Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust

Castle Hill Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Intensive/critical care	**Good**
End of life care	**Good**
Outpatients	**Requires improvement**

Summary of findings

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Summary of findings

Overall summary

Castle Hill Hospital is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates acute services from two main hospitals: Castle Hill and the Hull Royal Infirmary. The community services operated by the trust were not assessed as part of this review. The trust serves a population of 660,000 and provides a range of acute services to the residents of Hull and East Riding of Yorkshire as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire.

Castle Hill Hospital has 610 beds and provides acute medical and elective surgical services, including cardio-thoracic, breast, ear, nose and throat (ENT) and oncology services. Critical care is provided in two units, which support the cardiology and cardio-thoracic services. There are no accident and emergency services at this hospital: these are provided at Hull Royal Infirmary.

We found that the hospital was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing number of admissions. The shortage of nursing and medical staff, particularly junior doctors was impacting on the care patients received, leading to delays in assessment and treatment. There was a winter plan in operation, whereby additional beds had been opened on one ward, to alleviate pressure on bed space across the trust. Despite this, the high volume of admissions resulted in patients being moved around the hospital and across to Hull Royal Infirmary, often through the night. The hospital was not meeting all nationally set targets such as referral-to-treatment times in some specialties and backlogs had built up. A large number of outpatient appointments had been cancelled.

Staff were working hard to ensure the safety and welfare of patients, including working additional hours. We found that doctors were covering a number of areas in addition to their normal allocation and did not always have the necessary competencies for the speciality. Some staff reported that they were put under pressure to undertake additional workload and meet performance targets.

Patient feedback about care was generally positive and staff were reported to be caring and compassionate.

There were systems to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. All areas visited were clean.

There were systems in place for assessing, monitoring and addressing risk, with lines of reporting to the trust board. However, many staff told us that they did not have the time to report incidents, and there was little shared learning across divisions.

The trust was aware of the challenges over staff shortages and the high volume of admissions and had taken steps to address these. However, recruitment had proved difficult and had led to a high usage of locum staff. We saw some good examples of local leadership and highly motivated staff, but this was not consistent across the hospital. Staff felt generally supported by local leaders but not engaged with the executive management team.

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There were clear governance arrangements in place to assess, monitor and report risk to the trust board.

Staff told us that due to a lack of time they did not always report incidents and rarely received feedback. Lessons learnt from incidents across the hospital and trust wide were not routinely shared.

Nursing and medical staff shortages were experienced across all areas of the hospital and meant that the necessary experience and skills mix did not always meet recommendations by professional bodies. The lack of junior doctors was a particular concern and they reported that they were regularly being asked to cover a range of specialties, sometimes when they had yet to complete the necessary competencies. Junior doctors reported that handover, especially from night shift to day, was problematic.

There were systems to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. All areas visited were clean. Not all staff had received mandatory training.

Are services effective?

Good

The hospital was taking part in clinical audits, which allowed them to benchmark their performance against that of other hospitals and over time. Action plans had been developed following results to improve practice. For example, - in critical care the outcome to clinical audits were shared at staff handovers and at team meetings.

There were good safety checklists in place for staff to deliver a safe and effective service. Patients received care in line with best practice and national guidance. There was ongoing monitoring of care bundles.

The hospital had adopted the trust's new initiative, 'Pioneer Teams', in October 2012 to focus on a particular aspect of quality or efficiency, which had proved highly successful.

In line with national guidance, the trust had ceased to use the Liverpool Care Pathway for end of life care in January 2014 and replaced it with trust-developed guidelines on personalised management planning for the dying patient, symptom management and palliative rapid discharge pathway.

Summary of findings

Are services caring?

Good

Patients told us that the staff were caring, compassionate and their privacy and dignity were respected.

Each ward monitored the NHS Friends and Family Test and used the feedback to make local improvements. Analysis of local surveys showed that generally patients found staff caring. Operating theatre staff were observed to be kind to patients, promoting their privacy and dignity throughout their time in theatre.

Patients reported good and kind care on the critical care units and that staff had kept them fully informed regarding the progress of their family member. Staff were introducing new initiatives such as the 'Heather Hospital', a package practical measure to support families attending their relative at the end of their life.

Patients told us they had been involved in decisions about their care and treatment plans were discussed with them. We saw evidence in the care records that discussions between staff and the patient had been recorded.

Are services responsive to people's needs?

Requires improvement

The hospital was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing number of admissions. The shortage of nursing and medical staff, particularly junior doctors, was impacting on the care patients received, leading to delays in assessment and treatment. The arrangements in place to alleviate increasing numbers of admissions in the winter plan were not effective. This resulted in significant numbers of patients being moved within the hospital and across hospital sites, adding stress to staff and disruption to patient care.

The hospital had introduced a dementia strategy, which included the Butterfly Scheme. This alerted staff that a person may be vulnerable due to dementia. The critical care units were able to meet the needs of patients and the capacity of the units was sufficient to cater for the number of patients. The services were generic in that they cared for both patients at the dependency of Level 2 and Level 3.

At the listening events, we heard mixed responses about booking appointments: some people told us that the system was efficient; others had experienced delays and difficulties securing an appointment.

The hospital was not meeting all nationally set targets such as referral-to-treatment times in some specialties, clinic cancellations were high and backlogs had built up. There were insufficient slots for people in the NHS Choose and Book electronic appointment system.

Summary of findings

Are services well-led?

Requires improvement 

There were governance systems in place throughout the hospital and staff were aware of the line management arrangements. Staff reported that on a local level they felt well led and supported but did not feel engaged with the senior management and that the executive team was not visible. Not all staff were aware of trust-wide initiatives to involve and engage them.

Staff were able to raise concerns, but feedback was variable and often absent. Staff were not always reporting incidents, which meant that the trust was not collecting robust information on incidents to inform decisions and address risk. On the whole there was limited shared learning across the hospital.

Staff were working additional hours to cover shortages and the lack of junior doctors was a great concern, as they were covering a number of areas, sometimes outside their competencies. Staff felt under pressure to meet performance targets, and spoke of a bullying culture in some areas.

There was a varied and, overall poor completion of mandatory training and many staff were unable to attend additional course to enhance their skills. Junior doctors reported limited access to training in some areas.

The trust was aware of the significant challenges and were taking steps to cover gaps in staffing through more recruitment and use of locums. Additional funds had been agreed for more nursing staff and initiatives had been introduced to assess risk and take steps to address them on a daily basis, such as the twice daily safety briefing.

Summary of findings

What we found about each of the main services in the hospital

Medical care (including older people's care)

Requires improvement

There were systems in place to identify, investigate and learn from incidents. Ward staff assessed patients' risks and put plans in place to reduce them. Staff across wards and departments raised concerns about staffing levels, particularly the lack of healthcare support workers and staff on duty at night and weekends. We were particularly concerned about the low number of junior doctors and the impact this had on their workload. Handover arrangements between medical staff at the end of a night shift were reported as poor. The lack of available beds led to long delays in accessing assessment and treatment, with frequent movement of patients around the hospital and between Castle Hill Hospital and Hull Royal Infirmary.

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

We found staff committed and hardworking but struggling to provide a quality service due to staff shortages. Patients told us that staff were caring and we saw examples of compassionate care being given. The wards were well-led at the point of service delivery and staff felt supported, although some staff told us that there was a disconnect between the Board's executive team and the wards.

Surgery

Requires improvement

Ward areas and theatres were clean and guidelines were followed to prevent or reduce risks from infection. There were appropriate safety checks and risk assessments taking place and concerns were escalated appropriately. Daily safety briefings took place to discuss issues that could impact on patient care and take action to minimise risk. The World Health Organisation surgical safety checklist was used to ensure the safety of patients while undergoing procedures. National and best practice guidance was used to care and treat patients.

Wards and theatres were very busy and, to meet patients' needs, staff were often redeployed to different areas. Patients reported that, at times, this led to long waits for call bells to be answered. Junior doctors felt pressured and stretched to meet the demands of the service; senior clinicians confirmed that junior doctors' workload was high.

Summary of findings

Patients said staff were caring and compassionate, although staff were very busy. Treatment was explained to patients who were involved in decisions about their care. Patients were being transferred between wards and hospitals, sometimes a number of times, which was causing distress and put them at risk from lack of continuity of care.

Medical and nursing staff reported communication with the executive management team of the trust was poor and they were not visible.

Intensive/critical care

Good

The hospital provided a comprehensive, consultant-led critical care service with 24-hour cover, seven days a week. There were good safety checklists in place for staff to deliver a safe and effective service. Patients received care in line with national standards and there was ongoing monitoring of care bundles.

Infection prevention and control was well managed. Staff were aware of how to report incidents, but said sometimes feedback was limited. The critical care team provided an outreach service to ward areas, although at times they struggled to meet demand as there was no back up support. There was no dedicated medical staff allocated to this team.

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

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

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

End of life care

Good

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

In line with national guidance, the trust had ceased to use the Liverpool Care Pathway for end of life care in January 2014 and replaced it with trust-developed guidelines on personalised management planning for the dying patient, symptom management and palliative rapid discharge pathway.

Summary of findings

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

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

Outpatients

Requires improvement

There were systems in place to assess risk and escalate concerns. Staff were aware of how to report incidents and met regularly to discuss learning from incidents. The outpatient areas were clean. Staff were using good infection prevention practices.

Clinics visited were very busy. Staff were concerned about patients, particularly the frail elderly becoming dehydrated, with the hot conditions. There was a shortage of space in some clinical areas, which compromised patients' privacy and dignity.

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

Analysis of trust data showed that clinics were regularly cancelled by the hospital. There were insufficient slots on the NHS Choose and Book electronic appointment system causing delay and failure to meet referral-to-treatment time targets.

Summary of findings

What people who use the hospital say

Share Your Experience is a service organised by the CQC, whereby patients are asked to provide feedback on the standard of care they have received. In 2013 there were 22 comments, 21 of which were negative and one positive. The positive comment was about how caring the staff were. The negative comments were about the lack of staff, staff attitude towards patients and insufficient ways of communicating.

From January 2013 to December 2013 there were 226 reviews posted on the NHS Choices website about Castle Hill Hospital. The website uses a star rating system, with five stars being the highest. Castle Hill Hospital scored 4.5 stars overall, with 4.5 stars for all five areas rated but 4 stars for staff cooperation and involvement in decisions.

Healthwatch Kingston upon Hull and Healthwatch East Riding of Yorkshire shared the results of their surveys of people's views of the care they received in the trust's hospitals, collected January 2014. There were 73 comments received on Castle Hill Hospital. The results showed that 86% felt they were treated with kindness and respect, 90% felt services were safe, 89% felt their treatment met their needs and 71% rated the hospital as 'outstanding' or 'good'.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified and skilled staff and experienced staff across medical and surgical wards, particularly at night and weekends.
- Ensure that staff are suitably supported and receive appropriate training and complete their mandatory training.
- Ensure that junior doctors are appropriately supervised and are not taking on additional roles and responsibilities for which they have yet to complete competencies in.
- Ensure that there are suitable arrangements for on call, and junior doctors are not responsible for multiple pagers across different areas.
- Review why staff feel that they are experiencing bullying and feel pressure to undertake additional hours and put meeting targets above patient care.
- Ensure that only staff employed for caring duties support patients, including dealing with patients exhibiting challenging behaviour because of mental health illness or dementia.
- Review incident reporting to ensure that staff report incidents appropriately and in a timely manner.
- Ensure that staff receive feedback from incidents reported, including never events and complaints.
- Ensure lessons learned are disseminated across divisions.
- Ensure patients have access to hospital appointments and cancellation of outpatient clinics is kept to a minimum.
- Ensure patients' assessment and treatment is based on best practice guidelines and delivered in a timely manner.
- Ensure that there are suitable arrangements in place for pharmacy provision across all areas to provide clinical overview and reconciliation of patients' medications.
- Ensure that patient records are appropriately maintained.

Action the hospital SHOULD take to improve

- Review and improve the communication among clinicians, including handover arrangements, in particularly from night shift to day.
- Develop the auditing of the WHO checklist to include the completion of all sections.
- Review the information captured on the risk registers so that dates of inclusion are included.
- Identify a board level lead for the outpatients department.
- Ensure that staff who are involved with the care of patients living with dementia are suitably trained, for example portering staff.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- The trust had introduced Pioneer teams, which empowered staff to develop innovative solutions to drive improvement.
- The end of life team had developed a package of care to ensure that relatives and carers received the necessary support at the end of their relative or friend's life, which included access to parking and a pack of toiletries.
- The outpatients team had developed a means of identifying when a patient had special needs so they could plan their care appropriately before they arrived in the department.
- The trust has introduced 'Link Listeners', which gives representatives of staff access to the executive team.

Castle Hill Hospital

Detailed findings

Services we looked at:
Medical care (including older people's care); Surgery; Intensive/critical care; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Programme Director NHS Leadership Academy

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

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

Background to Castle Hill Hospital

Hull and East Yorkshire Hospitals NHS Trust was established in October 1999 as a result of a merger between Royal Hull Hospitals NHS Trust and East Yorkshire Hospitals NHS Trust. Castle Hill is one of the trust's two main hospitals. From 2012 to 2013 the trust treated 154,437 inpatients and saw 611,482 outpatients. The trust employs 8,000 staff.

Castle Hill Hospital has 610 beds and provides acute medical and elective surgical services, including cardio-thoracic, breast, ear, nose and throat (ENT) and oncology services. Critical care is provided in two units, which support the cardiology and cardio-thoracic services.

The hospital does not provide accident and emergency services: these are provided at Hull Royal Infirmary.

Castle Hill Hospital has a total of 19 critical care beds situated in two units. Both units are generic, meaning that they care for patients at both Levels 2 and 3. The hospital provided a comprehensive consultant-led critical care service, with 24-hour cover seven days a week.

End of life care services were provided by a palliative care team based at the Queen's Centre for Oncology and Haematology, but provided a service across Castle Hill Hospital and Hull Royal Infirmary and the local hospice. The team was available Monday to Friday, with helpline services out-of-hours during evenings and weekends.

The hospital provides outpatient services for a number of specialists, including ear, nose and throat, chemotherapy, radiotherapy, women's health, cardiology and endoscopy. Appointments usually originate from GP referrals through a paper referral system or NHS Choose and Book, which is a national electronic web-based appointment system that offers patients a choice of where to receive health care.

Castle Hill Hospital was inspected in July 2013 and found in breach of Regulation 13 (medication) for the regulated activities diagnostic and screening and treatment for disease, disorder or Injury. In October 2013, two further

breaches were identified for Regulation 9 (care and welfare) and Regulation 11 (safeguarding), for the same regulated activities. Compliance actions had been set for all three breaches and the trust was working to action plans to become compliant.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

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

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits on 3, 4 February and an unannounced on 11 February 2014. During the visits we held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit and outpatients. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held two listening events on 3 February 2014 in Hull and at Cottingham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. We also held a community focus group in partnership with Choices and Rights Disability Coalition, so that we could hear the views of harder to reach members of public.

The team would like to thank all those who attended the listening events.

Requires improvement

Medical care (including older people's care)

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

Information about the service

We visited the hospital twice, including one unannounced visit. We visited four wards at the hospital, including two wards providing care for older people, one ward providing respiratory healthcare for patients and one ward providing medical care as a winter pressures ward for medical patients on a surgical ward.

During our inspection we spoke with 29 patients, 12 relatives and 24 staff. We checked 21 patient records. We attended a number of focus groups and we observed care being delivered on the wards.

Summary of findings

There were systems in place to identify, investigate and learn from incidents. Ward staff assessed patients' risks and put plans in place to reduce them. Staff across wards and departments raised concerns about staffing levels, particularly the lack of healthcare support workers and staff on duty at night and weekends. We were particularly concerned about the low number of junior doctors and the impact this had on their workload. Handover arrangements between medical staff at the end of a night shift were reported as poor. The lack of available beds led to long delays in accessing assessment and treatment, with frequent movement of patients around the hospital and between Castle Hill Hospital and Hull Royal Infirmary.

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

We found staff committed and hardworking but struggling to provide a quality service due to staff shortages. Patients told us that staff were caring and we saw examples of compassionate care being given. The

Requires improvement

Medical care (including older people's care)

wards were well-led at the point of service delivery and staff felt supported, although some staff told us that there was a disconnect between the executive team and the wards.

Are medical care services safe?

Requires improvement

Safety and performance

Staffing levels

In October 2013, the trust carried out an acuity and dependency audit and identified that elderly medicine was very understaffed across the trust. (Acuity measures how ill a patient is and helps to decide the appropriate level of nursing/medical care required). The board was alerted to a significant risk in relation to medical staffing in the Medicine Health Group from September 2013 (Compliance and Risk Committee, October 2013). Wards were not always meeting Royal College of Nursing recommendations of 65:35 skills mix of registered nurses to health care assistants on duty on a day shift.

On-call arrangements

The shortage of medical staff from August 2013 was listed as a high risk on the trust's risk register, with an expected peak in January 2014 due to a lack of recruitment and maternity leave. The hospital faced challenges to meet capacity and demand. To alleviate the pressure on doctors, the hospital was introducing a 1:8 registrar rota, backfilling with internal locums and adding three more clinical fellow posts. Junior doctors told us that they were pressured to carry more than one pager – sometimes up to three – and had not always completed the competencies in the specialty required to answer calls. Junior doctors were sometimes stepping up into registrar roles. We were shown multiple text alerts to doctors to do locum work to cover gaps in shifts. Junior doctors felt supported by senior staff during the day. However, we heard how on one occasion the medical registrar had been called over to Hull Royal Infirmary one night, which left the junior doctors at Castle Hill Hospital unsupported. This meant that patients were put at risk as they were not always seen by appropriately experienced doctors and subjected to delayed assessment and decision making. We were informed by the trust following the inspection that the decision to move the registrar from Castle Hill Hospital would only be made in conjunction with the acute consultant physician on call, in

extreme circumstances and would be based on risk. This would be kept under regular review during the night so that the registrar could return to Castle Hill Hospital as soon as practicable.

Staff across wards and departments raised concerns about staffing levels. Staff were particularly concerned about levels and seniority of medical staff on duty at night and weekends. Action had been taken by the trust to reduce the risk. Patient safety briefings had been introduced, whereby senior managers and ward representatives met once a day to identify where risks were that day and to redeploy staff to where they were most needed. The trust had agreed an investment of £450,000 for increased nursing. We were informed that recruitment had commenced and jobs advertised.

Mandatory training

Not all staff groups had completed their mandatory training and the division was not meeting the trust target of 85%. The medicine division had achieved overall 72.1%, with medical staff completing 72.4% and nursing staff 76.6%. There were variations in attendance across wards and departments. (Staffing Metrics for November 2013, January 2014). Staff reported that access to mandatory training was problematic. Ward managers told us that, due to staffing issues on the wards, staff could not always be released to access training. At the focus groups, staff told us they often had to attend training in their own time and that mandatory training did not always take place due to staff shortages. Junior doctors told us they did not always receive training due to staffing pressures. We observed on one ward staff attending the ward on their days off to support newly qualified staff through their preceptorship training; this was due to staff shortages. (Preceptorship is a period of practical experience and training to guide and support all newly qualified practitioners to develop their confidence as an independent professional, and to refine their skills.)

Incident reporting

Staff did not always report incidents due to a lack of time to complete the documentation. Staff said they rarely received feedback, which we were told discouraged them from reporting. This meant the trust board could not be assured that data used on incident reporting accurately reflected the numbers occurring, and so be taken into account in addressing risk.

Cleanliness and infection prevention and control

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

We looked at the Patient-led assessments for the care environment (PLACE). The assessments looked at the environment in which care is provided as well as cleanliness, food, hydration and the extent to which care with privacy and dignity is provided. The hospital had scored 97.5% for cleanliness. We observed that hand-washing facilities and hand hygiene gels were available in all areas and staff and relatives were observed using these. The ward staff were encouraging relatives to use hand-washing facilities. Each ward had a housekeeper assigned to the ward.

Medication

At the CQC's last inspection of Castle Hill Hospital in October 2013, we found the management of medicines was not compliant with Regulation 13 of the Health and Social Care Act 2008. A pharmacist reviewed the management of medicines and found improvements had been made but more were still needed to ensure the use of medicines was safe and responsive. The pharmacy was open seven days a week and a pharmacist was always 'on call'. Nurses told us that there were often delays in obtaining medicines, apart from 'critical medicines' such as those used in Parkinson's disease or antibiotics. Of the 30 prescription charts checked across the trust, all were completed correctly. Nursing staff followed national guidance on the administration of medicine. Doctors told us there was a good clinical pharmacy service. We found effective systems in place to monitor and manage controlled drugs within the trust.

Staff told us about a new system they had introduced for the storage of patient medication in the medicine trolley on Ward 26. Each patient's medication had a designated drawer in the drugs trolley. Staff reported that this helped to reduce the risk of medication error and ensured that the patient's prescription was ready at the time of discharge.

Medical care (including older people's care)

However, some wards received limited pharmacist support, with a pharmacists and pharmacy technicians present on each ward for between 30 minutes and two hours a day. This meant that some patients' prescriptions were not clinically checked by a pharmacist and there was insufficient time to carry out medicine reconciliation (checking the patient continues to receive the medicines they were taking before admission, unless changed or stopped for medical reasons). The trust policy stated that 50% of inpatients should have had their medicines reconciled by a member of the pharmacy team at any one time, with a view to 50% of inpatients having their medicines reconciled within 24 hours of admission by the end of 2014. According to the trust's audit, 60% of inpatients at any one time had their medicines reconciled during November 2013, which meant they were meeting their own target, but not in line with the World Health Organisation's guidance 2007 on medication reconciliation within 24 hours of admission. The pharmacy team had reconciled medicines on less than a third of the 30 prescriptions checked across the trust.

Deteriorating patients

In response to concerns that staff may not recognise the deteriorating patient, the national early warning score (NEWS) had been introduced (corporate risk register, January 2014). Deteriorating scores where escalated to a critical care outreach team. Training for recognising the signs of a deteriorating patient had been recently introduced and intentional rounding had been implemented in some areas.

Learning and improvement

The wards completed audits for falls, pressure ulcers, and infection rates and staff were informed of their area's performance to drive improvement. However, staff said that learning from incidents was not routinely shared and therefore, improvements to care following incident investigation could not be consistently implemented across the trust.

Equipment

We found on wards visited that records of daily checks of the resuscitation trolley had taken place. We observed that there was pressure-relieving equipment available for use on the wards and staff confirmed it was available when needed to help reduce patients' risk of pressure sores.

Monitoring safety and responding to risk

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

Safety Thermometer

In line with other health groups across the trust, the medical wards were using the NHS Safety Thermometer to manage patient risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections. This is a tool designed to be used by frontline staff to measure a snapshot of harms and 'harm-free' care once a month. We observed the outcomes, including information on harm-free care days displayed on ward noticeboards. This information was being used to drive improvement and the number of days when patients remained harm free were increasing.

The wards displayed information about the transparency programme developed by NHS England, publishing harm data, staff experience and ward staffing levels. The results of harm-free care were displayed at the entrance of each ward. It informed patients and relatives how long the ward had been harm free. For example, the number of days since the ward had recorded patients acquiring a pressure ulcer or sustaining a fall on the ward.

Records

We looked at 21 patient records and found that patient assessments were generally completed. However, in one patient's record, food and fluid charts had not been fully completed for seven days. The patient had been identified at risk of malnutrition because they had low weight and they had lost weight during their stay in hospital. For one day, fluid and food intake had not been recorded after 9am.

Staff assessed patients' vulnerability to developing pressure sores, and there were care plans for those who were at risk. The care bundle for two patients, who had been identified in need of two-hourly repositioning, had gaps in their records. It was documented that they had both been repositioned at 7pm but then not repositioned until 11pm. During the day, the times of re-positioning

Requires improvement

Medical care (including older people's care)

between 10am and 4pm occurred more consistently every two hours but after 4pm the patients were not repositioned until 7pm. Staff could not be assured that patients were safe from developing pressure ulcers as their records were not being accurately maintained.

Following a previous inspection the trust had developed an action plan for improving the completion of documentation for turning frequencies and repositioning. The trust had reviewed the action plan in December 2013 and documented that the plan was on track to meet the timescale the trust set for completion of 17 January 2014.

The wards used care bundles to ensure that patients with particular conditions received appropriate care. We saw completed care bundles for skin integrity, falls and nutrition. A report to the Quality, Effectiveness and Safety Committee, 13 December 2013 highlighted the trust's poor compliance in this area. The hospital responded by introducing intentional rounding; this was being piloted in certain areas, which meant that every patient was reviewed every hour, and this had resulted in an improvement in the fluid balance monitoring and the trust's compliance. (Corporate Performance Report, Quality and Safety January 2014.) The trust has since informed us that intentional rounding now takes place on all wards.

Staff training

Safeguarding training had been developed for staff to understand what constituted abuse. Staff we spoke with were able to recognise the different types of abuse and how these should be recorded. However, not all staff not all staff had completed the appropriate levels for their role. For example, - for safeguarding children and young people Level 3, general medicine across both hospital only 52.5% met requirements.

Are medical care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

The hospital was participating in national clinical audits such as for Parkinson's disease and diabetes. Action plans were in place following results of audits, for example – with adult asthma, an action plan was in place to improve documentation and the standard of record keeping.

The trust contributed to the Myocardial Ischaemia National Audit Project (MINAP). 99.1% of patients received primary coronary intervention (which has better outcomes for patients than thrombolysis, the other form of treatment) compared with a national average of 95.3%. 91.7% of these patients received their intervention within 90 minutes with a median time of 111 minutes. Both of these measures are in line with the national average. For patients with a Non-ST elevation myocardial infarction (another type of heart attack) 97.9% were seen by a cardiologist during their admission and 91.4% were admitted to a cardiac ward. This is significantly better than the national average of 52.6%.

The hospital implemented a CQUIN payment framework for a pneumonia care bundle developed by the British Thoracic Society, focusing on making a correct and timely diagnosis of pneumonia at the point of admission. The number of patients who received every component of the bundle was 47% for September, October and November 2013 (Pneumonia Care Bundle Overview Report, Pneumonia, and CQUIN 2013). Issues identified for non-compliance were: time from admission to x-ray; and the recording of the patient assessment score in patients under 75 years old. As a result, an action plan had been developed.

Staff, equipment and facilities

We found staff worked hard to care for patients, but at times were stretched to deliver a service due to staff shortages. Staff reported that they were frequently moved to cover gaps in other ward's rotas and this was disruptive to their own wards. Some staff told us how the high number of patients outlying on their wards due added to their workloads, particularly with older patients with complex needs.

We checked the resuscitation equipment in areas visited and found that there was a system in place for checking equipment and ensuring that it was fit for use.

Multidisciplinary working and support

There was good multidisciplinary team working within teams and across other divisions. Multidisciplinary team meetings took place with partners in community and social care for assessment, treatment and discharge.

We attended a focus group for allied health professionals who told us the trust had recently reorganised occupational therapy and physiotherapy services to

Requires improvement

Medical care (including older people's care)

seven-day working to give patients better access to therapy services. However, the trust had not increased staffing levels to allow for this. Staff told us they worked overtime to cover the service.

Are medical care services caring?

Good

Compassion, dignity and empathy

We observed on all the wards we visited, staff caring for patients in a friendly, supportive and thoughtful manner.

The wards had risk assessments, care plans and appropriate monitoring to meet patients' nutritional needs. This included the use of red trays for patients who needed help with their meals, so that staff could identify them.

Patients told us they felt well cared for and staff responded to call bells. However, when the ward was busy, it could take a little longer for staff to respond. We observed drinks and call bells were placed within easy reach of the patients on all the wards we visited. We observed patients were clean and appropriately dressed. Patients told us that staff were caring and pleasant; however, they felt at times that there were not enough staff on the wards.

Involvement in care and decision making

NHS Choices allows patients to score services according to a five-star rating for care and involvement – with one star being the lowest and five stars the highest score. Information from NHS Choices showed that Castle Hill Hospital scored four stars for involvement in decisions overall from patients.

Following our previous inspection, when we were concerned about the involvement and consent of patients, the trust had developed an action plan to improve respecting and involving people in their care. The trust was implementing the use of a patient passport and improving patient-specific information in the care records. Most patients and their relatives we spoke with felt involved in their care.

Trust and communication

Patients, relatives and staff told us relatives were not always informed when patients were transferred to different wards, especially when it occurred overnight. Relatives told us they did not find out the patient had moved until they visited the ward.

We saw staff interacting with patients in a kind and considerate manner. Staff attitude to patients was good and they interacted well with relatives.

Emotional support

Patients and their relatives told us staff were caring and responsive to their needs. Most people felt informed about the care and treatment.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Due to consistent pressure on bed capacity we found that patients were often moved both within the hospital and between the two main sites of the trust. On Ward 16 a patient told us they had been transferred from a ward at Hull Royal Infirmary with two other patients at 4am. Staff told us they were trying to contact relatives to let them know that the patients had been transferred. Another patient who had suffered a head injury had been moved twice before being transferred to Castle Hill Hospital. In that time they had been in 10 different beds in five weeks. This meant that patients were experiencing disruption of their care by being moved through the night, sometimes to another site, which could have a detrimental impact, particularly on the frail and elderly.

We observed patients were cared for in single-sex bays in order to protect dignity.

Access to services

Patients were referred to the hospital by their GP or had been admitted as an emergency, sometimes from Hull Royal Infirmary. Treatment was available for cardiac conditions and there were critical care facilities available to support the cardiology and cardiothoracic services. There were multidisciplinary teams working across all wards for

patients at the end of their life and who had suffered a stroke. The stroke services operated at both hospital sites and there was an effective multidisciplinary team for the rehabilitation of stroke victims. This service had been extended to seven days a week and included therapists.

Vulnerable patients and capacity

The hospital was undertaking dementia mapping on the wards to understand the shortfalls in services from the patient's viewpoint. As a result the hospital had introduced a dementia strategy, which included the Butterfly Scheme– a system of care training provided by a not-for-profit organisation – for people living with dementia to deliver person-centred care. The hospital had a dementia lead nurse who was also the lead for the Butterfly Scheme. Under this scheme, a butterfly symbol identified patients living with dementia, so that staff could give an appropriate response. We found that not all ward staff had received training on the butterfly scheme.

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

The hospital was also developing a leaflet for patients and relatives to raise awareness about dementia.

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

Leaving hospital

Staff attended patient safety bed meetings, which they felt were useful as they provided multidisciplinary support to help relieve pressure on beds. Multidisciplinary meetings were also held daily to discuss when people were medically fit for discharge but required support at home. This helped identify the discharge needs of patients.

Discharge planning was started when the patient was admitted to hospital. The trust had 'in-reach' staff from all wards. These personnel told us they could access care services and liaise with care homes to begin the discharge process. All ward teams had trajectories for morning discharges and daily discharge numbers required. Not all areas were achieving the necessary number of morning discharges. Matrons focused on this by undertaking daily board rounds in the afternoons to improve the discharge planning. (Corporate Performance Report, Quality and Safety, January 2014.) In-reach staff told us they felt that the coordination of the transfer of patients had improved. However, analysis of patient feedback data and views expressed at the listening event showed that some patients were still experiencing problems with discharge arrangements.

The hospital had introduced an electronic patient record (Cayder patient flow manager) to improve patient information, including discharge information across the patient pathway. The system included a patient's full medical and social history information. This had led to information about the patient being available when they were transferred and allowed information about the status and care needs of the patient to be available to the receiving ward at the point of transfer. Staff told us it had improved the information about the needs and care of the patient, including information about discharge planning.

Requires improvement

Medical care (including older people's care)

Learning from experiences, concerns and complaints

The medical services were responding to feedback from patients using the 'I want great care tool', and action plans had been developed

We looked at information from the trust on complaints. The Medicine Health Group had received 79 complaints, including 20 complaints for elderly medicine, three for chest medicine and three for stroke medicine. Only 36 complaints had been escalated from the Patient Advice and Liaison Service (PALS) for this period.

Are medical care services well-led?

Requires improvement

Vision, strategy and risks

The trust was in the process of reviewing the acute and elderly medicine service provision to develop future models of care. The trust was working with local commissioners and providers to develop more integrated care pathways. The trust's winter plan was considered a high priority and aimed at developing clinical pathways to achieve, 'Right place, Right time' strategy for patients.

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

Governance arrangements

There were governance arrangements in place, with medicine forming one health group across the trust. Staff were aware of the arrangements and knew how to report concerns through the line management to the trust board. We found that not all incidents were reported externally in accordance with national guidance. For example, one case of delayed diagnosis was reported internally on 28 November 2013, but it was not reported externally as a serious incident until 17 December 2013. The national protocol states that a serious reportable incident should be reported within 48 hours from the time the incident is known. Serious incidents reported in January 2014 showed an improvement in reporting times but were still outside the 48-hour timescale. Patients could be at risk of harm because the investigation and learning from incidents was delayed. Staff were aware of the main risks and challenges on the wards and they had identified actions to address these areas.

Patient experiences, staff involvement and engagement

Healthwatch collected survey information from people in January 2014. Results from the survey showed that 86% of people felt they were treated with kindness and respect at Castle Hill Hospital; 90% of people who completed the survey felt that Castle Hill Hospital services ensured they were safe from harm. When we asked staff what improvements could be made to enhance the patient experience for people, they told us that the staffing level was the key issue.

Leadership and culture

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

Learning, improvement, innovation and sustainability

We showed staff a copy of the trust's first lessons learned bulletin. Staff told us they had not seen a copy of the bulletin before. Staff learning from incidents was completed at local level with ward managers and matrons. However, staff told us they did not receive lessons learned about incidents from other specialties across the trust.

The trust had introduced dementia training in January 2014. We looked at the dementia programme board minutes for 28 January 2014 and 375 staff had completed some form of dementia training. However, the January courses had to be cancelled due to lack of response. Some staff told us they were not able to attend training because of staff shortages and as they were needed to maintain staffing levels to facilitate service provision. Data from the trust showed that, at 31 December 2013, in General Medicine, 72.1% of staff had completed training and 85.9% of staff had received their appraisals.

Requires improvement

Surgery

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

Information about the service

The hospital provides a range of surgical services including cardiothoracic, spinal surgery, orthopaedic and acute general surgery. We visited four surgical wards including two cardiothoracic wards, an orthopaedic ward and orthopaedic/plastic surgery ward, the general operating theatres, day case theatres and the cardiothoracic suite. We talked with five patients and two relatives, 22 members of staff including matrons, ward managers, nursing staff (qualified and unqualified), and medical staff both senior and junior grades. We observed care and treatment and looked at care records for five people. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Ward areas and theatres were clean and guidelines were followed to prevent or reduce risks from infection. There were appropriate safety checks and risk assessments taking place and concerns were escalated appropriately. Daily safety briefings took place to discuss issues that could impact on patient care and take action to minimise risk. The World Health Organisation surgical safety checklist was used to ensure the safety of patients while undergoing procedures. National and best practice guidance was used to care and treat patients.

Wards and theatres were very busy and, to meet patients' needs, staff were often redeployed to different areas. Patients reported that, at times, this led to long waits for call bells to be answered. Junior doctors felt pressured and stretched to meet the demands of the service; senior clinicians confirmed that junior doctors' workload was high.

Patients said staff were caring and compassionate, although staff were very busy. Treatment was explained to patients who were involved in decisions about their care. Patients were being transferred between wards and hospitals, sometimes a number of times, which was causing distress and put them at risk from lack of continuity of care.

Medical and nursing staff reported communication with senior management of the trust was poor and the senior team were not visible. Clinicians spoke of a bullying culture, with pressure to meet performance targets in some areas.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

Safety and performance

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

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

In the operating theatres we observed safe surgical checks in place, which included the use of the WHO surgical safety checklist. We observed the implementation of all sections of the checklist and found that staff completed the checklist on all patients. Recent audits of the WHO checklist indicated that the trust scored 100% but this did not include auditing of all sections of the checklist. Completion of the checklist minimises the risk of avoidable errors to patients.

Incident reporting

Castle Hill Hospital had one never event (a largely preventable patient safety incident that should not occur) in cardiothoracic surgery over the period 1 December 2012 to 31 November 2013. A swab had been retained after surgery and the hospital carried out an investigation of the event in order to learn lessons from the incident. Staff outside of the health group were unaware of the incident, which meant that the opportunity to learn lessons was missed.

Cardiological conditions and procedures were identified as an elevated risk in tier 1 indicators – the key metrics the CQC uses to help decide where there is potential risk. Coronary artery bypass surgery was flagged as an 'outlier alert' (outside that reported for other similar trusts) and identified as an elevated risk in September 2013. This case was still active and the trust was responding to requests for information.

Staffing

The trust used the Safer Nursing tool to assess the level of nursing required to meet patient needs. We found that wards were not always meeting national guidance. A review of duty rotas for the surgical wards and the summary report for quarter 2 Acuity and Dependency Audit October 2013, showed that, although some wards and operating theatres were meeting establishment numbers, others carried a number of staff vacancies. For Wards 8 and 9, some posts were vacant for over six months. The high level of vacancies was impacting on staff morale and their ability to give good quality of care. The trust informed us that on Ward 8 and 9 in October 2013 there were 3.29 Registered Nurse vacancies, 3.03 none registered nurse vacancies and in March 2014 4.98 Registered nurse vacancies with 3.27 non registered nurse vacancies.

Nursing staff of all grades (qualified and unqualified) on Wards 8 and 9 reported they felt under pressure due to the workload and poor staffing levels. One nurse told us that, on night duty on Ward 8 at the weekend, there had been only two staff, one qualified and one unqualified; this meant that patients' pain relief and intravenous fluids were not given at the appropriate time because they had to wait for a member of staff to be available from the adjoining ward to assist. This sometimes caused a delay of up to an hour before patients received their medication. A review of duty rotas confirmed that the staffing level on Ward 8 was reduced to two nurses on night duty at a weekend, (one registered nurse and one auxiliary nurse). We were informed by the trust that at a weekend, the bed base on Wards 8 and 9 is dropped and Wards 8 and 9 work to support each other.

Patients said the nursing staff were very busy. One person said, "They always seem so busy, sometimes I don't like to ask them because they are so busy" and another person commented that, "The amount of work they have to do is high, they are always busy, they try to get to the buzzers when they can it just depends".

However, the trust had only identified nurse staffing levels on Ward 8 as moderate risk on the surgical risk register. This meant that the trust board may not be fully aware of the need for greater nursing staff across more than one ward in order to take appropriate action to ensure levels of staff are adequate to reduce risk to patients.

Mandatory training

Not all staff were completing their mandatory training, with ranges between the four surgical divisions from 70.3% to 72.6%; only division 4 had met the 85% target. Junior doctors reported departmental teaching was limited, although consultants told us that appraisals were completed.

Learning and improvement

We spoke with all staff groups about incident reporting and they were able to explain the process to follow to report incidents. Staff told us that learning from incidents relevant to their particular area was discussed at team meetings. They were unaware of learning from incidents across the wider trust.

The surgical divisions held regular governance meetings at various levels and there was a clear route for governance issues to be escalated and also to be cascaded down. However, we found that this mechanism was not always effective and outcomes from investigations did not often reach staff working on the wards below manager level.

Systems, processes and practices

Equipment

The surgical risk registers identified a number of pieces of equipment that required replacement. We observed that some equipment had been replaced in the operating theatre environment with some new operating tables and theatre trolleys in place. One senior nurse told us that there had been issues with the availability of equipment on loan from other departments, which had compromised patient safety. As a result, a new system for managing requests and the use of loan equipment had been introduced, which was working well.

We observed that checks were completed on resuscitation equipment in the ward areas on a daily basis and each week the seal on the trolley was broken to carry out a further check. Staff in theatres and ward areas told us that they usually had access to the equipment they needed. This meant that steps had been taken to minimise the risk to patients of unsafe equipment.

Cleanliness and Infection prevention and control

The trusts infection rates for Clostridium difficile (C. difficile) and MRSA for the period August 2012 to July 2013 lie within a statistically acceptable range However, we observed one area outside Theatre 7 in the general theatre suite to be cluttered with single-use items on open shelving outside the anaesthetic room doors. Patients were taken through this area, which put the items at risk of damage and possible infection risk.

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

Patient records

We reviewed five patient care records across four of the wards. Assessments had been completed accurately – for example, for pressure ulcers, venous thromboembolism (VTE or blood clots) and nutrition, and these records were well maintained. Entries in records were dated and often timed, signatures were present but often the name was not printed. There was clear evidence of entries in the medical notes at least once a day.

Medication

We observed the safe storage of medicines in two of the wards we visited and in the operating theatres. Medication cupboards and trolleys were locked when unattended. The drug fridge on Ward 8 was broken at the time of the inspection and drugs were being stored on the adjoining ward. We were told the fridge had broken the previous day and was waiting for repair.

Safeguarding

Nursing staff were able to explain how they would report and escalate any concerns. The percentage of staff who had completed training in safeguarding was over 80% in the areas we visited.

Are surgery services effective?
(for example, treatment is effective)

Requires improvement

Surgery

Good

Using evidence-based guidance

During 2012/13 the surgical services took part in all the clinical audits they were eligible to participate in – for example, Elective Surgery (National Patient Reported Outcome Measures Programme).

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

We found the surgical services were using best practice and national guidance and checking compliance with them for instance neurosurgery was compliant with NICE IPG documents.

Surgical speciality groups met on a monthly basis and considered mortality figures as part of their governance meetings. These figures were then taken to the mortality committee. We saw minutes from the meetings on 15 November 2013, 20 December 2013 and 17 January 2014, which confirmed this.

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

Performance, monitoring and improvement of outcomes

There were systems in place to monitor the use and checking of equipment and the surgical risk register identified a number of pieces of equipment that required replacement which was confirmed by staff. The age of equipment was noted and the need for replacement planned for. Aside from this staff reported that they had access to the equipment they required. We checked emergency equipment and other medical equipment and found it well maintained and appropriately checked and stocked.

Multidisciplinary working and support

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

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

Are surgery services caring?

Good

Compassion, dignity and empathy

Patients told us that the staff were caring and compassionate. Patients did say that the nursing staff didn't have time to have a conversation as they were just, "too busy". We observed staff during the visits to the ward areas and they were polite to patients, explaining what they were going to do and why. Screen curtains were closed when attending to individuals' personal needs and privacy and dignity were respected.

The Trust's own quality policy ("Setting the Standard"), ensured that Ward managers received feedback on their ward's progress against the Trusts 12 quality standards.

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

Involvement in care and decision making

Patients said that staff explained to them what they were doing and gave them choices about the care that was

delivered. One person said the surgeon had explained different treatment plans to follow for the particular condition they had and they had been able to express a choice as to which treatment plan to follow.

Trust and communication

Patients confirmed that they felt well informed about treatment and procedures. Patients had been given explanations as what treatments entailed and reported that they understood what they were consenting to. A range of information leaflets were available for patients to take away to inform them of the procedures and conditions and contact details for further information. Access to interpreters was made available and staff were aware of how to access these services when needed.

Emotional Support

Patients and their families reported that they felt staff were caring and supported them with their anxieties over procedures and operations. Staff had made them aware of support services available including the chaplaincy and other agencies.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Transfer of patients

Two of the 11 patients we talked to had experience of internal transfer while in hospital. One person told us they had been admitted to Hull Royal Infirmary then transferred to Castle Hill Hospital and transferred again to Hull Royal Infirmary. This person was unable to explain if this was for clinical reasons.

Discharge planning

Discharge planning was in place and the care records examined confirmed that discharge planning commenced well in advance of discharge. Patients were able to tell us what the plans were for their discharge and the expected date that they should be discharged. Overall, patients told us they felt well informed.

Vulnerable patients and capacity

Nursing staff were able to demonstrate an awareness of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards, which they told us were included as part of the safeguarding training. We saw in care records that dementia screening assessments had been completed appropriately. The electronic Cayder boards at the nursing station used a butterfly symbol to identify those patients who were living with a dementia type illness and who may be vulnerable. This meant that staff were alerted to those patients who they may have concerns about prior to an operation.

Access to services

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

A number of initiatives were taking place to improve access for patients within some services. For example, - advanced health practitioners had been introduced to run the cervical spine fracture clinics to increase access to appointments. Steps were being taken to deal with the delays in accessing treatment and appointments. In order to reduce the amount of cancelled theatre time, some services such as spinal surgery had been moved from Hull Royal Infirmary to Castle Hill Hospital.

Learning from experiences, concerns and complaints

Staff explained that patient and relative feedback, particularly around concerns or complaints, was taken seriously and we saw evidence that this was documented. For example, one patient who had raised concerns about the provision of a varied halal diet was visited by staff from the catering department to discuss their dietary preferences. Complaints were standing agenda items and discussed as part of the clinical governance meetings; the minutes of the meetings for 15 November 2013, 20 December 2013 and 17 January 2014 confirmed this.

Requires improvement

Surgery

Are surgery services well-led?

Requires improvement

Vision, strategy and risks

Staff were aware of wider trust strategy, and that more engagement was taking place with staff and patients. The staff in surgical areas were aware of the risks in their service and the risk register was reviewed regularly. Items on the surgical division's registers were not dated when they were added. This meant that it was not possible to identify when the issue was added to the register or if it was actioned in a timely manner.

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

Governance arrangements

There was a medical director who lead surgical services overall. Surgery at the trust was divided into four divisions and within each division there was a clinical lead for each surgical speciality. Each speciality held governance meetings and any concerns were escalated to the divisional governance meeting.

Leadership and culture

Most staff in each surgical division worked well together. Nursing and junior medical staff told us they felt well supported by their immediate line managers and senior staff in their surgical teams. They showed commitment to providing good quality care to patients. However, lessons learned from other areas were not shared, and staff were unaware of practices or initiatives taking place in other surgical divisions.

Medical and nursing staff told us that the communication with senior management of the trust was poor and the senior team were not visible or engaging with staff working in the surgical areas. Senior clinicians spoke of a bullying culture, with a command style, requiring immediate responses to requests but failing to engage in any conversations.

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

Patient experiences, staff involvement and engagement

Staff felt supported by their line managers but were struggling to deliver care as they would wish as they were so busy due to shortages of staff. Both medical and nursing staff told us that communication with senior management of the trust was poor and the executive team were not visible or engaging with staff working in the surgical areas. Junior medical staff felt pressured into working additional hours and covering posts senior to them. Senior clinicians spoke of a bullying culture in some specialities, and there was a lack of consultation before changes were made to the way their services were run.

Good

Intensive/critical care

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

Information about the service

Castle Hill Hospital has a total of 19 critical care beds situated in two units. They care for patients at both Levels 2 and 3. One unit is dedicated to cardiothoracic surgery. We spoke with four family members and three patients, six members of nursing staff, senior and junior medical staff. We observed care and treatment and looked at the care records for three people.

Summary of findings

The hospital provided a comprehensive, consultant-led critical care service with 24-hour cover, seven days a week. There were good safety checklists in place for staff to deliver a safe and effective service. Patients received care in line with national standards and there was ongoing monitoring of care bundles.

Infection prevention and control was well managed. Staff were aware of how to report incidents, but said sometimes feedback was limited. The critical care team provided an outreach service to ward areas, although at times they struggled to meet demand as there was no back up support. There was no dedicated medical staff allocated to this team.

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

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

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

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Safety and performance

The hospital provided a comprehensive consultant-led critical care service, with 24-hour cover seven days a week. The critical care service carried out safety briefings three times a day and there was a formalised system in place for staff to provide a safe patient handover. The units had good safety checklists in place for staff to deliver a safe and effective service. This included checklists for the equipment and cleaning.

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

The critical care team provided an outreach service to the ward areas. The national early warning score (NEWS), which is a system for standardising the assessment of acute illness severity, had been introduced across the trust to replace a previously used tool. The new system had led to an increase of referrals to the team, which had increased the workload. There was no dedicated medical staff allocated to this team. The staffing establishment for these services was 14 whole time equivalent staff which provided one nurse 24 hours a day. However, staff reported difficulties when there were further requests for support as there was no back up provided.

Learning and improvement

We spoke with all staff groups about incident reporting and they were able to explain the process to follow to report incidents and were confident in using the computerised system. Staff told us that they were not afraid to raise concerns or report risks or unsafe practice. Feedback from lessons learned was given at weekly meetings, which were time protected. However, junior medical and nursing staff told us that, individually, they had not always received feedback on reports they had made.

Systems, processes and practices

Staffing

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

Infection prevention and control

Infection prevention and control was well managed overall, and infection rates were low. The critical care areas were visibly clean and staff were observed to wear protective clothing. Hand-wash facilities and hand gel dispensers were available at the entrance to all the units we visited and staff were observed to adhere to the bare below the elbow policy for better hygiene. Overall, the records of training we reviewed identified that most staff had completed infection control training.

Patient records

Medical staff used pre-printed admission sheets and care documentation included a pre-printed booklet that incorporated all the required screening tools. We saw that documentation was complete. A number of care bundles and documentation to measure compliance were completed on a daily basis. This information was collated and audited at unit level. We looked at the care records for three patients. Appropriate screening assessments had been completed and there was ongoing monitoring of care bundles with daily care planning. The records we reviewed were complete, legible and safe.

Monitoring safety and responding to risk

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

Environment

There were two critical care areas at Castle Hill Hospital provided services for the cardiothoracic unit, and were well

Good

Intensive/critical care

designed and spacious. Both units cared for patients at Levels 2 and 3. The configuration of the dependency changed according to the patients' needs. Facilities for relatives were described as good.

The unit design was fit for purpose and there was adequate room between each bed. Storage facilities were tidy and clearly labelled with all items stored off the floor. Cleaning rotas were in use and daily records of fridge temperatures were recorded.

Safeguarding

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

Are intensive/critical services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

Patients received care in line with national standards. The units risk-rated themselves against the Intensive Care Society Core Standards for intensive care units, which was published in November 2013. Where they were not meeting the standards, an action plan was implemented. We saw evidence of this during the inspection. Criteria was used to determine the suitability of the patient to be admitted to the critical care units using the national early warning score (NEWS) system for acutely ill patients.

Performance, monitoring and improvement of outcomes

Bed occupancy for critical care was below the national average at 68% compared to the national average of 82.1%. The units monitored quality and safety issues, which were discussed at the team meetings. The critical care team had introduced a fast track, nurse-led system for the care of cardiac patients to enable care to be delivered promptly and safely.

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

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

Staff, equipment and facilities

Staff, equipment and facilities

There were two critical care areas with 19 beds. The critical care units supported the cardiology and cardio-thoracic surgical services and provide an outreach team to wards throughout the hospital. Both units cared for patients at care levels 2 and 3. The configuration of the dependency changed dependent on the patients' needs. The unit design was fit for purpose and there was adequate room between each bed. Storage facilities were tidy and clearly labelled, with all items stored off the floor.

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

Staff reported that they had sufficient equipment to provide the service and that daily checks were made to ensure that equipment was safe. We checked emergency and other equipment when we visited the units and found this to be the case.

Multidisciplinary working and support

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

Are intensive/critical services caring?

Good

Intensive/critical care

Good

Compassion, dignity and empathy

Patients and families described the staff as "wonderful" and they said they had received excellent care from all the staff. We observed staff to be kind, caring and compassionate maintaining the patient's privacy and dignity.

Involvement in care and decision making

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

Trust and communication

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

Emotional support

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

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

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

To accommodate patients' needs, the units introduced a system where staff moved between the general intensive care unit and the cardiothoracic intensive care unit. This also helped them to share and develop skills and breakdown barriers in communication. We observed that the facilities for patients requiring Level 1 in the ward areas were limited.

Discharges

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

Information

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

Learning from experiences, concerns and complaints

There were regular meetings and handovers taking place daily which included discussions over patient's and their families' concerns and complaints. Staff demonstrated a commitment to improving the service and were keen to learn from patients and their families on how they could develop the service better.

Good

Intensive/critical care

Are intensive/critical services well-led?

Good

Vision, strategy and risks

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

Leadership and culture

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

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

Good

End of life care

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

Information about the service

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

In accordance with national guidance, the trust had ceased using the Liverpool Pathway on 20 January 2014. They had replaced this with three guidance documents; Guidance for Development of a Personalised Management Plan for the Dying Patient; Guidance for Symptom Management for the Dying Patient and Palliative Rapid Discharge Pathway.

We visited inpatient wards in the Queen's Centre and two inpatient wards in the general hospital at Castle Hill. We spoke with the end of life care facilitator, nursing staff and their managers and two chaplains. We reviewed information we received via the listening event and bereavement surveys carried out by the trust. We reviewed the records of people who were receiving or had reviewed end of life care.

Summary of findings

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

In line with national guidance, the trust had ceased to use the Liverpool Care Pathway for end of life care in January 2014 and replaced it with trust-developed guidelines on personalised management planning for the dying patient, symptom management and palliative rapid discharge pathway.

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

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

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

The palliative care team provides consultant and specialist nurse services for patients at end of life across all specialties. The team has strong links with community and local hospice services. Staff providing end of life support reported to us that the team were accessible and responsive to their requests for support in providing end of life care for patients.

The hospital was aiming to ensure each ward had a link end of life nurse who received additional training and developed closer links with the palliative care team. The new guidance which had replaced the Liverpool Pathway was being implemented across all services and was being presented to ward-based staff by specialist palliative care consultants and the end of life facilitator. This will ensure staff have a better understanding of the guidance with the aim to improve end of life care for patients. The use of new guidance was audited to identify effectiveness and areas to improve practice.

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

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

Systems, processes and practices

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

Monitoring safety and responding to risk

We looked at the end of life care records for six patients and saw that the guidance for end of life had been followed; this included daily review, pain relief and check on preferred place of care. The records showed that regular discussion about patients' wishes and preferences had taken place and been agreed with them.

On one ward, a patient who had been transferred from Hull Royal Infirmary, with the decision not to resuscitate made, still had not had the correct documentation in their notes, despite staff at both hospitals raising this as an issues. This put them at risk of not receiving the appropriate treatment.

Anticipation and planning

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

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

Are end of life care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

National guidance

In accordance with national guidance, the hospital had ceased to use the Liverpool Pathway for delivering end of

Good

End of life care

life care on 20 January 2014. It had replaced this with three guidance documents: Guidance for Development of a Personalised Management Plan for the Dying Patient; Guidance for Symptom Management for the Dying Patient and Palliative Rapid Discharge Pathway.

Performance, monitoring and improvement of outcomes

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

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

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

Staff working in areas where end of life was more frequent – for example, on elderly wards and oncology services – were provided with specialist training. For other staff, training was provided by the end of life facilitator and palliative care team. Most wards identify an end of life champion who attended specialist training and was responsible for supporting other staff on the ward and linking with the palliative care team. The end of life facilitator had held two end of life champions 'lunch time drop-in events' which focused on patients' preferred place of care. As a result of patient feedback, staff were receiving advanced communication skills training in order to improve 'difficult conversations'.

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

Are end of life care services caring?

Good

Compassionate care

Staff were caring and compassionate. We heard from a range of people at our listening event and also from people who contacted us to describe their experiences of end of life care. A minority of people felt their experience could have been improved through better communication between staff and relatives; this has been acknowledged by the trust and additional training sourced. However, most people were very complimentary about their experience. They told us staff had been kind and understanding, particular on the oncology wards.

Staff told us that, wherever possible, people were moved to side rooms towards their end of life. Staff were able to give us examples of how they were able to ensure care was very personal to the patient and the need to be both flexible and innovative with regard to patient wishes.

Staff talked to us about the respect and dignity they gave to the patient following death and the support provided to families of the deceased. The bereavement centre instigates the trust's feedback survey where relatives have an opportunity to comment.

The hospital had a 24-hour chaplaincy service which offered support for patients and staff. They worked closely with the end of life care facilitator to monitor people receiving end of life care. Chaplains support and train

Good

End of life care

volunteers who visit patients on wards to offer spiritual support. The hospital chaplaincy had developed local networks to support patients to access support from different faiths and cultures.

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

Multidisciplinary working and support

End of life care was provided by the clinical team originally looking after the patient with support from the palliative care team, which meant patients were cared for by people they were familiar with. The palliative care team told us they attended multidisciplinary team meetings and took responsibility for daily monitoring of patients approaching the end of life. This helped ensure that patients were consulted about treatment, pain relief, spiritual and emotional needs.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

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

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

We looked at fifteen 15 do not attempt cardio-pulmonary resuscitation orders (DNA CPR) orders across a cross-section of wards (these orders record when a person states they do not want to be revived if they stop breathing or their heart stops beating, or the responsible clinician has discussed with the patient or relative that it would be inappropriate, unsuccessful or not in the patient's best interest to do this). Ten of the orders were completed fully. In the remaining five orders, we found incomplete information about discussions with the patient and their relatives, review dates, or the reason for the decision. This meant that there was no up-to-date record of consultation with patients or their relatives regarding their wishes. Our findings were in line with the trust's own audits of DNA CPR orders.

Vulnerable patients and capacity

We reviewed two patient records where patients lacked the capacity to make decisions. In both cases a mental capacity assessment in accordance with the Mental Capacity Act 2005 had been completed, following a multidisciplinary best interest meeting. Staff on the oncology and elderly care ward said that, where possible, relatives were included to determine best interest decisions. All staff confirmed they had received Mental Capacity Act 2005 and safeguarding adults training.

Access to services

The palliative care team told us they promoted referrals through visiting wards and attending multidisciplinary team meetings and holding awareness events. Every ward we visited had information visible at nurses' stations, with contact details for referrals. Staff said the response from the palliative care team was supportive and they responded swiftly to requests.

Facilities

The main bereavement centre is based at the Hull Royal Infirmary site. The systems in place for bereaved relatives were supportive and ensured, as far as possible, that the process for obtaining, and registering death was as straightforward as possible. Staff employed at the bereavement centre had received specialist training and were also supported by members of the Cruse charity. There were private facilities where people could talk to staff

Good

End of life care

about any issues. The bereavement centre had an appropriate viewing room which was nicely and sensitively decorated. There was information available for bereaved relatives to take away with them with regard to the procedures following bereavement.

Leaving hospital

The hospital had responded to patients' wishes to have a preferred place of care and had worked collaboratively with other partner agencies to develop a rapid discharge pathway of care. The pathway included the availability of anticipatory and 'just in case' drugs, specialist equipment and transport provision. The audit results into the effectiveness of the pathway indicated that, in the quarter 3 October to December 2013, 100% of patients achieved their preferred place of care. Staff gave us examples of instances where they had been able to assist patients achieve their preferred place of care and how they collaborated effectively with other agencies. In one example, a patient was able to return home within 24 hours of their request. The oncology unit had a direct phone line for families to use if they needed support following a discharge home. Staff told us they were proud to be able to respond to patients' wishes.

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

Learning from experiences, concerns and complaints

We saw evidence via the bereaved carer action plan that complaints had been responded to and learning developed into improved practice. Every eight weeks the hospital held a retrospective end of life case review group, with membership from health and social care organisations as well as hospital staff and palliative care team members. Anonymised patient journeys were analysed, identifying areas of good practice and areas for learning. The aim of the group was to encourage delivery of a collaborative, multi-professional, quality patient-centred end of life journey.

Are end of life care services well-led?

Good

Vision, strategy and risks

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

Governance arrangements

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

Leadership and culture

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

Patients' experiences, staff involvement and engagement

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

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

Good

End of life care

Learning, improvement, innovation and sustainability

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

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

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

Requires improvement

Outpatients

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

Information about the service

Castle Hill Hospital provides outpatient services for a number of specialists, including ear, nose and throat, chemotherapy, radiotherapy, women's health, cardiology and endoscopy. Appointments usually originate from GP referrals through a paper referral system or NHS Choose and Book, which is a national electronic web-based appointment system that offers patients a choice of where to receive health care.

We visited the general outpatients department, oncology and cardiology outpatients and spoke with six patients and four members of staff. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

There were systems in place to assess risk and escalate concerns. Staff were aware of how to report incidents and met regularly to discuss learning from incidents. The outpatient areas were clean. Staff were using good infection prevention practices.

Clinics visited were very busy. Staff were concerned about patients, particularly the frail elderly becoming dehydrated, with the hot conditions. There was a shortage of space in some clinical areas, which compromised patients' privacy and dignity.

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

Analysis of trust data showed that clinics were regularly cancelled by the hospital. There were insufficient slots on the NHS Choose and Book electronic appointment system causing delay and failure to meet referral-to-treatment time targets.

Requires improvement

Outpatients

Are outpatients services safe?

Good

Safety and performance

Managing risks

There was easy access to emergency resuscitation equipment in all outpatient areas. These were checked every day to ensure they were in good working order. The senior staff nurse in charge of general outpatients had a good awareness of the systems to report incidents. They told us they met with staff regularly and discussed learning from incidents. We reviewed the training records for staff and saw they had received appropriate and up-to-date mandatory training with regard to health and safety matters.

Staffing levels

Patients we spoke with across all outpatient clinics we attended said they thought there were sufficient staff available with the appropriate knowledge and skills. The senior staff nurse in general outpatients told us there were sufficient staff for the smooth running of clinics. They felt that the rota took account of delays in clinics which meant there were staff available until the last patient was seen. They told us that, where there were vacancies, these were covered by bank (overtime) staff

Learning and Improvement

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

Systems, processes and practices

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

Staff said that training was available but, because of the split sites (Castle Hill and Hull Royal Infirmary) attending at another site took a member of staff away from the department for longer periods, which left clinics short of staff. Staff told us that they received regular clinical supervision and appraisals.

Monitoring safety and responding to risk

Safeguarding patients

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

Patient records

Staff in all outpatient areas we visited confirmed that they received patient records in a timely manner which allowed them to review information and plan for the patient's visit. For example, as part of the Butterfly Scheme, patients suffering from dementia had a butterfly attached to their file to alert staff and help them ensure that the patient did not have to wait too long. We did observe some patient records located outside treatment rooms which we considered to compromise patient confidentiality.

Are outpatients services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

Staff, equipment and facilities

Staff told us that they received regular clinical supervision and appraisal. We reviewed the training records for staff and saw they had received appropriate and up-to-date mandatory training with regard to health and safety matters

The clinics we visited were very busy and appeared cramped. Clinics were very hot and a number of patients commented about this to us. There was a shortage of space in some clinical areas. We saw leaflets and posters displaying information about medical conditions.

Are outpatients services caring?

Requires improvement

Outpatients

Good

Inadequate

Compassionate care

We spoke to patients waiting for appointments and people who attended our listening events. We heard positive comments about staff attitude; that privacy and dignity were upheld and staff were caring towards patients. Comments we received from patients included: "staff are really friendly", "Delays are usual but staff keep me informed", and "Delays don't help with anxiety, but staff try to be reassuring".

During our observations in the clinics we saw staff to be kind, friendly and caring in their interactions with patients. They spoke with people in a clear way and explained to them what the process would be with regard to their appointment.

We reviewed information held by the trust about complaints received with regard to outpatients. Out of 18 complaints received, five related to the attitude and care patients felt they received from staff.

Involvement in care and decision making

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

Trust and communication

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

Emotional support

We observed staff taking time to explain processes to patients and heard staff reassuring patients. Patients told us staff seemed to have good knowledge of their speciality, which was reassuring to them. One person told us of the excellent support and time given to their daughter in explaining a complicated diagnosis.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

Trust-wide information we received indicated that clinics were regularly cancelled by the trust. For example, out of 45,678 appointments scheduled for December 2013, 11,097 were cancelled by the trust. We have no information about the potential impact of this on patient welfare. Delays in meeting outpatient appointments appears on the trust's risk register for review in February 2014 and is highlighted as 'action completion dated 09/10/13 not achieved' in the outpatient transformation steering group action tracker dated 03/01/14. This means the Trust has failed to complete action identified as high risk.

Most patients we spoke with told us they had had to wait for up to an hour for their appointments, which they accepted as the norm. However, everyone we spoke with said that felt they were sufficient allocated time for their consultation; appointments were unhurried and patients were given time for treatment and explanation about diagnosis and next steps. In the general outpatients department there was the facility for blood samples to be taken without the need to go to another area in the hospital. The senior staff nurse gave a recent example where they had helped a patient avoid two visits to different parts of the hospital by coordinating their appointments in the outpatients department.

Vulnerable patients and capacity

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

The environment

The environment of the clinics varied – for example, the outpatient departments situated in the Queen's Centre oncology unit were spacious, comfortable and had a pleasant outlook onto gardens; those in the main Castle Hill Hospital building were less so. All outpatient

departments had access to water and assisted toilet facilities. People at the listening event told us they struggled to locate wheelchairs to transport relatives to their appointments.

Parking

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

Learning from experiences, concerns and complaints

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

Booking appointments

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

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

Are outpatients services well-led?

Requires improvement

Vision, strategy and risks

The trust had systems in place to manage risk through its risk management strategy. Meeting referral to treatment times appeared on the trust's corporate risk register for cancer screening, ophthalmology, dermatology and radiology due to increased demand, staffing and lack of equipment. We were told that there had been between 6-8% increase in referrals and for some specialities this was as much as 20-60%. There had also been an increase in the cancer patient referrals impacting on the two week target. We found it difficult to identify robust action planning other than reviewing the risk regularly and making attempts to risk assess individual patients and increase clinics where possible. We were unable to source any evidence to measure effectiveness of action taken.

Governance arrangements

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

Leadership and culture

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

Learning, improvement, innovation and sustainability

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

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

Requires improvement

Outpatients

Managing quality and performance

We reviewed outpatient complaints and found of the 18 complaints made, six were upheld and six were partially upheld. Issues ranged from delays in receiving appointment and cancelled clinics (both impacting on delayed diagnosis and treatment) to the attitude of staff, lack of information and disregard to patient privacy and dignity. We were unable to find evidence of shared learning from complaints or compliments.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety. Patients experienced multiple moves around the hospital and across sites putting them at risk of delayed assessment and inconsistent care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 9 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety. Patients experienced multiple moves around the hospital and across sites putting them at risk of delayed assessment and inconsistent care and treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) Service users were not protected from risks relating to their health, welfare and safety as the provider's systems designed to assess, monitor the quality of the services and identify, assess and manage risks were ineffective.

This section is primarily information for the provider

Compliance actions

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

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

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

Appointments were cancelled leading to delayed diagnosis and treatments.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) Service users were not protected from risks relating to their health, welfare and safety as the provider's systems designed to assess, monitor the quality of the services and identify, assess and manage risks were ineffective. Not all incidents were reported and learning from incidents was not widely shared across the hospital. Junior doctors were covering multiple patient groups, without appropriate supervision and working outside their competencies putting patients at risk. Staff reported pressure to meet national targets as priority over patient care putting patients at risk. Appointments were cancelled leading to delayed diagnosis and treatments.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Management of medicines' There were not suitable arrangements in place for the oversight and reconciliation of patient's medicines by a pharmacist in some areas.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Management of medicines' There were not suitable arrangements in place for the oversight and reconciliation of patient's medicines by a pharmacist in some areas.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Staffing'. Inappropriate steps had been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There were significant shortage of junior doctors, who were working across multiple patient groups, sometimes outside their competency. There was a significant shortage of nursing staff across acute elderly medical wards and a shortage of staff across surgical services, including the operating theatre.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 22 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Staffing'. Inappropriate steps had been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There were significant shortage of junior doctors, who were working across multiple patient groups, sometimes outside their competency.

This section is primarily information for the provider

Compliance actions

There was a significant shortage of nursing staff across acute elderly medical wards and a shortage of staff across surgical services, including the operating theatre.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 (1) (a) & (b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Supporting workers'. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training, or had the opportunity to obtain further qualifications appropriate to the work they perform. There was insufficient supervision of junior doctors across medicine and surgery, particularly at night and weekends.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 (1) (a) & (b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 'Supporting workers'. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training, or had the opportunity to obtain further qualifications appropriate to the work they perform. There was insufficient supervision of junior doctors across medicine and surgery, particularly at night and weekends.