non-elective care than the England average. From January 2021 to December 2021, patients at the hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average. Of the top three specialties (medical oncology, clinical oncology and clinical haematology), by count of admission, all three had a higher than expected risk of readmission when compared to the England average.

Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. The health group had identified actions to improve outcomes from previous national and local audits, for example to hold a falls prevention week (September 2022) and education sessions with general practitioners (inflammatory arthritis). Initiatives to reduce falls within the trust had resulted in a reduction of falls for each thousand bed days to an average of 7.7%, a 0.6% decrease from the previous year.

We found there were medical patients outlying on non-medical wards on the day of inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses and internationally recruited nurses with a full induction and preceptorship.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust provided information which showed that the health group compliance with nurse appraisal completion was 72.1%, this did not meet the trust target. Ward managers had plans in place to complete appraisals, but told us operational challenges continued to affect the ability of staff to undertake appraisal.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The appraisal completion rate for medical staff within the health group was 91.4%, above the trust target of 90%.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Medical care (including older people's care)

Managers made sure staff received any specialist training for their role. On most wards we found link nurses were in place for falls, dementia and tissue viability. These members of staff had received training from specialist teams within the trust.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We found there were daily multidisciplinary team (MDT) meetings on each ward. These were attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. Each patient was discussed, and their changing needs and care plans updated as well as discharge planning.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The health group had access to teams for ongoing assessments of mental health, alcohol and psychiatric liaison. Although these were available 24 hours a day, we were told there were long waits at busy times. Initial assessments were carried out by consultants and registrars, and junior doctors had input if any patient concerns were identified.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Although, key services were available seven days a week to support timely patient care, we were not assured there was sufficient consultant cover in the evenings and at weekends.

Consultants led daily ward rounds on all wards. Patients are reviewed by consultants depending on the care pathway. Patients were reviewed by consultants depending on their care pathway. A review of patient notes showed they were clinically assessed by a consultant within 12 hours of admission.

However, we were not assured there was sufficient consultant cover in the evenings and at weekends. In the twelve months before inspection internal locums provided 0.8 whole time equivalent staff (1,686 hours) and external bank and locums provided 2.1 whole time equivalent staff (4,464 hours)

To address this, weekly meetings were held with medical staffing teams to gain assurance that cover for all shifts for the coming seven days was in place. A health group al patient flow meeting was held which reviewed overnight staffing so that plans for cover were identified and actioned.

An operational support manager had been employed to provide daily oversight of all rotas, liaising with the deputy director of operations and health group al general managers to support the filling of rota gaps by internal and external locums. Plans were communicated with on-call teams, residential medical officers and on-call consultants daily, and updates given to the site operational bed meetings.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Staff told us there was good access to diagnostic services.

Medical care (including older people's care)

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw information promoting healthy lifestyles and support on all wards and units visited.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were screened on admission for smoking and alcohol intake as part of the admission pathway and offered appropriate advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. However, they did not always follow national guidance to gain patients' consent and support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We reviewed ten patient records, and these showed staff formally assessed patient's capacity and ensured care and treatment was appropriate and safe. Patient care records reflected day to day decision making in respect to patient care and documentation of capacity for example receiving personal care.

A trust audit of Deprivation of Liberty Safeguards (DoLS) applications carried out between April and September 2022 raised a number of concerns, as follows:

- *The over propensity for nurses to complete the process;*
- *Patients may be illegally detained as the quality of the mental capacity assessments do not meet the legal requirements in line with the MCA 2005;*
- *Poor completion delays the process and the subsequent submission to the LA's which may lead to an illegal detention;*
- *Poor application of the fundamental capacity assessment leading to delays in the process;*
- *Poor compliance to the DATIX procedure to register restrictive process;*
- *Current paper-based process is time consuming and does not promote quality of completion.*

In response the trust decided to continue monthly audit, review fundamental Mental Capacity Act training, review existing documentation and pursue an information technology in preparation for the change to Liberty Protection Safeguards.

When patients could not give consent, staff made decisions but did not always document the best interest process. We reviewed do not attempt cardio-pulmonary resuscitation (DNACPR) forms and found inconsistent practice in recording the best interest decision making process. Staff told us this would usually be done by a doctor and they would document on the form that a discussion with the patient's family had taken place. However, this was not always documented.

A trust 'Audit of Mental Capacity Act (2005) Compliance and consent 4 process' also found variable results, for example, evidence of a best interest decision, completion of a best Interest discussion at the same time as a mental capacity assessment and evidence of family involvement.

Medical care (including older people's care)

The hospital made 4 DoLS applications in the three months before inspection. None of these were still open and awaiting decision from the local authority. The remaining were either cancelled before sent due to the patient being discharged or change in needs (2) or were awaiting to be sent to the local authority (2).

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information supplied by the trust showed that 70.9% of medical staff and 84.7% of nursing staff had received Mental Capacity Act training at the time of inspection. Further, 71.3% of medical staff and 83.2% of nursing staff had received Deprivation of Liberty Safeguards training. These completion rates did not meet trust compliance targets of 90%.

Is the service caring?

Good   

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff interact with patients in a way that ensured patients maintained their dignity throughout their care. We observed staff assisting patients with personal care in private, maintaining the dignity of the patient. We saw positive interactions between staff and patients. Staff introduced themselves to patients before providing care and included patients in discussions about their care. Staff communicated in a positive manner with patients whilst undertaking routine observations, assisting patients to eat and drink and assisting them with their care.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. All patients told us staff treated them well, with kindness and respect; all patients we spoke with praised staff and the total experience with the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff followed policy to keep patient care and treatment confidential. Bed curtains were drawn when providing care and treatment and we saw nursing and medical staff spoke with patients in private to maintain confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients said staff treated them well and with kindness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. We found patients were given emotional support when needed, and staff showed caring and empathy. Wards had designated family rooms to enable support to be given to patients by family and friends, and these were also used for discussions between staff and family members.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. One patient told us that all the staff had been brilliant and that they had been kept well informed about treatment options needed for their condition. They said that everyone smiled when passing their room and everyone knew their name.

The health group had electronic devices available for patients to contact family and friends. Patients could see and talk with their loved ones using remote technology.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff spending time with patients, their families and carers when discussing their discharge plan. Patients told us staff were knowledgeable and provided good care.

Staff talked with patients, families and carers in a way they could understand. Patients told us that the staff were always busy and working hard, but felt this did not compromise care. Patients who had raised concerns about their health were reassured by staff who took time to explain investigations and discharge plans to them and their families, and carers.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were able to give informal feedback on each ward, but were also able to complete the 'Friends and Family Test'; the health group had a 90.75% positive rating.

Staff supported patients to make advanced decisions about their care. The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) which supports conversations about care in a future emergency, was in place. It was designed to allow patients greater influence on what happens to them, and that their wishes are carried out appropriately, should they ever find themselves in an emergency situation where they are not able to express their wants and/or needs. We reviewed ten ReSPECT care records had found these had been completed appropriately and 82% of medical staff had completed ReSPECT training.

Patients gave positive feedback about the service. We received positive comments from all patients spoken with, this was complemented by positive comments from family members and carers.

Is the service responsive?

Requires Improvement ● ↓

Medical care (including older people's care)

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

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust confirmed there had been no mixed sex accommodation breaches in the last twelve months.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The trust had developed a five year 'Dementia and Delirium' strategy (2022-2027) which included aims to improve compliance with dementia, delirium and depression screening on admission, investigate potential themes relating to inequality in care (for example, length of stay, patient harms, safeguarding concerns), audit dementia and delirium care delivery and highlight areas for improvement (for example, documentation, communication and palliative care support) and support staff in the safe and appropriate use of deprivation of liberty, restraint and capacity to consent decisions.

The strategy had resulted in the appointment of a clinical educator to provide additional training and education support in dementia and learning disability, patient name boards had been improved to enable staff to easily identify patients' communication needs (for example, glasses, hearing aids) and harm risks (falls, pressure ulcers, nutrition), and dementia activity and companion volunteer roles have been developed.

The service had systems to help care for patients in need of additional support or specialist intervention. The health group had access to teams for ongoing support to patients with issues around mental health, alcohol dependency and psychiatric needs.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards were designed to meet the needs of patients living with dementia. The trust 'Dementia and Delirium Strategy 2022-2027) set out the trust's plan to deliver safe, high quality care and services to patients and their families living with dementia and/or experiencing delirium and established the dementia and delirium steering group.

The strategy aimed to place the person living with dementia and/or experiencing delirium, including their families/carers, at the forefront of the trust strategy by:

- developing and supporting local and national initiatives to reduce the risks of developing dementia;

Medical care (including older people's care)

- supporting regional dementia pathways to improve diagnosis rates;
- supporting delivery of patient engagement and experience initiatives;
- creating communications systems that actively seek to gain patient and essential care givers feedback;
- embedding digital systems that provide ongoing quality data to guide targeted quality improvement projects such as length of stay, falls and pressure ulcer prevention;
- ensuring current dementia friendly environments are maintained, ongoing projects completed, and all new builds/improvement projects adhere to Kings Fund principles; and
- establishing and promoting individualised spiritual care.

We found wards were dementia friendly, and staff supported patients living with dementia. Wards used the 'butterfly scheme' to identify patients living with dementia; a butterfly shaded in blue meant the patients had a confirmed diagnosis, an outline meant the patient could be suffering with delirium and might need reassessment. The butterfly was displayed above a patient's bed, on the name board and the patient's identity bracelet. This meant staff could easily see if a patient might need additional assistance in a discreet way.

The health group cared for patients with mobility difficulties and the ward environment had been designed to help those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request.

Although staff understood the policy on meeting the information and communication needs of patients with a disability or sensory loss, we did not observe this being applied.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We reviewed morbidity and mortality cases discussed in the three months before inspection and the minutes of the emergency medicine/acute medicine joint morbidity and mortality meeting. These showed a structured review of the patient journey within the hospital, patient outcomes, good practice and learning outcomes.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Some patients needed longer stays while they awaited treatment and discharge.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Since January 2022, there had been an increase in the total number of patients on the waiting list, this was consistent with the trend across the region and country (approximately 2% a month).

Medical care (including older people's care)

The number of patients treated increased by 33% during the 12 months to August 2022 (from just over 14,000 in August 2021 to almost 19,000 in August 2022). As of August 2022, there were almost 72,000 patients on the waiting list which was 22% more than in August 2021 (just under 59,000). The three specialties with the highest waiting lists were general surgery, 'other' and ear, nose and throat.

The number of patients waiting over 52 weeks for treatment had reduced over the 12 months to August 2022, although there had been an upward trend in numbers since June 2022.

The trust had the highest number of patients waiting over 52 weeks in the North East region, with 7.5% of the waiting list waiting over 52 weeks compared to a regional average of 3.4%.

Managers and staff worked to make sure patients did not stay longer than they needed to. From February 2021 to January 2022 the average length of stay for medical elective patients at the trust was 5.1 days, which was lower than the England average of 6.4 days. For medical non-elective patients, the average length of stay was 6.8 days, which was higher than the England average of 6.0 days.

From February 2021 to January 2022 the average length of stay for medical elective patients at Castle Hill Hospital was 5.0 days, which was lower than the England average of 6.4 days. Of the top three specialties, by count of admission, average length of stay for elective patients in cardiology and clinical haematology was lower than the England average; clinical oncology was higher than the England average.

For medical non-elective patients, the average length of stay was 5.1 days, which was lower than England average of 6.0 days. Of the top three specialties, by count of admission, average length of stay for non-elective patients in medical oncology and cardiology was about the same as the England average; clinical oncology was higher than the England average.

The percentage of patients treated within 18 weeks had steadily declined since January 2022, in line with regional and national trends.

Although, staff tried not to move patients between wards at night this did happen when there was a clear medical reason or in the best interest of the patient. The trust provided data which showed in the three months before inspection (August to September 2022) there were 31 bed moves at night (10 p.m. to 8 a.m.). Senior managers were aware that work was required to ensure that patients were not moved out of hours.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. The trust had a 'Non-criteria to Reside Patient Wards' standard operating procedure in place (June 2022). The Trust recognised there were patients with no criteria to reside who cannot be discharged due to lack of capacity and resource within social care. In response, the trust had established 'No Criteria to Reside Wards'. The aim was to ensure appropriate levels of care, effective deployment of resource and increase patient flow through the hospital.

The procedure identified that a delegated consultant will provide two weekly board rounds and a weekly virtual board round. Between rounds, advice is available by telephone from the named consultant for the ward. The health group ensured junior doctor cover was available for a minimum of one doctor working 9 a.m. to 9 p.m. daily (7 days a week) and after 9 p.m. cover was met by the on-call team.

Medical care (including older people's care)

Escalation of issues were made to the appropriate specialty and ward moves minimised as far as possible. If a patient did require an escalation to an acute ward, they would be transferred directly to a base ward covered by the appropriate specialty or named consultant. In exceptional circumstances (e.g. when the patient needs urgent transfer and a bed on the base ward is not readily available), patients were readmitted to either the acute medical assessment unit or elderly assessment unit. All efforts were made not to transfer the patient back to the emergency department.

In the six months prior to inspection (May to October 2022) the hospital had 5925 admissions of patients identified as 'non-criteria to reside' on to wards and assessment units, during our inspection there was an average of 131 'non-criteria to reside' patients across the two hospitals. Staff told us there were difficulties in accessing timely and appropriate care packages for patients on these wards. We were told that some patients stayed on no criteria to reside wards for a significant length of time awaiting social care packages; this meant some patients had to return to acute medical wards to receive more appropriate care.

The service moved patients only when there was a clear medical reason or in their best interest. Although, staff tried not to move patients between wards at night this did happen when there was a clear medical reason or in the best interest of the patient. The trust provided data which showed in the three months before inspection (August to September 2022) there were 126 bed moves at night (10 p.m. to 8 a.m.).

Managers and staff started planning each patient's discharge as early as possible. Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. There had been a steady increase in the percentage of patients delayed at discharge since July 2022. As of September 2022, 85% of patients were delayed at discharge, this was the highest in the local integrated care system (ICS) and almost 10% more than the regional average (76%).

For half of patients at the trust (55%) the main reason for the being delayed was due to waiting for availability of beds or resource assessment in adult social care settings. This was similar to the regional and national figures.

Patients with a documented discharge plan within 24 hours of admission were not admitted to a no criteria to reside ward unless necessary, due to bed availability pressures, and discharged directly from the admitting ward. The trust began the discharge process for all 'pathway 0' patients (patients whose needs can be met through normal ward care) on admission leading to patients being identified for discharge as soon as practicable. However, there were often delays in discharge due to the timing of the decision to discharge, for example in the afternoon, and the availability of social care beds and packages of care.

The trust had not developed other initiatives to ensure the discharge of patients as soon and as safely as practical ensuring patients care was optimised. For example, the trust had not instigated a 'discharge to assess' process such as the 'Hospital Discharge Service Guidance' (March 2020) which sets out how trusts and local authorities can plan and deliver hospital discharge and recovery services from acute hospital settings.

There were 22,053 'pathway 0' patients discharged in the six months before inspection; 3676 'pathway 0' patients discharged in the month before inspection (October 2022).

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Complaints information was available online and displayed on wards. However, we received some comments before inspection that the distinction between raising a concern with the Patient Advice and Liaison Service (PALS) and making a formal complaint was not clear.

The average turnaround time for complaints to be resolved or closed in the last 12 months was 76 days, this is above the trust target of 40 days. During interview the head of patient experience told us this delay was due to a historic backlog, the complexity of complaints and the ongoing process of 'test and challenge' of complaints within the health group.

In the three months before inspection, there were 33 complaints received by the health group, and at the time of the inspection there were around 160 open complaints across the trust.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The main themes of complaints were around inappropriate discharge, co-ordination of medical treatment and lack of explanation of care. The health group leadership team had initiated increased discharge planning on wards through the appointment of co-ordinators on each medical ward.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed six responses to formal complaints to the trust. We found these were not always written as sensitively as possible and needed improvement and contained medical terminology without explanation. The head of patient experience acknowledged that these findings were accurate and that they worked with individual specialities to improve the tone and sensitivity.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, we were told staff identified patients with communication needs were identified as soon as possible and interpreters and translation services accessed.

Is the service well-led?

Requires Improvement  

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

Leadership

Leaders had the skills and abilities to run the service. Although, they understood the priorities and issues the service faced, they had not always fully addressed these. They were visible and approachable in the service for patients and staff.

The medicine health group was led by a triumvirate of a medical director, an interim nurse director and a director of operations. The current make-up of the team had been formed in the last twelve months, had a variety of complementary experience and worked constructively.

Medical care (including older people's care)

The team had developed and was maintaining the group strategy, and operational plans for general medicine, specialist medicine, frailty and acute medicine, and cardiology. We were told that there was a positive reporting culture of incidents within the group, and the team was able to confirm the top risks, for example nurse staffing, non-criteria to reside patients, medical vacancies and impact on seven-day services.

The team was also working on improving patient discharges through in-reach to the emergency department and surgical wards to assess patients, improvements to the DoLS process and the digitalisation of medical records.

However, there were issues the leadership team had identified but had not yet fully addressed, for example non-criteria to reside patients, seven-day services, both nursing and medical recruitment, unsafe discharges and delayed discharges.

We found visible leadership on wards by matrons and ward managers. Staff told us they felt supported by matrons and senior nurses.

Vision and Strategy

The service had a vision for what it wanted to achieve and operational plans to turn it into action, developed with all relevant stakeholders.

The vision of the health group was to aim for excellence without exception, continue to put patients first, and to be a great place to work and a great place to receive care.

The medicine health group had operational plans in place for general medicine, specialist medicine, frailty and acute medicine, and cardiology. These allowed the health group to identify aims and key challenges for each service, for example performance, backlog, recovery, finance, capacity and workforce.

Regional issues such as ongoing reconfiguration of services to community-based provision, social and residential care availability, sustainability, pace of change within primary care and lack of GPs, were also identified.

Culture

Staff felt respected, supported and valued and were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers. However, some staff members expressed frustration at their having to change wards due to short staffing across the health group. Staff told us that staff shortages impacted on patient care as gaps in staffing were not always filled.

The most recent NHS Staff Survey showed the health group scored better than the trust average for 'we are always learning' (5.3, trust 5.2), the same as the trust for 'we are a team' (6.4) and 'staff engagement' (6.7), and within 0.2 of the trust average for the other metrics except 'we are safe and healthy' (5.4, trust 5.8).

In response a series of virtual executive led focus groups and manager briefings were held, the survey results were presented at health group business meetings, a bi-monthly staff forum was instigated, and a values survey were held.

The health group worked closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff had every opportunity to share feedback and were signposted to appropriate support where necessary.

Medical care (including older people's care)

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however these were not always effective. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We reviewed the minutes of governance meetings held within the health group. These showed ongoing actions, updates from specialities, incidents, risks, audits, complaints, performance and feedback from committees (falls, nutrition, information governance) were discussed.

The monthly governance report (October 2022) reported on the following, for example:

- number of incidents, the number of 'moderate harm and above' incidents, serious incidents;
- number of falls reported per 1000 bed days;
- hospital acquired pressure ulcers;
- clinical harm reviews;
- compliance with guidelines and quality standards;
- high-priority audits;
- mortality and morbidity meetings;
- 'Learning from Death' quarterly report; and
- complaints and PALS.

A monthly health group governance meeting and each speciality held their own governance meetings which fed into the health group governance meeting and then to the trust quality committees.

However, during our inspection we also found governance arrangements did not ensure robust compliance with all MCA and DoLS requirements, and all health group procedural documents had been appropriately reviewed.

Management of risk, issues and performance

Although, leaders and teams used systems to manage performance, they did not always identify and escalate relevant risks and issues, and did not identify actions to reduce their impact.

The health group had identified a number of high and moderate risks, these were included on the corporate risk register and local risk register.

Those identified as high risk were:

- the 'lack of adequate substantive consultant workforce in acute medicine'. This had been on the risk register since March 2021 and was mitigated through locum cover (long term and short term);
- the 'lack of suitably trained staff to perform cardiac stress testing'. This had been on the risk register since January 2022 and was mitigated by two staff members covering the service and restricted to one staff member allowed off at any one time. Additionally a business case for additional support to preform cardiac stress testing had been drafted, and was awaiting approval; and

Medical care (including older people's care)

- multiple junior doctor vacancies - risk to patient safety and care'. This had been on the risk register since January 2022 and was mitigated by advanced clinical practitioners, reviews of weekly rotas, rota gaps reviewed with medical staffing and clinical leads, re-deployment of existing staff to cover shortfalls and the authorisation of locum and agency staff

In addition, there were eight identified moderate risks, for example the risk to patient safety due to same day emergency care (SDEC) beds used overnight for acute medical unit patients due to lack of capacity, and the inability to provide timely medical care to stroke patients. All moderate risks had mitigation in place.

However, there were a number of risks and issues which had an impact on the health group which had been identified and not yet resolved, or had not been actioned. For example:

- the health group had shortages in the established numbers of medical and nursing staff;
- staff training did not meet trust targets;
- the majority of procedural documents within the health group were overdue for review;
- the health group did not meet the trust target for completing a VTE risk assessment within 24 hours of patient admission;
- staff did not always follow national guidance to gain patients' consent and support patients who lacked capacity to make their own decisions; and
- there were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

We found information systems were integrated and secure, to prevent unauthorised access of information. Systems were used to record and share patient sensitive data and there were clear processes to ensure compliance with access protocols.

However, although plans were in place to migrate all patient information to the electronic system, this had not yet happened, and clinician notes were still written and stored in paper format. This caused staff some difficulty in aligning patient progress across the two formats.

Managers understood performance targets including quality and data from clinical and internal audits. The trust participated in national clinical audit projects and clinical outcome quality indicators.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust has developed networks for staff, for example within black, Asian and minority ethnic groups (BAME), lesbian, gay, bisexual, transgender, queer (LGBTQ+) and disability.

Medical care (including older people's care)

We interviewed a patient representative who confirmed patients, relatives and carers can raise issues and they are listened to by the trust. The trust has set up a patient council with volunteer representatives, particularly involving younger age and those interested in improving services. We were told the trust listened to issues and made changes where necessary. Further, the trust had set up patient user groups (for example, respiratory patients group) and included patient representatives on trust committees.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust participated in the Friends and Family Test (FFT) which showed that 90% of respondents gave a positive rating for the trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The health group provided examples of innovative practice.

For example, a project had been completed on the reduction of the carbon footprint from the use of asthma inhalers. Short-acting beta agonist (SABA) inhalers account for 70 per cent of the total carbon footprint of all inhalers in the country and uncontrolled asthma has a higher carbon impact than controlled asthma.

Frequent SABA use is a feature of uncontrolled asthma and is associated with increased risk of asthma attacks. Reducing SABA over-use can achieve important outcomes for both patients and the environment. Collaboration between NHS providers, the University of Hull and a commercial pharmaceutical company used a co-designed intervention to identify and address SABA over-use to improve asthma outcomes and reduce asthma's environmental impact.

The health group also prepared for and proactively managed patients during the COVID-19 pandemic. Learning from what was happening elsewhere across the continent, the health group proactively increased the ability to provide non-invasive ventilatory support on the respiratory ward, in advance of admissions with respiratory failure. Of 24 beds on the respiratory ward the group was able to provide this facility for up to 16 patients. Outcome data was prospectively collected. This initiative was recognised at the 'HullLive' Health & Care Awards 2021 with "Team of the Year" and "Nurse of the Year" awards.

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Requires Improvement  

Is the service safe?

Inadequate   

Our rating of safe went down. We rated it as inadequate

Mandatory training

The service did not always provide mandatory training in key skills to all staff and did not always make sure everyone completed it.

Training was offered as either face to face or through an electronic learning portal. Staff told us they were offered time to complete the course when they could.

Nursing and medical staff did not always receive or keep up to date with their mandatory training. We reviewed training compliance figures across all the wards we visited and saw that the compliance rates were below the trusts 90% target. We requested the mandatory training data for the surgical health group overall and saw nursing staff mandatory training compliance was slightly below the trust target of 88% and medical staff compliance was 72%.

The mandatory training was comprehensive; however, it did not always meet the needs of patients and staff. We reviewed resuscitation training rates across the wards we visited and saw it was significantly below the trust target. On some wards compliance was as low as 52%. Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. These courses were not part of the mandatory training list. Staff told us they could access electronic training modules if they requested it.

Managers monitored mandatory training and alerted staff when they needed to update their training. Compliance figures were collated through the human resources monthly reports and sent to senior ward staff who told us that they had difficulty accessing certain courses such as the resuscitation training, as it was constantly oversubscribed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff did not always have training on how to recognise and report abuse. The safeguard lead for the health group, had not completed the appropriate level of safeguarding training.

We reviewed the mandatory training compliance figures and saw that 84% of staff within the health group had completed level 2 adults safeguarding training and 86% had completed level 2 children's safeguarding training. These figures fell slightly below the trusts target of 90%. However, the data did not include the completion of level 4 adults safeguarding lead. Following inspection the provider confirmed that the level 4 training is a requirement for the corporate safeguarding team who have named leads consistent with the NHS accountability framework.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Ward staff knew who to contact and where safeguarding policies were for support. Staff were able to articulate examples of recent safeguarding alerts made and understood those patients who were most vulnerable and required safeguarding input. They used online

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forms to refer any safeguarding notifications or queries to the local authority multi-agency safeguarding hub. Nursing staff said they would inform their nurse in charge or matron depending on the severity of their concern and liaise with the social work team who were based within the trust. Staff described multi-disciplinary team working to ensure patients were protected. Staff could also add any safeguarding issues to the electronic recording system.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We reviewed the most recent safeguarding alerts submitted by the trust and saw that patients were referred to the local authority safeguarding team as appropriate. Staff told us they received feedback following submission of these alerts where possible.

Staff told us the social work team based at HRI were extremely supportive and provided ongoing guidance regarding complex safeguarding matters.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service did not always use systems to identify and prevent surgical site infections. Staff used equipment to protect patients, themselves and others from infection. However, control measures were not always in place.

Most ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. We saw completed cleaning schedules in ward areas. However, we visited urology at Castle Hill Hospital (CHH) and saw floors were littered with some rubbish particularly around the bin areas and there was a noticeable smell of urine upon entering the area. Bins appeared to be close to capacity. Staff told us that cleaning schedules were not always completed as domestic staff followed a routine rather than complete a formal check. We reviewed the trusts infection prevention and control audits and saw that compliance was as low as 76% across one month for this ward.

We reviewed equipment with 'I am clean stickers' which were generally in date. The provider told us they carried out monthly infection prevention and control (IPC) assurance visits across all wards. We reviewed the data submitted by the service; however, this did not cover all surgical wards, and did not provide clear overall compliance data for the service. For example, we saw audits appeared to be completed inconsistently and we did not receive any action plans to address low scores. We saw audits were completely inconsistently. Therefore, we were not assured that robust IPC monitoring was in place.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We requested hand hygiene audits for the surgical health group and saw compliance was recorded as 100% in the most recent audit dated 1st April 2022 to the 30th of October 2022. However, staff did not always observe the Standard Infection Prevention and Control Precautions policy, as they were not always bare below the elbow and did not always wear surgical masks. We saw examples of this on ward 15, however, during the inspection, we observed that most staff were compliant with hand hygiene policies.

Sanitiser was available at the entrance of all wards we visited, and we saw these were regularly replenished.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE) and we observed staff using gloves and aprons appropriately.

There was no patient led assessments of the care environment (PLACE) audit data as this was suspended nationally in response to the COVID19 pandemic and had only just recommenced. We did not see any evidence of recent audit results specific to IPC displayed on the wards that's we visited.

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Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always store clinical waste safely

The service did not always have suitable facilities to meet the needs of patients' families. No wards we visited had environmental provision for patients with dementia or delirium. In addition, we did not see any equipment provided such as brightly coloured drinking cups and plates in use on the wards we visited.

The service had sufficient suitable equipment to help them to safely care for patients. All staff told us they had sufficient equipment to safely care for patients. We saw storage cupboards were stocked with adequate supplies and all equipment we checked was in date.

We visited several wards with out of date or blank information boards and panels. On other wards we saw that information that was displayed did not always match what staff told us. Staff told us this was due to staff shortages and the movement of staff throughout the day.

We found no medical gas signs on the storeroom doors of all wards we visited. These rooms stored Entonox and oxygen inappropriately on the floor behind the door. Storeroom doors were all unlocked which meant medical gases were accessible to anyone on the ward.

Resuscitation trollies we reviewed were checked daily and checks were documented. Defibrillators had also been checked and serviced in the previous year. Records were clear and provided guidance and clarity to staff on what to check and how to record it accurately.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimised risks. Staff identified but did not always act upon quickly, patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS). We reviewed nine patients records and found that all had a completed NEWS score recorded within the electronic database system. All staff told us that an escalated NEWS score would automatically trigger a medical review.

Staff completed an initial assessment for each patient upon admission / arrival, using a series of systematic question and answer stages to determine the frequency of subsequent assessments. The individual assessments then flagged as a colour, with red indicating patients who were at particular high risk such as falls. Staff told us they completed these assessments for each patient and included pressure ulcer risk assessments and venous thromboembolism assessments where appropriate. We saw pre-determined assessments were not personalised to the patient and did not clearly define how risks would be managed. We saw some evidence of personalised risk management by staff adding narrative into the free text nursing update section, but this was not consistently completed.

Senior ward staff told us they had oversight of these assessments and demonstrated the ward overview screens on the electronic recording systems. We saw some assessments were displaying as red indicating assessments were overdue. In most cases we saw they were just recently over their due time. For example, within the hour. The electronic recording system was not utilised by all departments, for example theatres. Patient observations including NEWS was recorded on a paper-based system by recovery staff, which was then handed to the ward when patients transferred across. However, systems were not cohesive and the transfer of paper to electronic records resulted in some observations and

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assessments missed, for example pain scoring. In addition, staff told us that the process of transferring information to the electronic system was time consuming and took away the time spent delivering care. Staff told us there was also a risk that not all information would be transferred accurately. We received concerns prior to inspection as part of our planning, that this was a specific concern. We requested the most recent audits of the electronic recording system, but they were not provided. The lack of auditing of the electronic system by the provider, suggested a lack of oversight of these concerns and the potential for ongoing unmanaged risk.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff told us that risk was always discussed at handover. However, we observed a ward handover and saw risk was not discussed for each patient. Risk within theatres should be recorded as part of the surgical safety checklist. However, we saw two examples of patients with known risks such as allergies and confusion and the checklists were not completed.

We reviewed the completion of surgical safety checklists in all of the theatres we visited. We saw the trust had designed a checklist which only required one signature to confirm all aspects of the pause and check processes had been completed. This signature was made at the end of the surgical procedure by the lead clinician. The form did not provide an option to evidence that all aspects of the pause and check process had been completed.

Staff told us that these checklists were regularly audited. We requested the most recent audits and saw the last completed audit was August 2022 and was shown to be incomplete with no pre op checks carried out.

Therefore, we were not assured that risk and safety management processes were robust and did not always protect patients from possible harm.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. However, bank and agency staff were not given a full induction.

The service did not have enough nursing and support staff to keep patients safe. On all wards we visited actual nurse staffing was consistently below planned establishment.

Several wards we visited reported scenarios where only one registered nurse was left on the ward to manage a typical ward size of 27 patients. Staff told us where time allowed, an electronic alert was submitted for these incidents, due to staff feeling unsafe. We requested the electronic incident data from the trust in relation to concerns of unsafe staffing levels and saw 354 incidents were reported by staff on the wards trust wide in the last twelve months.

We reviewed trust sickness levels and saw Nursing and Midwifery staff which reported a 4.3% sickness rate. In addition, the trust wide vacancy rate for October 2022 was 6.2%. Staff told us recruitment was ongoing and there had been several nursing appointments which was encouraging. None of the wards we visited had a full complement of staff, at the time of inspection.

Not all wards displayed planned and actual staffing numbers. Staff told us this was because staff were moved around constantly to meet the needs of the busiest wards and departments. However senior ward staff confirmed the recent

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recruitment success and were able to make several new nursing appointments on most of the wards we visited. These newly registered nurses were either waiting for essential recruitment checks to be processed or were approaching their actual start date, at the time of inspection. Staff saw this as hugely positive and a boost to the staff's morale. Some wards had newly qualified nurses working in a supernumerary basis whilst awaiting confirmation of their RGN PIN.

Ward staff told us there were two-night practitioners onsite to support all departments, across the two sites. However due to specific ward pressures, these staff were unable to support all wards. Senior leaders told us they had recently introduced a pastoral matron who was available up to 10p.m Monday to Friday, with a specific remit to support staff morale during particularly challenging staffing situations.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior lead nurses held daily beds management meetings across all health groups. This included oversight of staffing numbers, access and flow with cross-divisional matrons reviewing pressures across each site. We observed a beds management meeting which was held four times each day and was attended by matrons from each health group, the enhanced care team and the bed management matron. They discussed expected admissions and discharges, wards with challenges such as high acuity patients and increased admission numbers. We observed proactive discussion between the staff who prioritised the demand across the various health groups and considered appropriate staffing levels. Recently senior leaders had introduced band 6 staff to observe these meetings, so that they had a greater understanding of the trust pressures. In addition to the patient placement meetings, the Trust held separate Safe Care meetings. These were held 4 times per day to respond in a timely way to any staffing challenges.

Managers limited their use of agency staff and requested staff familiar with the service. For example, internal bank staff. Senior ward staff told us unfilled shifts were offered to bank staff and if these remained unfilled after two days they would go out to agency. We observed this during the bed management meeting. We requested induction checklists for bank staff whom had recently worked on the wards we visited. Senior ward staff told us some induction information was given, but this was not recorded.

Due to the consistently low staffing numbers, the electronic incident concerns raised by staff and the lack of formal recorded bank staff induction, we were not assured that staffing levels kept patients safe.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. In the last twelve months reviewed, the proportion of consultants and junior doctors reported to be working at the trust were higher than the England averages.

We saw the percentage of consultants at this trust were 55% when compared to 50% as the England average.

We saw the percentage of junior doctors at this trust were 15% when compared to 11% as the England average.

In the same reporting period, we saw the following grades reported to be working at the trust were lower than the England averages.

We saw the percentage of middle career doctors at this trust were 6% when compared to 11% as the England average.

We saw the percentage of Registrar doctors at this trust were 24% when compared to 28% as the England average.

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The trust recognised difficulties regarding the rostering of junior doctors and the ongoing pressures. The current Junior Doctor fill rate trust wide was at 96% and work was ongoing with India and Pakistan to recruit new doctors.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always kept up to date. Records were easily available to all staff providing care but not always stored securely.

The service used both electronic and paper-based records in which to record nursing and medical information for patients. The use of the electronic recording system was inconsistent across the trust as it was being phased in gradually by the trust.

The ability to navigate the electronic system varied according to the time they had used it and staff were open in relation to their own competencies using the system.

Not all staff had access to the electronic recording database. Senior ward staff told us that band 2 staff were unable to add or review nursing assessments as this had been blocked by the trust. This caused frustration amongst staff as many band 2 staff were student nurses who had completed their training but were waiting for PIN and registration. These staff were unable to add any documentation. One student told us they had worked on the ward for a month and had not documented anything anywhere.

Medical and therapy staff completed paper record reviews. However, nurses told us they rarely, if ever, reviewed patients' paper notes. Some nursing records were paper based such as those completed by theatre staff. We reviewed eight paper records and saw none of them outlined risk such as falls, delirium or tissue viability issues. We spoke with senior managers who told us that risk was not recorded on the paper-based system but would be shared verbally at handover.

We reviewed three sets of paper records for patients on ward 15 at Castle Hill Hospital and found all had multiple loose sheets that had not been filed. These included records from the current admission. Staff explained records had come to the ward in that state from other departments, but we noted patients had been on the ward for several weeks. Staff explained the ward clerk would file loose sheets on each patient's discharge. We reviewed these records and saw that they were not filed in date order. Loose documents were placed randomly within patient files, and we did not see any locked notes trolleys on this ward. Therefore, we were not assured patient paper records were managed safely and securely.

Most of the senior ward staff told us that the electronic recording system did not offer real time monitoring. For example, we reviewed the dashboard which showed the nurse in charge which assessments were due. Many assessments showed as red, meaning overdue. However, some assessments were completed but were not showing on the dashboard. We were able to corroborate this on several wards we visited.

Patient notes were not always comprehensive or up to date. We reviewed three patient records, all of whom had a diagnosis of dementia. Despite there being a flag on the electronic recording system to show the patient had a diagnosis of dementia there was no further support outlined within the system, such as communication tools, visual and nutritional aids. We requested paper records for these patients and saw there was no further information regarding the care and management of these patients.

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We reviewed five surgical safety checklists and saw that only one was signed to confirm that all aspects of the pause and check processes were carried out. This indicated that the appropriate checks in accordance with WHO guidance was not completed. This meant that patients were not appropriately protected from the potential of harm due to the absence of mandatory record keeping. Therefore, we were not assured that individual care records including clinical data, written, stored and managed, kept people safe.

We saw some Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents in use. ReSPECT is a process (endorsed by the Resuscitation Council) that creates personalised recommendation for a person's clinical care in a future emergency, in which the patient is unable to make or express choices; and it includes advance decision making around resuscitation.

We requested audit data in relation to ReSPECT forms, however the provider submitted data for only ward 10 at HRI, information which showed poor document compliance. Following inspection the provider submitted annual audit data which showed variable compliance across the trust. We did not see any further action plans in which to address and improve document completion and we were not assured that the use of this document was consistent across all wards we visited.

Medicines

Ward staff used systems and processes to safely, administer, record and store medicines. However, theatre staff did not always administer controlled drugs safely.

The hospital used an electronic system to prescribe medicines for patients. However, staff used a paper-based system within theatres, as the electronic system had not been introduced yet.

Ward staff completed medicines records accurately. However, theatre staff did not always follow safe practice or the trust's procedure when completing records of the administration of controlled drugs.

We reviewed the controlled drugs records in theatre one and saw signatures were missing on the 30th September and the 5th October. Staff told us they had contacted the doctor who was required to sign at the time of administration, but this had not been addressed at the time of inspection.

Staff did not always review patients' medicines regularly and provided specific advice to patients and carers about their medicines. We spoke with pharmacy staff who told us they were not sure when audits were last undertaken. Senior managers confirmed that there were plans to audit medicines in theatre, but currently none were undertaken.

Most of the fridges we reviewed were within their required temperature range. However, on ward 14 at CHH we saw it was consistently at 1 degree Celsius. The normal range for a medicine's fridge should be between 2 and 8 degrees Celsius. This had not been escalated since the 14th of October. We saw this issue had been escalated several times to pharmacy but was still an issue at the time of inspection. We also saw examples of patients who had not received timely medication due to items being out of stock. Again, we saw that these issues were escalated to pharmacy.

However, we reviewed 10 electronic medication records on the wards we visited and saw only one concern, which was addressed immediately.

Records showed that preparations for parenteral (by injection) nutrition were not kept at the right temperature on one ward.

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The service did not always have systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We talked to several members of staff, but their responses were varied in how safety alerts and incidents were discussed.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and report incidents and near misses. Managers investigated incidents although they did not always share lessons learned, with the whole team.

Staff knew what incidents to report but did not always report them. The service reported four surgery related never events between November 2021 and August 2022. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers. The never events varied in theme and were unconnected. The incident type included retained swab, medication, wrong implant and wrong site block.

Managers did not always investigate incidents thoroughly. We saw insufficient pace when sharing the learning, resulting in potential subsequent harm to patients. We reviewed all four reports relating to these incidents and saw delays in the time taken to fully investigate them. For example, we saw three reports that did not have a sign off date to conclude the investigation. These incidents occurred in June, July and August 2022. In the same incident reports, we saw that actions to be taken following the incident, were still ongoing at the time of inspection.

We reviewed the trusts policy in relation to incident reporting which included a pathway outlining the process, however timescales for completion of the full investigation were not defined.

In the never event report relating to medication dated June 2022, we saw an action was required, to complete a training needs analysis for medicines management and development of clear objectives competencies for operating department practitioners (ODPs). These and four other actions were not completed at the time of inspection. We found concerns with medicine management as part of our inspection and saw further poor practice. We also intervened to prevent a patient receiving medications in error.

In the never event report relating to the retained swab, we saw within the findings that staff had omitted to sign some surgical safety checklist documents. During inspection we saw five of the six surgical safety checklists that we reviewed, had not been signed.

In the serious incident report relating to the wrong site block dated July 2022 we saw within the report findings that there was no 'pause and check process' or 'stop before you block'. In the five surgical safety checklist records we reviewed; we saw no evidence to confirm these processes had been completed. Staff told us the process had been followed but it was not recorded.

In the serious incident report relating to sub optimal care dated June 2022 we saw that all actions following the incident, were not complete at the time of inspection.

We reviewed a series of recent serious incidents within the health group and saw further delays in both the completion and roll out of learning following the incident.

Surgery

Some ward staff were able to give us examples of learning from serious incidents, however they could not list the top three incident-related risks on their ward or department beyond broad categories such as falls. Theatre staff at both sites told us they had received information regarding the most recent never events and told us these were discussed at staff meetings, safety bulletins and safety huddles. However, we saw ongoing themes such as poor medicines management was still an issue in theatres, due to the lack of robust and timely incident management processes.

We also reviewed safety bulletins displayed on ward notice boards which were recently dated but did not include information regarding never events.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us they reported patient incidents quickly and with confidence. Some staff were confident to report staffing concerns, but others said staffing concerns using the electronic incident reporting system were rarely resolved, and they had stopped using the system. Some medical staff also told us it was pointless reporting incidents and concerns because nobody listened anymore.

Therefore, we are not assured that patients are protected from the potential of harm due to the ongoing potential risk.

Is the service effective?

Requires Improvement ● ↓

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. However, staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff told us that policies were regularly reviewed and updated in accordance with national guidance and best practice.

We requested a copy of the trust policy in relation to the frequency of policy review and saw clear processes for the development and review of all policies in line with national guidance and best practice, across the trust.

Staff knew where to access policies and guidance on the intranet. We requested information from the provider to demonstrate how NICE guidance has been implemented within the surgical health care group.

Staff did not always follow up-to-date policies to plan or deliver high quality care according to best practice and national guidance.

We reviewed the trusts policy in relation to the Mental Capacity Act, Deprivation of Liberty, Consent and Physical restraint and saw that it was not dated as current, did not have a review date and was not shown to have been ratified. Processes for obtaining consent for those patients who lacked capacity were not clear and contradictory. For example, the requirement to complete of a formal capacity assessment prior to the use of consent form 4 was not defined within the trusts own policy.

Surgery

We also reviewed the Local Safety Standards in relation to invasive procedures policy which is used in conjunction with the WHO safety check audits and saw again that it was not dated as current, did not have a review date and was not shown to have been ratified. Providers are required to demonstrate that policies are regularly reviewed and updated to ensure staff follow the most up to date national guidance or current best practice.

The trust provided data in relation to the review of current policies. This data showed that 64% of policies were currently in date in November 2022, meaning 36% were out of date or overdue. The provider told us they had developed a procedural document improvement plan to address this backlog and have added this to their risk register. The surgical health group specific policies showed that 17% were out of date and 83% compliant.

Staff did not always protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed three patients' records, all of whom were recorded as being confused and may lack capacity. We saw capacity assessments were not completed and we did not see any evidence of best interest decision making processes. This is not in line with the Mental Capacity Act 2005.

Therefore, we were not assured that policies were always developed and reviewed in accordance with best practice and national guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw patients requiring additional hydration and nutritional intervention were monitored through fluid balance charts and nutritional intake records. As with other patient records, recovery staff used paper records and consistently recorded fluid intake and output. These stopped once the patient reached the ward and electronic records were completed instead. Fluid balance intake was recorded on both paper and electronic systems depending on which wards has access to the electronic systems. We reviewed five fluid balance records and saw that they were fully completed.

Some wards we visited had introduced snack rounds twice a day to increase calorie intake for those patients most at risk.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw MUST scores were used for all patients. Staff explained those at risk such as patients with frailty had dietician input. We saw evidence of dietician involvement in the records that we reviewed.

Specialist support from staff such as dietitians and speech and language therapists was available for those patients who required them. We did not see any volunteers or nutritional assistants on any of the wards that we visited.

Patients waiting to have surgery were not left nil by mouth for long periods. We requested fasting audit data from the trust, but this was not provided.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. However, they did not always give pain relief in a timely way or support those unable to communicate using suitable assessment tools.

Surgery

Staff did not assess patients' pain using a recognised tool; however pain relief was given in line with individual needs and best practice on most wards that we reviewed.

We saw patients receiving care in theatre following surgery, were assessed using a pain score. Numerical scores were recorded on the paper documents that we reviewed. However, these scores were not continued once the patients transferred to the wards. None of the wards we visited had a recognised pain scoring tool and although the electronic recording system had capacity to record pain, staff were not using it. We asked ward staff on each ward we visited what pain scoring tool was being used and all staff told us there was none in use. Ward staff told us that they would ask patients to describe their pain but there was no tool to support patients who were unable to communicate or for those with specific needs such as dementia or learning difficulties. Some staff told us that the electronic recording system could be used to record pain but none of the staff we spoke with knew how to do this.

Ward staff told us they could refer patients to a specialist pain team and we saw evidence of involvement within the records we reviewed.

We reviewed ten electronic prescribing and administering records and saw medication was given as appropriate.

We requested pain audit data completed by the trust, but this was not provided.

Patient outcomes

Staff monitored the effectiveness of some care and treatment. They used the findings to make improvements and achieve good outcomes for patients.

The service participated in national audits. We reviewed the National Hip Fracture database and saw it was last published in August 2021 using data from January to December 2019). Castle Hill Hospital had three that were the same but also one that was worse and one that was much worse.

The indicators that were worse and much worse were the same for both hospitals were the risk adjusted 5-year hip revision ratio and the number of patients consented to have personal details included in the National Joint Registry.

We also reviewed the National Emergency Laparotomy Audit and saw it was last published in January 2022 using data from December 2018 to November 2019.

Due the pandemic there have been delays to the publication of some audits. Data in the latest publications was at least two years old or data was not available at trust level.

The National Bowel Cancer Audit last reported in 2020 with incomplete data showing for the trust. However, a report published post inspection in December 2022, demonstrated a report was submitted with completed data.

The National Oesophago-gastric Cancer Audit was last published in August 2021 using data from April 2017 to March 2019. The National Ophthalmology Database Audit was last published in January 2021 and the trust did not sign up to this audit or declined to participate.

The National Prostate Cancer Audit was last published in March 2021 using data from April 2018 to March 2019 and The National Cardiac Audit Programme – Adult Cardiac Surgery was last published in March 2019 using data from April 2014 to March 2017.

Surgery

We asked senior managers what plans were in place to re commence data submission into these national audits. We were told that the health group conducted internal reviews with the data collected through their own internal governance processes, but we were not assured that this internal data was used to bench mark the trusts own performance against similar sized trusts nationally.

Outcomes for patients were mixed, and inconsistent when compared to the England average.

For all specialties overall at trust and hospital level and also for elective and non-elective patients, the trust had longer average stays than the national average between February 2021 and January 2022. Specialties with the most notable differences compared to the England average were Colorectal Surgery with patients having longer lengths of stay on average than the national average. This was the case at both hospitals but particularly for non-elective patients at Castle Hill Hospital (just over 9 days compared to just under a week nationally).

The average length of stay for both elective patients was longer at Castle Hill Hospital than the national average for Trauma and Orthopaedics. However average length of stay was much lower than the national average for non-elective patients at the hospital with patients on average staying for just under a day compared to almost 8 days nationally.

The Cancelled Elective Operations data collection was paused in April 2020 due to the pandemic. For the quarters for which we have data, the trust was cancelling a similar number of operations each quarter. The percentage of the cancellations that weren't treated within 28 days was higher than pre-pandemic however, figures were below the national average.

All patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average. Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Thoracic Surgery patients at Castle Hill Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

For patients having elective Neurosurgery at the trust the average length of stay was 4.2 days. The average for England was 5.4 days.

Both SHMI and HSMR show mortality to be higher than expected from January 2020 to March 2022. In-hospital mortality following admission with a primary diagnosis of Septicaemia (except in labour) was higher than expected from January 2021 to December 2021.

Managers and staff carried out some audits to check improvement over time. We requested the trusts recent audit data in relation to pain and preoperative fasting. We did not receive any audit data in relation to pain. We did not receive any preoperative fasting audits.

We saw the trust had a Commissioning for Quality and Innovation (CQUIN) framework in place '...supporting patients to drink, eat and mobilise after surgery' with the aim to ensure surgical patients are supported to eat, drink and mobilise within 24 hours of surgery ending. We saw no data was submitted for this in quarter one.

Patient related outcome measures (PROMS) data was incomplete at the time of inspection. The PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. These areas are nationally selected procedures.

Surgery

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance. Staff induction was not always recorded, and link nurse training had not been renewed.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke with several staff working in newly appointed senior nursing roles. Many of whom had been in their current role for less than 12 months but were supported by matrons and colleagues working at a similar grade.

Managers gave all new staff a full induction tailored to their role before they started work. We saw induction booklets were tailored to the staff specific role to ensure training was appropriate.

We asked to review bank staff induction checklists, to ensure staff working on these wards were provided with a basic overview of the operational aspects of the ward such as patient escalation processes. All staff told us induction was not recorded and information was given verbally.

Managers did not always make sure staff received specialist training for their role. The provider told us that link nurses were in place across all wards and departments and had specialist training in areas such as tissue viability, dementia, and falls. The use of nurse link roles also varied between wards. On some wards the link roles had gone when staff left and on other wards there were clear link roles and responsibilities for all members of the ward team, and those with special interests were encouraged to develop. We requested to speak with link nurses on the wards that we visited, but staff told us link nurse's arrangements had not been updated since the pandemic and training had lapsed.

The clinical educators supported the learning and development needs of staff. Senior ward staff told us that newly qualified nurses were provided with ongoing support through their preceptorship period. All staff we spoke with told us that the support received was invaluable.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us meeting notes were emailed to all staff by ward managers and we found printed copies were displayed on staff noticeboards.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. Trust wide staff appraisal data was submitted by the provider for the health group. We saw that the overall appraisal compliance figures for surgery was 69%, which was lower than the trust target of 90%. We saw the lowest compliance rate was at ward 10 CHH at 12% and the highest at 100% in day surgery CHH. Medical staff appraisal rates were submitted separately but did not include junior doctor compliance rates and therefore an overall compliance rate cannot be determined.

Some managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward managers in day surgery at Castle Hill Hospital confirmed this. Following the inspection, the Trust provided us with information about the training days allocated to staff to reflect the training required and CPD monies which is available for all staff to apply for academic qualifications.

Senior staff told us the trust and directorate encouraged staff to undertake extended roles and to develop professionally with advanced nurse practitioner and apprentice nurse posts. They completed specific training and competence checks before taking on additional specialist patient care tasks.

Surgery

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Ward staff told us that managers ensured time was made available where possible to complete training and share courses which were available throughout the trust.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers described the support they offered to staff and actions taken when improvements were required. We saw additional support was offered to all staff during the peak of the pandemic, alongside additional training updates such as IPC.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We reviewed ward rounds which were conducted several times and saw patient information exchanged using the electronic recording system. However, this information was not detailed and did not include discussion in regard to risk.

We saw consultants and allied health professionals arriving to the wards at various points of the day, which impacted on the senior sister or nurse in charge having to repeat essential handover information. Handovers were not co-ordinated to ensure all members of the multi-disciplinary team were present. We did not see robust handovers for staff who had been absent for several days and therefore needed additional information regarding the patients receiving care. Senior ward staff told us that handovers were printed off, so that the exchange of information was standardised, however these documents were shredded at the end of each day. We reviewed these documents and saw risk was again not always identified.

All wards in the Surgery Health group have a discharge assistant. However, we spoke with ward clerks who liaised with families, social workers, and care home managers, and booked district nurse and GP practice nurse appointments to ensure patient discharges went as smoothly as possible.

Ward staff were supported by theatre porters who came to the ward to collect patients for theatre.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. All managers we spoke with told us that trying to bring staff together due to staffing shortages was challenging but tried to ensure meeting minutes were read by all staff where possible.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Ward staff told us consultants led daily ward rounds on all wards, however this did not include weekends at Castle Hill Hospital. Staff told us patients were reviewed daily by consultants depending on their health group or speciality.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Castle Hill offered a Monday to Friday provision with bloods needing to be sent across HRI after 4p.m each day.

The service offered seven day 24-hour discharge and the pharmacy was open seven days a week at HRI.

We saw plans to increase theatre capacity at CHH as part of a new day surgery build project. This would increase the number of theatres by four and move towards a six-day theatre provision once staff were appointed.

Surgery

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Wards we visited had lots of information available for patients on leaflet racks. However, we did not see any staff giving patients leaflets post-procedure or before discharge. We did not see any evidence of health promotion during ward rounds or handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Managers did not always monitor the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. All staff we spoke with understood when to apply Deprivation of Liberty Safeguards and we saw two recorded applications which were completed and documented appropriately. Training for staff was provided by the trust as part of the Mental Capacity Act module. However, we requested training compliance figures from the provider and saw 82% of nursing staff within the health group had completed mental capacity training compared to 70% of medical staff, which was significantly below the trusts internal 90% target.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. We reviewed the records of two patients recorded as having dementia or confusion as part of the initial assessment process. Neither of these patients had a mental capacity assessment undertaken. We saw that patients were not always consented appropriately. On ward 15 at Castle Hill Hospital a patient had been consented twice for the same surgical procedure using two different consent forms. One which was based on the patient having capacity (consent form 1) and another used when the patient does not have capacity (consent form 4). We saw medical staff proceeded to complete a consent 4 form for both patients to consent for surgical procedures. This consent 4 form is used when patients are deemed to lack capacity. These consent forms were not appropriate as mental capacity had not been formally assessed first. We also saw that the four-stage pillar process for assessing capacity as defined within the legislation had not been followed.

We saw in one of the patient files consent for care and treatment was only obtained through discussion with families. Staff we spoke with told us this was usual practice. We did not see any evidence of consent for care and treatment in the other file we reviewed.

We reviewed the trusts policy in relation to mental capacity assessments and saw the policy clearly states that the person who has overall responsibility for the patient's care must undertake a formal mental capacity assessment using the four-stage pillars process.

The trust undertook an audit of Mental Capacity Act (2005) compliance in January 2022 following a serious case review. The audit identified several failings in relation to the lack of best interest decision making, failure to complete the four-stage capacity assessment and poor recording of discussion in relation to decision making. The audit was due to be repeated in April 2022, but this was not completed.

Surgery

When patients could not give consent, staff did not always make decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not see evidence of best interest decision making documents in any of the files we reviewed.

Therefore, we are not assured that consent was always obtained or recorded in line with relevant guidance and legislation. There is a lack of consistency in how people's mental capacity is assessed and not all decision-making is informed or in line with guidance and legislation.

Is the service caring?

Good   

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

Compassionate care

Staff treated patients with compassion and kindness, however respecting privacy and dignity was not always maintained in some of the areas we visited.

Staff followed policy to try to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff holding sensitive conversations respectfully.

Side rooms were available on all the wards we visited and were utilised where possible, for those patients particularly in need, such as end of life or those requiring isolation.

Patients said staff treated them well and with kindness. Patients at Castle Hill Hospital told us "The staff all care so much. I couldn't ask for anything more" and "they are all really good, 10 out of 10 for everything". Patients told us staff preserved their dignity and only helped them with personal care "when I first had my operation and couldn't do it myself". "All the staff are polite and work very hard but make the time to talk to you and understand what you need".

Emotional support

Staff did not always provide emotional support to patients to minimise their distress. They did not always understand patients' personal, cultural, or religious needs.

Staff told us that additional care was always provided, for example, additional observations known as 'Spaces', but none of the records we reviewed demonstrated personalised care planning for specific needs or emotional support. We also reviewed on two of the wards we visited that these checks were not completed in a timely way and were showing as red on the electronic screen meaning overdue. Senior ward staff told us that that this screen is often incorrect, as checks may have been carried out but not logged into the system.

Staff recognised that time providing emotional care including enhanced interaction was limited. All staff we spoke with found the lack of staff to be a significant barrier to delivering quality emotional support. However, all staff were motivated to provide this care whenever they could and we saw staff working together to ensure patients received the optimum level of care with the staffing resources that they had.

Surgery

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. However, we did not observe this support on any of the wards we visited.

Understanding and involvement of patients and those close to them

Staff did not always support and involve patients to understand their condition and make decisions about their care and treatment.

Staff did not always make sure patients understood their care and treatment. We reviewed the records of eight patients and saw clear communication recording between medical staff, allied health care professionals such as speech and language services and patients' families.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff interaction with families and patients' carers and saw information was provided in a way that was easily understood.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service. We saw within the last patient survey report, that patients felt that staff did not always provide communication around expectations following surgery. Patients said that further communication was needed so that they know what to expect before and after surgery. Feedback during the inspection however was positive. One relative at Castle Hill Hospital said, "the doctor explained it all very clearly so my wife could understand what was happening". They told us therapists had helped them prepare for discharge home.

Is the service responsive?

Requires Improvement ● ↓

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met some of the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. Service staff told us they had good access to the trust's own social work team, specialist palliative care and mental health teams. The electronic system however did not support staff to refer to these services as it did not have the functionality to raise an automatic referral. Manual contact was required to access supporting services, which added to the existing workload of staff.

The service relieved pressure on other departments when they could treat patients in a day. We reviewed the beds management process and saw patients who were safe to be transferred were moved regularly to accommodate elective surgical patients. The demands on the beds however meant some patients operations were cancelled on the same day.

Surgery

We saw examples of this during the inspection resulting in frustration and distress for some patients. We reviewed the number of same-day cancelled operations within the health group and saw 1445 were cancelled in the last 12 months. The highest number of cancelled operations was due to emergency cases requiring theatre space, followed by the lack of critical care beds.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We asked several staff if their wards had any mixed sex breaches in the last six months and none told us they had. Day surgery however, on both sites did not provide separate areas for male and female patients.

We asked several staff what provision was in place to support transgender individuals who were transitioning. Staff were not aware of any specific support for patients undergoing surgery.

The upper GI service has established a STT two week wait referral pathway for patients referred in from GPs with suspected Oesophagogastric cancer. All patients that meet the referral criteria go straight to endoscopy and are scoped in the main by a consultant Upper GI Surgeon. All patients are now dated within 2 weeks of referral and the majority discharged at this appointment. The new pathway is in line with national guidance, has improved patient experience, and significantly reduced the time patients wait for a diagnosis and treatment. The service has received positive patient and GP feedback following the introduction of the new pathway. During the past 12 months Upper GI Service has been successful in securing funding for a 3rd Clinical Nurse Specialist. This now enables the Upper GI CNS service to support patients in oncology clinics, not just surgical clinics – offering support to the patient on the whole of the pathway from pre-diagnosis to end of treatment rather than just focussing on the surgical element of the pathway. Managers told us the change has been well received by patients and the feedback has been positive.

The service had some systems to help care for patients in need of additional support or specialist intervention. We saw specialist teams such as pain and dietary service staff involved in the care and treatment of the patients we reviewed.

We spoke with staff regarding specialist provision for bariatric patients, however we were told that day surgery was not an option as these patients would be admitted for specialist surgical support. The service has developed a patient information video for patients to view at their first outpatient appointment outlining the bariatric pathway and surgery types.

The use of volunteers had been paused during the pandemic. Following inspection, the trust told us there were 53 active volunteers within the surgery health group.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.

Wards were not always designed to meet the needs of patients living with dementia. We did not see any evidence of adaptation for patients with a dementia such as appropriately coloured bays or specifically designed signage. Several senior ward staff told us they would include discussion around the needs of specific patients with dementia as part of the safety huddle, but we did not see records relating to specialist intervention or support.

We saw in day surgery at Castle Hill Hospital that patients cohorted together both prior to surgery and in recovery. The recovery bay was large and staff told us that steps were taken to care for women and men in separate areas where possible. However, we saw mixed sex care provided at the time of inspection and we were not assured that privacy and dignity was maintained.

Surgery

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw examples of the documents in use on some of the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Two patients we spoke with could understand English but had been offered access to information in their first language if they needed it.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they could access language support when required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw only two employed nutritional assistants for the health group despite all staff recognising the support and the benefits to patients that these additional posts provided.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards

Managers monitored waiting times but did not always make sure patients could access services when needed or receive treatment within agreed timeframes and national targets.

Managers reported growing waiting lists which they said was worrying but they said this was in line with national direction.

Health group staff met to discuss key deliverable target measures. Managers said staff understood and contributed to good recovery action plans.

Managers monitored waiting times and made sure patients could access emergency services when needed. Medical staff we spoke with said their elective procedure waiting lists were growing and plans were in place to tackle the waiting lists. Additional theatre lists were introduced to address some of the most significant waits such as urology, and mutual aid was provided by a neighbouring trust to support with backlogs. The trust told us a significant elective recovery programme is in place and the core capacity is supported by a comprehensive range of insourcing, outsourcing, internal waiting list initiatives and additional clinics with mutual aid (both within the ICS and wider for regional services). The elective recovery programme is supported by a financial plan, effective performance monitoring/management and a Patient Access and Concierge Team who support conversations with patients to ensure that they are treated as soon as possible. The Trust told us they continue to prioritise all patients in terms of their clinical priority – to ensure that those patients with the highest clinical priority are treated soonest.

Most specialties at the trust had readmission rates that were below or similar to the England average from January to December 2021. The notable exceptions were non-elective thoracic surgery patients at Castle Hill Hospital.

Surgery

For all specialties overall at trust and therefore location level, and for elective and non-elective patients – the trust had longer average stays than the national average between February 2021 and January 2022. Specialties with the most notable differences compared to the England average were Colorectal Surgery with patients having longer lengths of stay on average than the national average. This was the case at both sites but particularly for non-elective patients at Castle Hill Hospital (just over 9 days compared to just under a week nationally).

Average length of stay for elective patients was longer at Castle Hill Hospital than the national average for Trauma and Orthopaedics. However average length of stay was much lower than the national average for non-elective patients at the hospital with patients on average staying for just under a day compared to almost 8 days nationally.

The Cancelled Elective Operations collection was paused in April 2020 due to the pandemic. For the quarters for which we have data, the trust was cancelling a similar number of operations per quarter. The percentage of the cancellations that weren't treated within 28 days was higher than pre-pandemic however, figures were below the national average.

We reviewed cancer waiting times and saw the current national standard for being seen within two weeks of referral is 93%, from the trust's data provided, this was met in July and August 2022.

The national standard for being treated within 62 days of a decision to treat is 85%, this was not met by the trust in any month from September 2021 to August 2022 based on the data provided.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The trust reported significant numbers 'no criteria to reside' patients who were ready for discharge but were unable to do so due to external factors. We reviewed trust figures and saw that they ranged from 150 to 180 at any one time. Work was ongoing with the wider system to try to address the issues.

Managers monitored patient transfers and followed national standards. We observed patients transferred to other wards where it was deemed safe and appropriate to do so, to free up capacity for elective surgical patients or urgent admissions.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service displayed information about how to raise a concern in some patient areas. We saw some PALS information displayed on wards we visited but this was not consistent. Wards we visited did not have friends and family test feedback boxes and display boards were out of date and did not show current feedback. However, patients, relatives and carers knew how to complain or raise concerns. A patient we asked, said they would feel confident asking ward staff how to raise a complaint or concern.

The trust supplied a log of complaints for the surgical health care group that showed 120 complaints had been received from patients and relatives, in the last twelve months. The highest number of complaints related to treatment and the second highest communication. Matrons told us they investigated complaints and identified themes on behalf of other wards to retain an independent view, investigation and any identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Surgery

Managers told us they shared feedback from complaints with staff and learning was used to improve the service. However, the complaints spreadsheet provided to us did not show what actions had been taken or any changes made as a result of complaints. We saw examples of concerns raised by patients in staff communication files on some of the wards we visited.

Staff could give examples of how they used patient feedback to improve daily practice. This included access for ward staff to interpreter equipment to help patients whose first language was not English and for patients who used sign language.

Is the service well-led?

Requires Improvement  

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

Leadership

Leaders understood the challenges the service faced; however, intervention or remedial action was not always timely or effective. Senior leaders were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Clinical specialities across the trust were defined as divisional health groups. Each health group was led by a Medical director, Nurse Director and Director of Operations. Within the health group of surgery also sat surgical speciality, trauma, theatres, anaesthetic and critical care and digestive diseases. A Clinical Director was appointed for each of the subgroups. Deputy Directors had also been recently introduced as part of the overall succession planning.

Senior matrons provided oversight of ward and theatre management and governance support arrangements in conjunction with business managers. Matrons provided line manager support to staff across the health group across all wards and theatres.

New objectives for the surgical health group were set out in April 2022 which include new elective recovery working patterns, with a defined service and quality improvement focus.

Local leaders we spoke with understood the new direction for leadership and spoke with passion regarding the services that they represent.

Senior ward staff told us they felt supported by their matrons and sought daily support through visible engagement. Staff told us they were able to escalate issues to their senior managers and felt issues were addressed where it was possible to do so. However, staff told us they did not see senior members of the health group and attendance on the wards was rare.

Vision and Strategy

The service had a vision for what it wanted to achieve but did not have a health group specific strategy to turn it into action. The vision and operational plan did not always focus on sustainability of services and aligned to local plans within the wider health economy. Leaders did not always understand or know how to apply them and monitor progress.

Surgery

We reviewed the trust Strategy 2019-24 which detailed the vision for - Great Staff; Great Care; Great Future. The health group did not have an overarching strategy due to its recent development but instead had developed an operational plan outlining key objectives and plan for 2022/2023. The document listed demand and capacity, quality, finance, workforce and infrastructure and equipment as the domains in which to define the objectives.

Key areas for recovery included orthopaedics, urology and oral surgery. Increasing theatre and cancer treatment capacity was also outlined. Several objectives including the retention of staff and the recruitment of new staff were also listed.

The document also outlined a number of key priorities which linked to the trust's quality and clinical strategies. These included; consistent and sustained planned activity and income targets, delivery of agreed performance thresholds and trajectories partnership working and delivery leadership and organisational capacity.

We saw an operational plan was also developed for each of the subgroups within the health group. Target periods for achieving objectives were shown, however they were not detailed.

We also reviewed the theatre transformation strategy which outlined key objectives to improve theatre utilisation with the development of a day surgery pathway, day surgery ward and the provision of dedicated day surgery teams. The trust outlined plans to introduce a demand and capacity model across all theatres to ensure efficiencies through effective access and flow processes. We reviewed the overarching plans including the benefits for patients and the reduction of long waits; however, we did not see timescales for this strategy or when the phased approach would commence. Following inspection, the trust submitted a theatre strategy update report dated September 2022 which showed only one activity as completed.

We also saw a theatre utilisation plan was in progress at the time of inspection, but there were no timescales aligned to the plan and we were not provided with an update to show the plan was being implemented. The project end date was shown to be March 2023.

Culture

Some staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff morale and wellbeing varied, and a few staff told us their morale was quite poor due to the staffing challenges. However, nursing staff generally felt well supported by their local managers and matrons and several staff told us that they felt managers were doing 'all that they can to support them'.

Staff told us they understood the staffing challenges whilst trying to maintain staff morale and provide support.

We reviewed the NHS Staff survey results 2021 and saw theatre and surgical staff scored lower across all responses when compared to colleagues from other departments. Questions included how valued staff felt and how safe and how healthy they felt they were. We did not see an action plan to address these low scores or any developments to specifically address how valued staff felt.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

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The health group met through a governance committee to review standard agenda topics such as incidents, clinical harm, risk, pressure ulcers, falls and audit results.

We reviewed the governance committee meeting minutes dated August 2022 and saw all areas were discussed but the minutes did not include detail sufficient for effective professional discussion. For example, the health group advised that there had been six serious incidents but there was no recorded discussion in regard to the nature of the serious incidents or the immediate actions taken to reduce future incidents.

We also saw two never events were recorded within the same minutes but there was no further recorded discussion.

Audit delays were outlined also but there was no plan to drive improvement or action plan created to monitor audit findings.

It was not clear what scrutiny was applied to delays or general poor performance. For example, there were 28 new clinical harm reports outlined within the same minutes, but no recorded discussion to address mitigation from further harm.

We spoke with senior leaders in regard to the apparent lack of learning in regard to the reported never events. Leaders told us learning and the roll out of actions takes time. We again reviewed the August governance committee meeting minutes and saw that learning following serious incident was shown as 'no data available'. The minutes referred to a possible lack of staff within this department.

Senior leaders told us that the service review team meet on a 6-weekly basis with attendance from all levels of staff; DGMs business manager, strategy planning manager, consultants, matrons, staff who want to be involved. We were also told of monthly clinical leads meetings. Governance leads and consultants are involved in making changes.

Due to the lack of scrutiny, insufficient information and lack of oversight in regard to risk we were not assured that robust governance processes were in place. We are also not assured that poor performance was fully sighted by the board, due to the lack of pace to drive improvement.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance effectively. They did not always identify and escalated relevant risks and issues and did not always identify actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders within the health group told us that elective recovery was their biggest challenge with no single solution to address this, thus requiring a multifaceted long-term plan incorporating more staff, more theatres, investment new builds and facilities. We saw plans to address this within the day surgery development strategy.

The current focus was to efficiently manage the delivering of services whilst reducing long waits and backlogs. Managers told us this involved all staff working collaboratively together to meet the complex needs of patients and changing ways of working to get 'most good' for patients. This involved any aspect of problem solving by working together.

Senior leaders told us there were 35 risks identified within the health group risk register, seven of which were rated as high risks. These included general capacity, theatre, beds, nurse staffing and ICU capacity. Managers told us they had rated 22 moderate risks specific to workforce issues, for example consultant shortages. Each register was reviewed and managed monthly to achieve the lowest level of risk.

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Most backlogs developed during COVID-19 and were rated high risk. Measures were taken to mitigate with enhanced IPC measures and were then downgraded to moderate. Staffing numbers across certain areas such as ICU, anaesthetics, ODPs, remain a challenge. Capacity difficulties within orthopaedics and trauma in both ward and theatres were recently downgraded.

Major trauma centre including arthroplasty remains high risk but managing better and expect to downgrade.

We saw three risk registers were reviewed every month. This included the corporate, COVID-19 and high operational registers. We reviewed the surgery governance committee minutes and saw that these were standard agenda items.

However, we were not assured that risk was prioritised as the minutes were not sufficiently detailed to ensure robust discussions were held in regard to clinical risk. We saw audit information was scant and incomplete and never events were not discussed fully.

For example, we reviewed the August 2022 minutes and saw key information was missing for several agenda items. This included mortality and morbidity learning, serious incident learning, incident and duration and medication incident reports. As such, learning from these incidents was not discussed. None of the audits discussed at this meeting led to any action plan being developed to ensure improvement was made.

We spoke with senior managers regarding concerns we saw within theatres and specifically in regard to controlled drugs. Managers were not aware of the current practice undertaken by some staff, as recent internal audits undertaken by the trust had not identified these issues. We spoke with pharmacy staff in regard to the recent audit findings within theatres, however they were unsure when audits were last completed in regard to medication. The auditing of medication in theatres was an internal action following a never event. We saw this was not completed at the time of inspection.

We also raised the concerns we saw regarding the inappropriate example of consent forms. We asked when consent was audited but we were told it used to be mandatory but was not audited currently.

Leaders were disappointed to learn that we found concerns when reviewing the surgical safety checklists. We saw within the safe September performance report that the frequency of WHO audits had been doubled but results were not available at the time of inspection.

We asked senior managers about the learning following the recent numbers of never events within the health group and were told that there had been six never events to date, but the majority of them had not caused patient harm. Managers told us all incidents were discussed at team meetings and lessons learnt discussed to prevent recurrence, for example informing the GP in a more timely fashion if a procedure has been cancelled due to high blood pressure - to prompt them to treat quickly and inform the team when safe to scope the patient.

A consultant learning event had been organised to share their experiences and this had been successful with 180 people attending. The new Patient Safety Incident Reporting Framework, improvement month and Surgery Safer September were all new initiatives to ensure learning was captured and rapidly embedded. Managers told us Patient Safety Incident Investigation (PSII) Training is planned in November to drive a systems approach to investigations and improvement, alongside Human Factors & Patient Safety for Senior Leaders.

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Information Management

The service collected some reliable data and analysed it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated and secure.

We found some of the trust's systems and processes for recording inconsistent, for example the lack of electronic recording systems in theatres. Consequently, ward staff spent time transferring paper-based information into the electronic recording systems which posed a risk of lost information during the transfer process. We saw staff confidence using the electronic systems varied from ward to ward. All staff we asked to guide us through the electronic systems told us there were sections of the systems they had not accessed before.

Staff told us that not all staff could enter data into the electronic records. We saw examples of this when recently qualified nursing staff employed as band two staff were required to have patients' assessments signed off by a senior nurse before they could be added. Ward staff told us these created delays in recording patient observations, which often showed as not completed.

We saw internet dropouts on some of the wards we visited, and staff reported occasions when the electronic system failed completely, resulting in staff having to move to paper based systems. This created concerns in relation to medicines management.

We found some electronic systems were not being used to their full potential. For example, no electronic referral could be made to specialist staff such as palliative or pain teams. Ward staff were still required to make a manual referral.

We saw patient records which were not stored securely on some of the wards we visited.

We saw a large percentage of trust policies were overdue and 43 patient information leaflets were out of date, posing a risk that both staff and patients were not following up to date guidance and advice.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

We saw the last NHS staff survey was conducted in 2021. We saw the trust had developed overarching objectives in which to support staff. These included improving staff engagement, raise awareness of staff survey plans, ensure wellbeing was embedded in everything, development of managers abilities to have supportive and compassionate conversations with staff and support improvement. We saw these objectives were an outline of proposed plans but did not have sufficient detail including timescales and clear actions to be undertaken.

The trust reintroduced 'Greatix' to recognise staff idea and any learning. There had been 135 ideas received to date which the trust was reviewing for implementation.

The trust submitted of examples of benefits for staff such as wellbeing days and the introduction of a tuck shop.

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The trust had recently rolled out a cultural health survey across all departments. We reviewed the survey and saw all key metrics had shown some deterioration since 2017, indicating that the system is under more pressure than before. Staff remained focused on working together and will take ownership, with continued efforts to ensure patient welfare is paramount. However, the survey highlighted feelings of staff fire-fighting and are unable to 'look up and take stock'.

We saw plans for a People Recovery plan which was aimed to address health and wellbeing, develop inclusive teams and unlocking potential. We saw overarching plans to increase engagement with staff and aims to design a recovery plan for each health group. However, we did not see any updates regarding the progress of this roll out.

A senior manager and a team of staff had visited Liverpool to review their SHMI and their approach to the management of Sepsis.

The bowel screening service was working with organisations across the region to develop a health inequalities strategy to increase participation in bowel screening in areas of low uptake.

The trust told us some alcohol dependent service users were not engaging with community support providers. As such, the trust employed an expert by experience charitable volunteer who provided an alternative peer support. This was met with positive feedback from the patients and the Alcohol Liaison team.

The trust told us stoma patients were routinely being contacted for regular follow-ups and community visits, however, through the use of a patient feedback survey, the trust found that not all users wanted these appointments. Therefore, the trust had set up a patient helpline and provided patients options on their pathway preference. The majority of patients after the first 6 months were happy to be put onto Patient Initiated Follow Up access plans with access to the helpline in the meantime should they require any urgent assistance.

The bariatric service has updated post-discharge bariatric Information leaflets for General Practitioners and patients. This is sent to the patient and their GP on discharge outlining all of the post-operative requirements, including what bloods are required and what multivitamins and supplements. It includes the Top 10 tips for General Practitioners post bariatric surgery.

We saw the last family and friends survey carried out by the trust and saw that Castle Hill Hospital received a 92% positive response rate.

We requested examples of recent public engagement, but this was not provided.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The bowel screening service offered 'attend anywhere' appointments for patients, so that they can have a virtual face-to-face appointment rather than a telephone appointment, reducing the need for patients to travel in. The screening programme have also gone 'paper lite' to make sure all the patient documentation was visible to all staff no matter where they were working within the region.

Over the past 12 months, the colorectal service had introduced robotic surgery for patients undergoing major cancer surgery. The activity was currently being delivered by two consultants within the department, with a plan to train further

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consultants in the future. The service had also been able to secure funding from the Cancer Alliance to appoint a Band 4 Cancer Care Co-Ordinator. The trust told us the post was pivotal in ensuring that patients were able to move along the cancer pathways in a timely fashion. They also provided an additional point of contact for patients who had any concerns or queries.

GI Physiology at Hull University Teaching Hospitals NHS Trust was one (of only 4) accredited GI Physiology services in the UK that have (and continue) to be involved in the Improving Quality in Physiological Services (IQIPS) scheme.

The Upper GI service had also begun to implement the use of robotic surgery, in the first instance for patients diagnosed with Oesophagogastric cancer. The service was planning to focus on 'robotic-assisted minimally invasive oesophagectomy (RAMIE)' in the first instance, with the process bringing improvements/reductions in length of stay and post-surgical morbidity amongst other benefits. The trust advised the aim would be then for the Hepatobiliary service to introduce the robot for pancreatic cancer resections.