Hull and East Yorkshire Hospitals NHS Trust

Castle Hill Hospital

Quality Report

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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 (including older people's care)	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Hull and East Yorkshire Hospitals NHS Trust operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham. Castle Hill Hospital has cardiac and elective surgical facilities, medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT), a breast surgery facility and outpatients as well as the Queen's Centre for Oncology and Haematology. In total, the trust has approximately 1,300 beds and 7,400 staff. The CHH site has over 600 beds. The trust provides services for a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull and 342,200 in the East Riding of Yorkshire.

We completed a comprehensive inspection of the trust from the 28 June to the 1 July 2016 which included a review of progress made on the previous inspections in May 2015 and February 2014. We inspected the five core services delivered from CHH which were medicine, surgery, critical care, end of life care and outpatients and diagnostics. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

We rated CHH overall as 'Requires improvement'; the safe, effective, responsive and well led domains were rated as 'Requires improvement' with caring rated as 'Good. There had been improvements made for referral to treatment times (RTT); whilst the trust was not achieving the national standard it was meeting the local trajectories agreed with commissioners and NHS Improvement. Surgery services had improved. End of life care remained 'Good' across all domains. However, there was deterioration in the ratings overall for critical care from 'Good' to 'Requires improvement'. Outpatients and diagnostics had improved in some areas and deteriorated in others which changed the rating from 'Good' in 2015 to 'Requires improvement' overall.

Our key findings were as follows:

- The trust reported and investigated incidents appropriately and the previous backlog had reduced. However, staff in some areas could not tell us about lessons learned or changes to practice.
- The trust had effectively responded to a serious incident reported by Radiology in December 2015 related to a failure to print 50,000 radiology reports. A further seven serious incidents regarding specific patients had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- A backlog of 30,000 patient episodes/appointments had been identified by the trust prior to the inspection. There had been eight serious incidents declared in outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- Staff were not always assessing and responding appropriately to patient risk. The trust used a National Early Warning Score (NEWS) to identify deterioration in a patient's condition. We saw some examples of when escalation of a deteriorating patient had not happened in a timely way and some staff were unclear about what to do if a patient's score increased (indicating deterioration). The trust was aware of this and was putting actions in place to improve this.
- Falls risk assessments were often not completed or not fully completed. Nutritional assessments were partly completed in the patient records, which may have resulted in a failure to identify patients at risk of malnutrition. We also found poor compliance with the completion of fluid balance charts.
- Nurse staffing shortages were evident across the majority of medical and surgical wards and Board reports indicated that safer staffing levels were not always met. The trust recognised this was an issue and had put in place twice daily safety briefings and associated actions to minimise risk to patients as well as new ward support roles, such as discharge facilitators.
- There were also some gaps within the medical staffing, especially within critical care.

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- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust had deteriorated and was 112.2 which was higher than the England average (100) in March 2016. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 98.6 in May 2016 which was similar to the England ratio (100) of observed deaths and expected deaths.
- There were three active outlier mortality alerts at the time of the inspection. These were for septicaemia (except in labour), coronary artery bypass graft (CABG) and reduction of fracture of bone (upper and lower limb). This meant that deaths within these areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable, what lessons could be learnt and actions were then put in place.
- Although medicines were stored and administered appropriately, we found gaps and errors in the recording of medicines administration and in the monitoring of checks of controlled drugs which had been a concern at our 2015 inspection.
- Leadership had improved. There was a clear vision and strategy for the trust with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork.
- Feedback from patients and relatives was positive. We saw good interactions between staff and patients. Staff maintained patients' privacy and dignity when providing care. Caring within medicine had improved.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks, if required, during the day.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited.

We saw several areas of outstanding practice including:

- The urology service had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The critical care teacher trainers had been shortlisted for a national nursing award for their training courses and had been asked to write an article for a national nursing journal.
- The responsiveness of the Specialist Palliative Care Team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement team initiative of providing cards for relatives to write messages to their loved ones.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

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

Importantly, the trust must ensure that:

- Planning and delivery of care meets the national standards for the referral-to-treatment time indicators and eliminates any backlog of patients waiting for follow ups with particular regard to longest waits.
- Learning from Never events is further disseminated and lessons learnt are embedded.
- Staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- Staff have the skills, competence and experience to provide safe care and treatment especially for patients requiring critical care services.
- Staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.

Summary of findings

- Staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.
- Staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- Patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- Review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- Outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.
- Medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- There are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

In addition there were areas where the trust should take action and these are reported at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)	Requires improvement 	We rated medical care services as 'requires improvement' overall because: • We found the trust had not addressed some issues raised from the comprehensive inspection in February 2014, for example: low nursing and medical staffing levels. The planned nurse and medical staffing levels were not consistently achieved and this impacted on the capacity of the medical wards. • Systems and processes were not completed consistently such as control checks of fridge temperatures and controlled drugs. Medication administration was not always completed and we observed gaps in medication charts that were not accounted for. • Audits were not always completed within the timeframe set by the trust when standards were not at acceptable levels. The trust 3G audit identified that nutrition standards were not always met and food charts were not always fully completed which would indicate if further referrals were needed. These were not highlighted as risks on the medicine risk register. • Some staff did not possess the specialist competencies that were required for specialist wards. • The trust was not achieving specific outcome targets, such as primary percutaneous coronary intervention (PPCI) • We observed nurse and medical leadership on the wards however ward managers were not always allowed to remain supernumerary due to nurse staffing levels. However: • The trust had addressed some of the issues raised from the comprehensive inspection in February 2014, for example: the lack of available beds that led to long delays in accessing and treatment, frequent bed moves and the disconnect between the executive team and the

Summary of findings

wards. A local improvement plan was in place and, at the time of inspection, targets were being achieved to meet the 18 week referral to treatment national indicator.

- The majority of patients and relatives felt involved in their care and thought staff were compassionate about the care they provided. Staff felt proud of the care they delivered and enjoyed working at the hospital.
- We observed patient centred multidisciplinary team working.

Surgery

Requires improvement

In 2015 we rated surgical services at CHH as 'inadequate'. At the 2016 inspection we rated surgical services at CHH as 'requires improvement' overall because;

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective.
- We had concerns over the effectiveness of the 'Five steps to safer surgery' checklist, from our observations it was apparent this process was not embedded as a routine part of clinical roles.
- From medical notes we reviewed and staff we spoke with, we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. Nursing staff did not always complete accurately the falls and dementia risk assessments. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.

Summary of findings

- Patients were not always able to access services for treatment in a timely way; the trust did not meet national performance standards for treatment and cancer standards.

However;

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dietitians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI) we carried out, showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- The trust had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

Critical care **Requires improvement**

We rated critical care as 'requires improvement' because;

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified risks to the service that were not on the risk register. We were concerned about the out of hours medical cover at CHH and the impact of the trust's reconfiguration of services. There was a lack of recognition of this or forward planning from the Health Group management team or executive team to mitigate the risks.
- Controls for some of the risks that had been identified were limited and unsustainable and

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there was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action on some of the risks on the risk register.

- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts to cover CHH. Some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place which was not in line with guidelines for the provision of intensive care services (2015).
- Junior medical staff that worked on ICU2 out of hours did not have skills in tracheostomy and epidural management.
- Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units.The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the cardiac arrest and transfer team which meant they may not always be immediately available or on site.
- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015). Patients did not have access to formal psychology input following critical care.
- The service had limited formal mechanisms for collecting patient or relative feedback.

However,

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

- There was clear nursing and medical leadership on the units and in the critical care outreach team and it was clear that staff had confidence in the units' leadership.
- We observed patient centred multidisciplinary team working.

End of life care

Good

The last comprehensive inspection of End of life care services at the hospital was in February 2014, when we found the service to be good. During this inspection we rated this core service as 'good' overall because;

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and managers shared the learning from incidents. Mandatory training across most services was above the trust targets and medicines were prescribed and administered safely in line with policy and staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multidisciplinary working across all teams. The trust had recently employed more resources to provide seven-day specialist palliative care nursing availability. Consent to care and treatment was obtained in line with legislation and guidance.
- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the

Summary of findings

patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and patients' choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.

- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the Specialist Palliative Care Team (SPCT) were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

Outpatients and diagnostic imaging

Requires improvement

We rated outpatients and diagnostic imaging services as 'requires improvement' overall. [KK1] We rated the safe and responsive domains domain as 'inadequate', the well-led domain as 'requires improvement' and the caring domain as 'good'. The effective domain was inspected but not rated. This was because we are currently not confident we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

- Radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further six serious incidents regarding specific patients had been reported, of which three related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.

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- In addition, a cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should. Three of these serious incidents were at the HRI site and six at the CHH site; all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery and a serious incident was declared in December 2015 due to 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents related to printing errors, being declared by the time of the inspection.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies for nursing and support staff in some outpatient specialties, and in radiology there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.
- Outpatients and radiology had increased their appointment capacity by running clinics out of hours and at the weekends, to cope with the increased demand and ensure patients had their appointments. However, there were ongoing concerns about the trust not meeting national standards for referral to treatment and urgent cancer treatment. However, a plan was in place and locally agreed trajectories, agreed with

commissioners and NHSI were being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action to review any issues.

- Staff providing care and treatment to people in outpatients and radiology were caring. Patients gave positive feedback about the care they received and we saw staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing impairment or those who needed an interpreter.
- The facilities and premises used to deliver services were good. The environment in all of the areas visited was in good state of repair, clean and comfortable and sufficient well-maintained equipment was available.
- We found there were a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.
- Outpatient services were split between the four Health Groups, meaning there were different levels of management and clinical support for each service. There was no outpatients risk register. Risks were identified on risk registers of Health Groups; however, this did not allow a cohesive oversight. There was also limited evidence of outpatient audits and quality monitoring.
- There was inconsistency in the governance and management oversight in outpatients due to it being split across the four Health Groups. This was starting to be addressed with the setting up of a weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient transformation project'

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was also in progress, but this was running behind schedule. This project's aims included improving clinic utilisation, bookings processes and performance against standards. We were also told that an overarching management post was to be developed.

- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme in which all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Castle Hill Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging;

Detailed findings

Contents

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. It operates from two main hospital sites – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) in Cottingham.

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

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

Kingston Upon Hull Unitary Authority scored significantly worse than the England averages for 21 of the 32 indicators in the 2015 Area Health Profiles. The city had the highest long term unemployment of any local authority in England. It also scored particularly badly for smoking prevalence, smoking-related deaths, deaths from cancer among under-75s and female life expectancy. The city scored significantly better than the England average for incidences of malignant melanoma and TB. The cancer mortality rate in Hull (360.8 per 100,000) is significantly higher than the England average (285.4 per 100,000). By contrast East Riding of Yorkshire Local Authority scored significantly better than the England averages for 14 of the 32 indicators in the area health profiles. The area scored significantly worse than the averages for three indicators: smoking status at the time of delivery, recorded diabetes and deaths and serious injuries on roads. In the 2015 Indices of Multiple Deprivation, Hull ranked as the third most deprived local authority in England. On the other hand the East Riding of Yorkshire was ranked the 195th most deprived local authority in England.

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

The inspection in May 2015 was a focused inspection which did not look across the whole service provision; but focused on the areas defined by the information that triggered the need for the focused inspection including the previous inspection in February 2014. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services inspected. At CHH we inspected domains in surgery together with outpatients and diagnostic services. The overall rating for CHH and the Trust was Requires Improvement. The Trust was found in breach of the

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Health and Social Care Act (Regulated Activities) regulations 2014. These included: Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 14 (Meeting nutritional and hydration needs), and Regulation 16 (Receiving and acting on complaints), Regulation 17 (Good governance) and Regulation 18 (Staffing).

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

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Julie Walton, Care Quality Commission

The inspection team consisted of two inspection managers, 18 CQC inspectors and 24 specialists including; an adult safeguarding specialist, an A&E doctor and nurse, a critical care doctor and nurse, two end of life nurses, a maternity doctor and midwife, a medical doctor and nurses, outpatient doctor and nurse, paediatric doctor and nurse, surgery doctor and nurse, radiographer, a junior doctor, two student nurses and two trust-wide specialists.

How we carried out this inspection

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

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

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

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostics

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations

included the local Clinical Commissioning Groups, NHS England, NHS Improvement, Health Education England, Healthwatch, various medical Royal Colleges and other stakeholders.

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

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, and allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients,families and staff from ward areas. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

At CHH we inspected medicine, surgery, critical care, end of life care and outpatients and diagnostics. In addition, we carried out unannounced inspections on 9 June and the 11 July 2016.

Facts and data about Castle Hill Hospital

Castle Hill Hospital is one of the main hospital sites for Hull and East Yorkshire Hospitals NHS Trust. The trust operates services from two main hospitals – Hull Royal Infirmary and Castle Hill Hospital – with a minor injuries unit at East Riding of Yorkshire Community Hospital in Beverley and some outpatient services in other locations.

Castle Hill Hospital has cardiac and elective surgical facilities, medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT) and breast surgery facility and outpatients. It has the regional Queen's Centre for Oncology and Haematology. 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 (HRI).

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

The trust had 1,294 beds at the time of the inspection of which: 1,162 were available for general and acute care, 77 for maternity and 40 for critical care. The trust's management structure was based on four Health Groups: Surgery, Medicine, Family and Women's Health and Clinical Support along with the corporate functions.

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

The medical staff skill mix had similar percentages to the England average with 37% being consultants compared with 39% nationally; 5% were middle career compared with 9% nationally; specialist registrars were 40% compared with 38% nationally and junior doctors were at 18% compared with 15% nationally.

The financial data for 2015/16 included:

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

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

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

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

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Medical care (including older people's care)

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

Information about the service

Castle Hill Hospital is part of Hull and East Yorkshire Hospitals NHS Trust. Medical care was provided across two sites in the trust with Castle Hill Hospital providing cardiology, oncology and haematology services. Acute medical services including older people's care was provided at Hull Royal Infirmary.

Between January 2015 and December 2015, there were approximately 65,000 medical episodes of care carried out in this trust with approximately 27,000 at this hospital site. Day cases accounted for 76% of all episodes, emergency admissions 13% and elective admissions 11%.

Medical services were managed within the Medicine Health Group and Clinical Support Health Group. The cardiology department at Castle Hill Hospital was a tertiary referral centre covering a local population of 550,000 with a total catchment area of 1.2 million. The trust provided primary percutaneous coronary intervention (PPCI); this allowed the ambulance crew to transfer a patient straight to the cardiology department when the cardiac monitor readings met a specific criteria. Cardiac procedures were held in the cardiology catheter laboratory and 11 beds were available for overnight stay Monday to Friday. There was also a 12 bedded cardiac monitoring unit (CMU) which managed level 2 patients and two general cardiology wards (wards 26 and 28) with a total of 43 beds. There was also an infectious diseases ward (ward 20) with a total of 19 beds.

Castle Hill Hospital provided inpatient care in the Queen's Centre for Oncology and Haematology building. There were five wards at the Queen's Centre (ward 29 to ward 33) with four of them being dedicated to the care of cancer patients and the other being specifically for rehabilitation. There were 112 beds in total with 99 of them being for cancer patients and 15 for rehabilitation. Wards 30 through to 32 were primarily oncology wards and 33 was primarily the haematology ward; ward 33 also incorporated a high dependency unit. Ward 33 also cared for teenage and young adults between 18 and 24 years of age in a specific area of the ward.

During the inspection we looked at 23 patient records, 25 prescription charts, spoke with 11 patients and relatives, and 31 staff including doctors, nurses, therapists, care support workers, ward managers, matrons, administrative assistants and student nurses. We also attended two multidisciplinary team meetings. We visited all the cardiology areas – ward 26, 28, CMU, cardiac catheter laboratory and 5 day care unit. We also visited ward 29 rehabilitation ward, ward 20 infectious diseases and wards 30, 31 and 33.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. Before the inspection, we reviewed performance information from, and about the trust. We also carried out unannounced inspections on 9 June 2016 and 11 July 2016.

A comprehensive inspection of medicine at Castle Hill Hospital was carried out in February 2014, where safe, responsive and well-led were rated as requires improvement. Areas of improvement were identified that

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the hospital must take action for including: ensuring sufficient numbers of suitably skilled staff were in place across medical wards particularly at nights and weekends. The hospital needed to ensure suitable arrangements for on call and junior doctors to be appropriately supervised and not responsible for multiple pagers across different areas. Both effective and caring domains were rated as good. In April 2015 following a reconfiguration of services and transformation of the acute medical care pathway, wards were moved from Castle Hill Hospital to Hull Royal Infirmary. These services were then followed up within the Hull Royal Infirmary CQC inspection in May 2015.

Summary of findings

In 2014 we rated medical care services as 'Requires improvement' overall, this rating was unchanged in 2016 because:

- Planned nurse and medical staffing levels were not consistently achieved and this impacted on the capacity of the medical wards.
- Systems and processes were not completed consistently such as control checks of fridge temperatures and controlled drugs. Medication administration was not always completed and we observed gaps in medication charts that were not accounted for.
- Audits were not always completed within the timeframe set by the trust when standards were not at acceptable levels. The trust failed to meet the nutrition and hydration standards set by the trust. These were not highlighted as risks on the medicine risk register.
- Some staff did not possess the specialist competencies that were required for specialist wards.
- Patient outcome performance data was variable with some being below the national average, for example the primary percutaneous coronary intervention (PPCI) target was not consistently met.
- We observed nurse and medical leadership on the wards however ward managers were not always allowed to remain supernumerary due to nurse staffing levels.

However:

- The trust had addressed some of the issues raised from the comprehensive inspection in February 2014, for example: the lack of available beds that led to long delays in accessing and treatment, frequent bed moves and the disconnect between the executive team and the wards.
- The majority of patients and relatives felt involved in their care and thought staff were compassionate about the care they provided.
- Staff felt proud of the care they delivered and enjoyed working at the hospital.
- We observed patient centred multidisciplinary team working.

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Are medical care services safe?

Requires improvement

In 2014 we rated safe as 'requires improvement'. In 2016 this rating was unchanged because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example there were still staff shortages within nursing and medical staff.
- Some audits for specific wards remained below the trust standards for infection control.
- Systems and processes were not completed appropriately such as control checks of fridge temperatures and controlled drugs.
- There were gaps in medication administration and no review of competency for registered nurses administering medication.

However we also found:

- Staff understood their responsibility in reporting incidents and were encouraged to complete these.
- When errors occurred, the trust reviewed the process and lessons learnt were implemented.
- Staff understood their role and responsibility in safeguarding children and adults.

Incidents

- There were no never events reported in medical services between May 2015 and April 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Between April 2015 and April 2016, there were 5180 incidents reported for the Medicine Health Group across the trust. The Medicine Health Group included emergency medicine, general medicine, elderly medicine and specialist medicine divisions. The majority of these incidents resulted in no harm or low harm however, 78 caused moderate harm, 18 caused severe harm and four resulted in patient death.
- There were 27 serious incidents reported for medicine between May 2015 and April 2016. Serious incidents are incidents that require further investigation and reporting. The most prevalent incident types were slips, trips and falls (nine), pressure ulcers (seven) and sub-optimal care of the deteriorating patient (six).
- There had been two serious investigations into the care of patients receiving PPCI where patients were diverted to the emergency department at Hull Royal Infirmary due to inconsistencies regarding the patient's ECG readings and then back to cardiology at Castle Hill Hospital. As a result of the second incident the referral form was being redesigned by the trust to ensure the same consistency was maintained.
- Serious incidents were all investigated. We looked at examples of incidents, which had been investigated and found that staff had completed a thorough root cause analysis and action plans completed. The trust held meetings to review the serious incidents reports.
- Mortality and Morbidity meetings were held monthly. We saw minutes of the renal department mortality and morbidity meetings, which showed discussion of each case with learning points and actions identified to prevent reoccurrence.
- The trust produced a monthly lessons learnt bulletin, staff positively commented on this during the inspection and this was provided to all staff. The lessons learned newsletter was circulated electronically every month and was available on the intranet for sharing with the ward teams.
- Staff understood how to report incidents using the electronic reporting system and identified a positive incident reporting culture. However, they told us that they would not routinely report short staffing concerns as this was highlighted within the daily safety brief completed by the trust.
- Most staff received feedback about incidents and gave us examples of incidents and changes that had occurred as a result.
- We observed information displayed on ward 26 following a recent drug incident surrounding venous thromboembolism prophylaxis dose. As a result of the incident, staff now double checked the dosage.
- Incidents were investigated at a ward level and fed back to staff individually and at ward meetings. However we

did hear how incidents were not generally shared between wards and team meetings were not always regular. Therefore learning may not have been provided to staff early.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke with understood the principles of the duty of candour however more junior members of staff were not knowledgeable.
- The incident reporting system had a mandatory field for duty of candour. We reviewed a root cause analysis following a serious incident which resulted in patient harm and saw that staff had followed the policy correctly.
- The trust had a 'Being Open when Patients are Harmed Policy' which set out the process for duty of candour. We observed the policy and flow chart displayed in ward areas.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), catheter and urinary tract infections (CUTIs). Between March 2015 and March 2016, staff reported 50 pressure ulcers, 22 falls with harm and 20 CUTIs in medical services across both hospital sites.
- Patient safety thermometer data showed that between March 2015 and October 2015 there was an upward trend in the prevalence of new pressure ulcers reported. There was then a downward trend in prevalence from January 2016 to March 2016. There was also a downward trend in the prevalence of falls from April 2015 to March 2016. The prevalence of urinary tract infections in patients with a catheter fell in April 2015 and May 2015, since then the rate has been fairly stable. Overall this showed an improving picture for harm free care.
- On inspection we observed safety thermometer information displayed. On ward 31 it was confirmed in May 2016 the ward had provided 100% harm free care.

Cleanliness, infection control and hygiene

- We observed a patient undergoing a coronary angiograph. This is an invasive procedure involving insertion of instruments in to the patient's blood stream; it is a procedure carried out under sterile conditions. The 'scrub' team consisted of the medical consultant and healthcare practitioner; both of whom wore a sterile single patient use surgical scrub gown and sterile gloves.
- During the inspection one staff member highlighted to a colleague that they were not adhering to the correct infection control standards and requested that they re-scrub and put on a fresh sterile gown and gloves.
- The trust aimed to undertake monthly hand hygiene audits. We reviewed hand hygiene audits from April 2016 to June 2016.Ward 26 submitted that in April 2016, 76 hand hygiene observations were recorded with 100% compliance. No other data was submitted for the remaining two months. Other cardiology wards did not submit any data. The trust highlighted that there was a reduced compliance regarding the completion of audits. As a solution from July 2016 an alternative audit tool will be implemented across all the clinical areas.
- During our inspection we saw ward cleanliness audit findings on ward 26 which showed 95% and 99.3% compliance for May 2016.
- We observed staff using appropriate personal protective equipment when completing clinical tasks. Staff complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- Hand washing facilities were available at the front of all ward areas and signage to remind people the importance of handwashing. Handwashing basins and hand wash gel were available at various locations throughout the wards.
- On ward 33, the results from an infection control audit showed they had not been meeting infection control standards and were in a red category of less than 80% compliance. They did not meet the criteria in eight areas which included 85% compliance in hand hygiene training and commodes were visibly clean and identified as clean with tape in place. At this level the ward required to be re-audited within three months; the ward was re-audited and the standards had improved to a good category of 89 – 94.9% compliance.
- On ward 30 there were nine areas where the standard was not met such as information was not cascaded from

the infection control link practitioner to the ward staff, waste was not managed and segregated appropriately and infection control risk assessments were not carried out on admission and documented.
- Information submitted by the trust identified that wards 28 and 32 met all the criteria of the infection control standard.
- Each ward had an infection control link practitioner, part of their role was to cascade information to the nurse in charge and team. Evidence was presented that this occurred on four out of five wards areas.
- We observed clinical waste and domestic waste were appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- We saw patients were nursed in side rooms or allocated bays. Some patients were nursed in isolation following infection control procedures to ensure cross infection was eliminated; this included the appropriate use of personal protective equipment (PPE). Some patients were receiving chemotherapy and appropriate infection control measures were in place. We observed staff using PPE, washing their hands or using hand gels when entering and leaving side rooms and allocated bays.
- Equipment was identified as being clean by using the cleaning assurance stickers.
- Patients were cohorted on ward 20a with positive Clostridium difficile infection; this practice was to discontinue in July 2016 and patients would be managed on their individual wards. A patient management pathway was in place that staff were aware of. Review meeting were held daily and weekly to discuss all patients with the infection.
- Staff completed infection prevention and control training as part of their mandatory training programme; the overall compliance was 73% which was below the trust's target of 85%. Although some individual staff groups received 90% or above such as medical staff in infectious diseases, the lowest compliance was estates and ancillary with 42.9%.

Environment and equipment

- Most of the wards were in spacious, new buildings specifically designed for specialist services although ward 20 was in an old block building surrounded by empty ward areas. The environment surrounding ward 20 was old fashioned however there were plans to move out of there soon so no further adaptations were being completed. Medical staff commented that ward 20 was geographically far away from all the other wards and this took time for medical teams to reach a deteriorating patient.
- Wards had identified areas to keep equipment such as mattresses, hoists and ward areas appeared clean and well maintained. Bed areas were spacious and in some areas, four bedded areas allowed for six cubicle spaces although only four were ever used. Many of the wards had day rooms and other rooms for patients to use.
- The cardiology unit was around seven years old; the environment was in a good state of repair and a suitable layout.
- The unit had recently purchased two new echocardiograph machines and the third existing machine was functioning well; service contracts were in place with the manufacturer.
- The unit had two cardiac analyser machines which were due for renewal; a business case had been submitted for two new cardiac analyser machines.
- Resuscitation equipment was available on all of the wards; records indicated that these were checked on a daily basis and ready for use.
- Equipment was checked and had been serviced correctly and dates recorded. Ward 33 has a transplant bay of five cubicles; these were all hepafiltered, serviced annually and monitored as part of maintenance schedule.

Medicines

- All patients had a drug administration record. Within the record it allowed for the prescriber to identify the patient's allergies and VTE assessment. There was also a record of any omitted medication and a numbered scale to identify the reason why the medication was omitted.
- We checked drug administration records on 25 patients; on ten occasions we saw that medication was not signed for by a registered nurse or any indication to why it may not have been given. One of these was a low molecular weight heparin, which can be used for prophylaxis or treatment of deep vein thrombosis or pulmonary embolism. We asked if the medication had been administered, but staff could not confirm if the medication had been given; the patient was also unable to confirm. This meant we could not be assured that patients were receiving all the medications they needed.

- We observed that allergies were recorded and VTE assessments were completed. Some staff identified that the VTE assessment needed to be completed online also, therefore staff were duplicating the information. All the records were legible, signed and dated, on one occasion a new drug dosage had been written over the original dose rather than rewriting the medication.
- We also observed a chemotherapy prescription chart completed in full and in accordance with local policy.
- We saw antibiotics had been prescribed as per trust guidelines in the prescription charts we reviewed. Start dates were recorded and the rationale for why antibiotics needed was recorded.
- We observed two medication rounds. One staff member was interrupted during the medication round by another staff member. The appropriate patient checks were completed, however during one of the observations the staff member signed for the administration prior to giving the patient the medication. The staff member stated this was their common practice. We raised this with the trust and the ward manager; we visited the ward the next day and the ward manager advised us appropriate steps had been taken. There was no mechanism in place to review the competency of registered nurses administering medication.
- We observed the checking of a controlled drug and insulin dose with two staff members in line with trust policy.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked cabinets. Expiry dates were checked and the stock was rotated appropriately.
- Controlled drugs were appropriately stored with access restricted to authorised staff.
- We found that daily checks for controlled drug medication were not always completed. On ward 32 there were 71 occasions since January 2016 where the check had not been completed including one gap of seven consecutive days; this was not in line with trust policy and meant that robust safety checks were not in place. When the check had not been completed it normally stated it was 'not checked due to ward demands'.
- In documents provided by the trust, concerns had been raised in January 2016 at the Safe Medication Practice Committee. This highlighted that staff were not following the procedure to complete controlled drug books and it was agreed to complete an audit. An audit was completed over a three month period from October 2015; ward 20 had compliance of 100% for October and November 2015, 93% for December. Ward 32 had compliance of 61% in October 2015, 50% in November 2015 and 45% in December. Further monthly audits were carried out; wards 29 and 30 completed checks 100% in months February 2016 to June 2016. Ward 32 remained the lowest ward to complete the checks with 45% in March 2016, this steadily increased over the months with 80% in June 2016.
- We checked the fridge temperature records on four of the wards and found there were gaps in the daily recording of the fridge temperature records; this was not in line with the trust policy. On one ward the fridge temperature was recorded out of range consecutively for 13 days in a row and there was no evidence of escalation. We discussed this with the ward staff who took steps to address it. This meant that drugs may not have been stored at the correct temperature required.
- One of the medication fridges on ward 30 was for chemotherapy drugs; this was faulty and not in use. This had been reported several times. The chemotherapy drugs were stored in the other medication fridge appropriately.
- We found on some wards detailed flowchart instructions of what to do in the event of out of range temperature readings.
- We found the appropriate risk assessment and patient agreement had been completed for patients who were self-medicating.
- A lessons learnt approach was taken with drug errors, incidents were reported, investigated and a staff completed a piece of written reflection. On ward 30, a monthly audit of medication cards was completed by the staff.
- An audit was undertaken of the administration of daltaparin following the administration of an injection to the wrong patient. The audit was completed over an eight week period from November 2015 which included four patients on wards at Castle Hill Hospital. At each intervention the nurse was assessed as administering the correct medication and adhering to the appropriate personal protective equipment (PPE).
- National Institute of Clinical Excellence (NICE) guidance recommends in an acute setting, medicines reconciliation should be carried out within 24 hours. The trust submitted a trust wide medicines reconciliation

audit for three months from April 2016. In April 2016, 66% of medicines were reconciled within 24 hours, this increased to 77% and 76% on consecutive months. The trust target was 80% compliance; this was not met for the three months.

Records

- Care plans were spilt into care bundles which related to certain risks such as nutrition, skin care, falls care bundle which included bed rail assessment and moving and handling assessment. The care bundles were generic assessments with an area for individualised care to be added for each patient. We observed that individual care planning was completed.
- Intentional rounding was in place for each patient. This was a document where staff completed regular checks with patients at set intervals carrying out scheduled tasks or observations such as pain, positioning, comfort, checking call bells and drinks were within reach. We saw that these were used and appropriately completed.
- The majority of medical and nursing notes were paper records and were stored securely on the ward. Each ward also used a patient electronic board which also had patient information stored.
- We reviewed 23 sets of patient records, which represented a sample of the services we visited. Most of the records we reviewed were completed appropriately in line with professional standards, with relevant risk assessments and descriptions of staff interaction with the patient.
- Nutritional assessments were partly completed on the patient records that we observed. The trust used a validated nutritional screening tool on the wards to identify adults who were malnourished. The daily food chart identified how much food had been consumed at each mealtime, and a rag rating was given to the amount of food eaten. For example, if none or only a quarter of the meal was eaten, a red indicator was given or if the whole meal was eaten a green indicator was given. The totals were to be added up to identify the overall malnutrition risk to the patient and if a referral to a dietitian was needed. We observed that this part of the food chart was not always completed to identify the malnutrition risk to the patient. Three records had not been fully completed, these included food chart scores that were not always completed. One of these patients had been identified at a high risk for nutritional intake, but the risk was not completed for three days.
- On ward 30 staff had highlighted improvements were needed and were working towards improving the documentation. A quality assurance audit was completed every month; in June 2016 this highlighted issues with skin integrity assessments that staff were working on. Staff had been involved in the process to ensure record keeping was understood and improvements developed.
- Staff completed information governance training, with an overall compliance of 85%. Most staff groups within the medical care services achieved over the trust target of 85% with some achieving 100%. The lowest compliance was for medical staff in infectious diseases who achieved 64%.

Safeguarding

- The trust had policies and procedures for safeguarding children and adults at risk. Both polices were in date and required to be reviewed in December 2016. This included guidance on local safeguarding pathways and contact details. Staff were aware how to access these on the intranet.
- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- Patients with safeguarding concerns were documented as part of the trust daily safety brief based at Hull Royal Infirmary. We attended one of the daily safety brief meetings whilst on inspection and this confirmed that staff from Castle Hill Hospital contributed and were part of the safety brief.
- Staff completed safeguarding children and vulnerable adult training which both exceeded the trust target of 85%. Most staff groups within the medical care services achieved over the trust target with some reaching 100%. The lowest compliance was for medical staff in cardiology who achieved 73%.

Mandatory training

- The trusts mandatory training programme included infection control, fire safety, information governance, resuscitation, moving and handling training, major incident training, safeguarding children, vulnerable adults, mental capacity act and safety training. The trust target for mandatory training was above 85%.
- Most staff groups within medicine fell below the trust target of 85% for resuscitation; these included healthcare assistants, medical staff and nursing staff

from most wards areas. The lowest compliance was healthcare assistants and other support staff in cardiology at 37.5%. Healthcare assistants and other support staff on ward 20 were the only area to obtain 100% compliance.

- Overall compliance was below the 85% target for conflict resolution and fire safety although for some individual groups compliance was improved. For example, the healthcare assistants and other support staff groups in cardiology and infectious diseases compliance was 100% for conflict resolution and fire safety.
- Other mandatory training met the 85% target such as moving and handling, safety, and major incident training.
- Training was either completed face to face training or online for certain subjects.
- Some staff commented that training was not often cancelled; bank staff worked on the ward to allow permanent staff to attend training.
- Training was reviewed every month and staff were aware it was their own responsibility to book on training courses. During the inspection, training on ward 30 was at 83% compliance which was much improved for the ward, although this was just under the trust's target of 85%.

Assessing and responding to patient risk

- The catheter laboratory unit used the WHO checklist. We observed a patient being checked by staff before entering the procedure room; this included, but was not limited to, checking the procedure, site, allergies and consent. Other appropriate checks were conducted with the patient and the staff team within the procedure room.
- During our observations of the coronary angiography, we noted that surgical swabs, sutures, hypodermic needles and a surgical blade were used during the procedure. We noted that these items were not 'counted out' between two members of staff before, during and after the procedure. We also noted that a 'sticky' surgical pad was not used during the procedure to prevent sharps from accidently being moved and/or lost during procedures. At the end of the procedure, some swabs remained on the surgical trolley which were placed in to a bin and some swabs remained on the sterile sheet on top of the patient; these were collected up along with the sterile sheet and but in the bin together.
- The critical care outreach team covered both hospital sites, providing care 24 hours a day seven days a week. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them through the National Early Warning Score (NEWS) referral system. The team supported patients nursed on wards with tracheostomies and delivered Non-invasive Ventilation (NIV) outside of critical care.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care. Medical areas used a paper system to record the score.
- The trust submitted audit data for three months from April to June 2016 which measured NEWS compliance. It measured whether the patients NEWS had been calculated correctly and whether appropriate action been taken. Twenty patients per month were audited. The audit showed 100% compliance for most areas, although some wards did not submit any data for some months. In April 2016, on ward 33 the audit showed only 25% had appropriate action taken and documented response to the NEWS score. This had increased to an average of 97% for May and June 2016.
- Staff on ward 33 ward had completed simulated NEWS training following an incident where a NEWS score was not escalated appropriately. Staff thought the training was valuable and this had improved the understanding of the policy and escalation.
- We observed on one patient a NEWS score of seven was escalated and actioned appropriately.
- One patient's care plan identified that the patient was refusing their medication at times; this had been appropriately recorded on the drug administration record. However, the issue was not escalated to medical staff in line with the policy.
- All patient falls were reported and investigated. The trust Falls Committee held monthly meetings and was attended by a Medicine Health Group representative, multi-disciplinary team (MDT), risk and safety representative, consultant in elderly care and the director of nursing. Staff could identify some of the reasons why patients had fallen, for example one patient was advised not to mobilise independently, however the patient mobilised without supervision and fell. This was reported and appropriately documented.

- One patient was identified on the falls care bundle as requiring assistance; this should have triggered a multi-factorial assessment to be completed; however on this patient it was not completed.
- Wards had access to pressure pads, alarms and high risk patients were moved to more visible areas.
- There was no falls team at Castle Hill Hospital and when one to one supervision had to be provided this was provided by the ward staff. Staff involved family and provided one to one nursing when needed. It was highlighted on the trust's risk register regarding the unavailability of staff at short notice to provide one to one care. Security staff could be used for exceptional covering or if patients were wandering into other patient areas.
- An e-learning package had been developed on falls prevention.

Nursing staffing

- The trust used the Safer Nursing Care tool to determine patient acuity. This was translated to the safety brief giving the number of patients and their acuity. The trust aimed for staffing ratios of 1:8 on general medical wards and 1:2 on CMU; however, this was reviewed on a twice daily basis at the safety brief in line with acuity. This enabled the organisation to respond to areas and provide additional staff where needed.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the trust's risk register. A monthly nursing and midwifery staffing report was collated for the trust board identifying key risks for specific wards. Controls put in place by the trust to reduce the risk included a clear escalation process and discussion at the safety brief meetings, use of bank and agency staff, staff deployment from other clinical areas and projects focusing on recruitment, mentorship and retention of staff. The trust was working with the local university in securing permanent positions for newly qualified staff. In September 2016, 74 nurses were due to commence employment with the trust.
- Staff shortages were evident across the majority of wards and the trust's safer staffing levels were not met. On six of the wards, during our inspection, none met the actual planned level of registered nurses or health care staff; these included specialist areas such as oncology, haematology, rehabilitation, neurology and cardiology. Staff were aware how to escalate their concerns regarding staffing.
- We reviewed staff fill rates for the trust and these were not always met. In March 2016 on ward 33 the average fill rate for registered nurses was 57% alongside 78% for healthcare staff. These figures were the same for April 2016 and May 2016. The ward had been below the staff fill rate target of 80% since April 2015. The figure had improved to 80% fill rate for June 2016.
- On ward 33 there were 5.5 whole time equivalent (WTE) vacancies for registered nurses. Ward 32 had provided the ward with an extra registered nurse for a six month period. The vacancies had been filled with student nurses that completed their course in September 2016. The ward also had 2.4 WTE vacancies for health care staff. Bank staff were used to cover vacancies and occasionally agency staff were used. However, due to the complexity of the patients on the ward skill mix was not always maintained. Staff were required to look after patients requiring chemotherapy and transplant-related needs, therefore specific skills were required. The ward manager was expected to work in the planned numbers of staff more than the allocated allowance due to the staff shortages. This was confirmed in the safe staffing report where the supervisory charge nurse capacity was below 19% for 10 months with the exception of 2 months where the capacity was 35% and 42% in August 2015 and May 2016.
- We reviewed the nurse staffing on ward 29 from 1 April 2016 to 9 June 2016. The number of registered nurses on a day shift was under the planned number 59 days out of 70.
- We reviewed the nurse staffing on ward 28 and CMU; the electronic off duty identified which shifts remained uncovered to meet the planned staffing numbers required. We looked at a period of two weeks and on all three shift patterns; early, late and nights at least one shift was not covered. Many vacancies had been filled with student nurses, for example we were informed on four wards that vacancies had been filled with student nurses that were due to qualify until September 2016.
- Information submitted by the trust showed the Medicine Health Group had 42.3 whole-time equivalent (WTE) nursing vacancies from their 772.69 WTE establishment.

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- Board reports from January 2016 to March 2016 identified that staff turnover was high on wards 28, 30, 31, 33.
- The Medicine Health Group used bank and agency staff to improve staffing levels. Information submitted by the trust showed the usage ranged between 12.2% and 0.2% for registered nurses. Ward 29 used the most bank and agency; the highest month was June 2015 at 12.2% this reduced slightly in other months and fluctuated, raising to 7.9% in March 2016.
- The service lead for echocardiography described how the numbers of newly qualified echocardiographers was limited; this made recruiting new staff challenging.
- Wards worked well and supported each other with staffing although at times it was difficult to move staff due to the actual planned levels of all the wards.
- Planned hours for Allied Health Professional (AHPs) staff in March 2016 for the Medicine Health Group, were 842.0. However the actual hours completed were 504.5 leaving a deficit of 337.5 hours. Planned hours for unqualified staff was met at 280 hours.
- Within the cardiology catheter laboratory one staff member was due to leave their post and the vacancy had already been filled.
- Staff on the wards often completed extra shifts to reach the required levels and ward managers commented how well their staff were at covering the extra shifts. Often the same bank staff were used to provide continuity to the patients and bank staff.
- Some wards had over recruited to non-registered staff to compensate for registered nurse shortfalls. However not all the medical wards at Castle Hill Hospital had discharge facilitators or ward hygienists. Staff, where the extra staff had been employed, felt positive about the roles.
- We observed a nursing handover where clear information was provided and plans were made for discharge. Staff completed and updated an electronic handover sheet. Staff felt the handover was beneficial for receiving up to date information. Wards had implemented a pre-recorded handover between the day and night staff to ensure maximum staff numbers remained on the ward during shift transition. This was followed up by a bedside summary.

Medical staffing

- The medical staffing for the Health Group was made up of 28% consultants, 5% middle grade, 39% registrars and 28% junior doctors. The percentage of consultants was lower than the England average and the percentage of junior doctors was lower than the England average. The proportion of middle grade doctors and registrars was about the same as the England average.
- We examined the medical staff rota and talked with consultants and junior doctors. There were two junior doctor vacancies in cardiology. Bank and locum staff had only been used in August 2015 and March 2016 which covered 2.3% of the total bill spent. Staff confirmed that minimal locums had been used and they felt overstretched and stressed in the work they were expected to complete. Junior doctors felt supported by the medical team and felt that staff were experienced to provide assistance.
- In minutes provided by the trust, one of the main financial pressures was the amount spent on agency junior doctors on ward 29. Bank and agency money were used every month for the neurology speciality, for example, the highest bank and agency use was 34.1% in the month of June 2015. The amount fluctuated over several months and more recently in March 2016 the usage was 7.2%.
- All staff completed an induction including locum staff.
- There was consultant cover during the day from 9am to 5pm. Staff commented that consultants would sometimes come in on weekends to complete a ward round. There was cover for the rapid access chest pain and consultants covered on call for the PPCI.
- The trust had highlighted on the risk register the lack of senior medical cover on ward 29 where at times there was no senior input into patient care. This was caused by a consultant working single handedly with no clear cover in place from the trust. In addition patients were not being seen by a senior member of the medical team on a daily basis as the trust expected. Controls had been put in place to minimise patient harm, these included referral to RMO3 doctor when senior medical input required and review by neurology consultant.
- Staff commented that they felt medical staffing on call was not effective; one example given was in January 2016 where a junior doctor was carrying three bleep monitors to manage. This was reported as an incident. At weekends, the junior doctors and middle grades managed the majority of hours.
- Medical staff sickness was low with the highest percentage at 1.5% in August 2015.

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Major incident awareness and training

- The trust had a major incident and business continuity plan. Policies were also accessible for winter plan, escalation plan, severe weather and pandemic flu.
- Staff explained how to access the major incident and continuity plans on the intranet and an awareness of their role.

Are medical care services effective?

Requires improvement

In 2014 we rated effective as 'Good'. In 2016 we identified concerns which meant the service was rated 'Requires improvement' because:

- The trust's own ward-based '3G' audits were not always acted upon and completed in the timeframes agreed.
- Some staff did not possess specialist competencies required for the medical ward they were on.
- Patient outcome performance data was variable with some being below the national average, for example the primary percutaneous coronary intervention (PPCI) target was not consistently met.

However we also found:

- Patient's pain control was managed effectively.
- Multidisciplinary teams worked together to understand and meet patient's needs.

Evidence-based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. The trust followed NICE guidelines for patients with spinal cord compression.
- Staff demonstrated an awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward. We reviewed clinical guidelines on the intranet. Of the three that we reviewed, all had an identified author/ owner and all had review dates.
- The trust had an ongoing monthly audit programme for safe care, which included tissue viability, fluids and nutrition, observations and documentation. The results of these audits were combined in the Safe Care Summary Report.
- The pharmacy team completed audits on the wards looking at compliance with fridge monitoring, 24 hours controlled drug checks and resus trolley checks to ensure patient safety was maintained.
- The trust participated in national audits such as percutaneous coronary interventional procedures, heart failure, myocardial ischaemia national audit project and COPD audit.
- We asked staff in the cardiology laboratory about national bodies that provided best guidance for cardiology practice and whether benchmarking audits had been conducted against national standards; there was lack of certainty around this. The service manager mentioned three national bodies, but audit information was limited. The three bodies mentioned were the British Heart Rhythm Society, British Cardiovascular Society and The Registration Council for Clinical Physiologists.

Pain relief

- We observed staff respond to patient's pain requests promptly and effectively and patients commented their pain was managed well.
- Nursing staff used and documented an evidence based pain score to assess patient's needs. We saw from patients care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- On reviewing 25 prescription charts, 23 patients were prescribed pain relief on the 'as needed' part of the prescription chart. This allowed the patient to receive medication for pain relief quickly to alleviate their symptoms.

Nutrition and hydration

- We observed a patient menu folder that was for each patient. Staff commented that they had seen an improvement in patients selecting foods rather than the usual menus.
- Staff had completed training to support patients who had difficulty in swallowing. The dietitian and speech and language team provided assistance when needed.
- Protected meal times were in place. We observed a meal time and saw that patients were encouraged to sit in the dining area for their meals. Drinks were provided at meal times and between meals; we observed that drinks were placed within patients' reach.

- Assistance was offered to patients during mealtimes. Patients who were known to require assistance with meals were identified at nurse handover. A nutrition board was observed in one office with information about patients with special dietary requirements and comments regarding assistance needed.
- A breakfast club was in place on ward 26 for all patients, assisted by therapists and nursing staff.
- Staff on ward 29 told us about 'take 5' which was an initiative which staff undertook in regards to malnutrition. This included screening and weighing patients twice weekly, including a more specific assessment for patients that had been identified as a moderate or high malnutrition risk. A new nutrition section had been included on the patient discharge letter which highlighted their nutritional care whilst on the ward.
- Two wards did not meet the 3G audit for the nutrition and hydration standard set by the trust. We asked the trust to submit the last two nutritional audits. Ward 28 received 78% in the nutrition audit which the trust had rated as an inadequate scoring. For ward 33, in June 2015, the ward did not meet the required standard for nutrition and hydration with 47% and an inadequate rating. We were informed on inspection that the dietitian came to work with staff to improve the score. The audit was reviewed next in December 2015, where the score increased to 57% and remained an inadequate score. The same actions were not being met in both audits, such as food charts not totalled and necessary action taken and the patients weight was not monitored appropriately to their nutritional risk. This means we could not be assured that patients received adequate monitoring.
- The trust identified that audits should be reviewed in three months when a ward received an inadequate rating. The nutritional audits for ward 33 were not reviewed within this time period.

Patient outcomes

- PPCI is a surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart. The performance for PPCI identified the percentage of patients that receive PPCI from the patient's initial phone call for help to the procedure within 150 minutes; the target is 90%. From April 2015 to April 2016 the standard was not met for six months with the lowest being 84.8% in September 2015. Four months were consecutively below 90% from December 2015 to March 2016. It was recognised that the trust was working closely with other organisations and actions were in place in regards to the PPCI target.
- In the National Diabetes Inpatient Audit 2015, the trust was in the upper England quartile for eight of the 18 indicators. However, the trust was in the lower England quartile for prescription errors (31.4%) and although between the upper and lower quartiles for medication errors, it was still worse than the England median.
- For the period January 2015 to December 2015 the average length of stay for this hospital was shorter than England for elective care. However, data showed it was longer for clinical oncology and clinical haematology. For non-elective care, the average length of stay was longer than the England average, particularly in medical and clinical oncology.
- In the National Audit of Percutaneous Coronary Interventions the trust performed well in the audit, better than the national average for two out of three indicators.
- Castle Hill Hospital performed well in the Heart Failure Audit 2013/14. The hospital scored better than the England average for all the in-hospital care indicators. It also performed better than or the same as the England average for all but one of the seven discharge indicators.
- We saw that when performance was below the standard required in national audits, an action plan was formed and documented.
- From December 2014 to November 2015, risk of readmission at this hospital was higher than expected for elective clinical haematology and non-elective cardiology.

Competent staff

- Overall compliance with appraisals for the Medicine Health Group (across sites) for 2015 to 2016 was 79.9%. This had improved over the past two years where compliance had been 68.7% and 74.9%. Staff on two wards confirmed they had received an appraisal and the ward managers identified that 100% of appraisals had been completed. One staff member identified within their appraisal that they required more support with information technology and they had completed a computer course.

Medical care (including older people's care)

- Preceptorship packages for new members of staff were in place and they were allocated an amount of supernumerary time in order to progress with competencies.
- Nursing staff were required to complete further competencies packages for specialised skills and were assessed to identify competency levels. On ward 33, only 35% have completed the extended skills competencies. This was highlighted within the Medicine Health Group's risk register where controls were added to reduce the risk to patients; such as limiting patient numbers, offering overtime and the use of bank staff for non-specialised care.
- An intrathecal competency register was available and observed on the ward wall. Staff completed competency updates annually.
- Staff felt the specialist registrars offered training and support and the trust had a good focus on training. The senior medical team offered structured teaching sessions to junior doctors which had been effective. They were due to roll out training to other medical grades.
- Junior medical staff commented that training was excellent. A junior doctor commented how their request to fully experience the stroke pathway was supported by gaining experience during the rotation to experience patient flow from acute care through to rehabilitation.
- Therapists had developed competencies for ward based rehabilitation staff of all grades to support patient care.
- Wards provided placements for student nurses.

Multidisciplinary working

- We saw good examples of multidisciplinary team (MDT) working during our inspection. All wards carried out daily board rounds and weekly multidisciplinary meetings. We saw examples of staff interacting, both formally and informally, to discuss patient's care between teams and seek advice from colleagues. Therapist had an individualised activity plan for each patient which fed into the MDT meeting.
- Staff spoke positively about close MDT working and felt they had good working relationships.
- We observed a MDT meeting on ward 29 where all staff contributed equally and discussed the ongoing care of patients. Staff talked about how to transfer and mobilise patients, precautions to take and equipment to use. Also discussion around discharge planning and care packages was observed. We also observed a board round on ward 30 and 33 where all staff attended and provided an overview of the patient's care.
- Goal setting meetings were in place for patients on one ward within two weeks of admission and then according to individual progress.
- Staff had access to specialist services in order to provide care to patients. We were informed that ward 31 had forged strong links and partnerships with specialist MacMillan colleagues to support patient transition into the community.

Seven-day services

- Further work on the acute medical pathways is underway as part of the Urgent and Emergency Care Programme. In addition, changes had been made to junior medical rotas to increase doctor presence at weekends and overnight.
- Physiotherapy teams offered a seven day service across the wards; four physiotherapists were available at the weekend plus an on call service out of hours.
- Nurse practitioners worked out of hours and helped support staff on the wards.
- Consultant cover was provided via on call for the wards from 9 am to 9 pm.
- Pharmacy staff were available seven days a week including bank holidays. The on call pharmacist could be called outside opening hours for any urgent emergency items or advice. Clinical Pharmacy services were provided to the vast majority of wards throughout Monday to Friday with a selected service to key admission areas at a weekend.
- Imagining services were available on the site Monday to Saturday plus on call the rest of the time for urgent and emergency work.
- The cardiac catheter laboratory was open Monday to Friday plus on call the rest of the time for urgent and emergency care needs.

Access to information

- The trust used the same electronic patient board on each ward. This allowed for up to date information to be stored and informed the nursing handover record for staff. Staff could complete electronic referrals and record the pathways patients were on. The trust used three IT systems, some staff found this inefficient and slow to work at times.

Medical care (including older people's care)

- By using the trust's intranet, staff had access to relevant guidance and policies. Staff we spoke with were aware of how to access policies and were advised to look on the intranet for the latest version. All staff had access to an email account and could access the intranet from home through a secure system.
- Staff were able to access blood results and x-rays using electronic results services.
- Medical and nursing records were accessible on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated an understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Some staff were more confident with the process as they worked in areas where more patients were admitted that required a DoLs in place.
- The DoLs protocol was on display on some of the wards.
- We looked at the paperwork for a patient with a DoLS in place; this was appropriately completed and reviewed.
- We observed staff obtaining verbal consent and giving an explanation prior to completing a procedure. Patients we spoke with also said that staff asked for consent prior to delivering care.
- The electronic computer system identified any patient that had a DoLS in place.
- We reviewed two sets of patient's notes whilst in the cardiac catheter laboratory. In both cases, consent for the procedure did not follow the trust policy on two stage consent. On one patient's consent form, the patient had signed for the procedure on the day; there was no signature prior to the day of surgery. On the second patient's consent form, there was the patients' signature from the pre-assessment clinic but no signature on the day of the procedure. The second patient did have a copy of their consent provided.
- Staff completed mental capacity act training with an overall compliance of 88%. Most staff groups within the medical care services achieved over the trust target with some reaching 100%. The lowest compliance was for medical staff in cardiology who achieved 73%.
- Staff completed DoLS training with an overall compliance of 87%. Most staff groups within the medical care services achieved over the trust target with one area reaching 100%. One of the lowest compliances was medical staff in cardiology who achieved 76%.

Are medical care services caring?

Good

In 2014 we rated caring as 'good'. This remained as 'Good' in 2016 because:

- Feedback from patients and relatives was positive.
- Staff maintained patients' privacy and dignity when providing care.
- Patients and relatives told us that staff kept them informed of their treatment and progress and involved them in decision making.
- Staff were proud of the care they delivered to patients on their wards and enjoyed working there.
- Patients and families told us that they received compassionate care and that staff went above and beyond to provide individual care.

Compassionate care

- The Friends and Family Test response rate for this hospital was higher than the England average from March 2015 to April 2016. There were good test results across all wards, these included some months where 100% of families and friends would recommend the medical ward they had received care. The lowest month was July 2015 on ward 31 where 83.3% would recommend the care they received.
- We observed that most wards displayed the most recent Friends and Family Test information as well as cards and letters received from patients.
- All patients and relatives spoke positively of the care they received. Patients described staff as being very helpful and supportive of their needs.
- We observed staff interacting with patients on the wards in a caring and compassionate manner. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We observed that staff respected the privacy and dignity of patients. Staff were sensitive in the way they discussed aspects of the patient's care with them.
- We visited CMU that could be a mixed gender bay area in line with Department of Health guidance due to the level of patient care that was required. Patients were

asked on admission their preference and moved to a single cubicle where requested and appropriate. At the time of inspection there was no mixed sex accommodation within CMU.
- We checked eight patient bed areas on one ward and all the patients had access to nurse call system and drinks.

Understanding and involvement of patients and those close to them

- Patients commented that they felt involved in their care and described being included in the decision making about treatments they received.
- Rehabilitation goals were discussed and agreed with patients and their families at goal setting meetings. We saw evidence in the records where patients and their relatives had been involved in the decision making about their care and treatment.
- In one of the ward areas the day room was decorated with banners and football memorabilia for a long stay patient who was an avid football supporter.
- Patients were encouraged to bring in personal belongings to make the patient feel more comfortable. We viewed some of the rooms and observed personal pictures and belongings.
- We observed staff involving patients in their care in a way they could understand.

Emotional support

- We observed staff interacting with patients and relatives in a supportive and reassuring manner.
- We heard good examples of staff providing additional emotional support to patients. For example, one staff member went shopping with a patient to buy clothes and a wig to allow the patient to attend the wedding. The staff member also agreed to take the patient to the wedding.
- On one of the wards, staff told us that they served meals in the dining area to support social interaction and prevent isolation however staff respected the individual choice of the patient of where to eat their meal.

Are medical care services responsive?

Good

In 2014 we rated responsive as 'Requires improvement'. In 2016 this has improved and was rated as 'Good' because:

- People knew how to raise concerns and the process to follow.
- Services were planned in a way to meet the needs of the local population.
- Patients' individual needs were met such as interpreters and support for people with disabilities.

However we also found:

- A local improvement plan was in place and, at the time of inspection, targets were being achieved to meet the 18 week referral to treatment indicator.

Service planning and delivery to meet the needs of local people

- The trust worked closely with local Clinical Commissioning Groups (CCGs), stakeholders, patients and staff to plan and deliver services to meet the needs of local people.
- The teenage and young adult's area was designed with facilities for patients of that age and supported by the Teenage Cancer Trust.
- The Queen's Centre was designed to hold various other services to be close together, including support groups and a patient information centre.
- Quiet areas were available on ward areas we visited to enable patients and relatives to be somewhere more private.

Access and flow

- Data for the period April 2015 to March 2016 showed that overall the trust was not meeting the 90% standard for the percentage of patients receiving treatment within 18 weeks of referral. The percentage achieved by the trust was worse than the England average. By speciality, the worse area was cardiology at 71.8%.
- The management team were aware of the failure to meet the referral to treatment targets and had agreed an improvement plan with the local CCGs to work towards achieving this. There was an agreed trajectory for improvement and the trust was currently ahead of trajectory.
- Information regarding bed moves between March 2015 and February 2016, indicated that across medical services for Castle Hill Hospital, 46% of patients had no moves, 34% were moved once during their stay, 12%

were moved twice, 5% three times and 3% of patients were moved 4 or more times. There were 58 patients moved wards after 10pm from October 2015 to March 2016.

- At Castle Hill Hospital from January to December 2015, the average length of stay was shorter than the England average for elective care, but longer than the average for non-elective care. Elective clinical oncology and clinical haematology and non-elective cardiology, clinical oncology and medical oncology had longer than average lengths of stay.
- Some patients had direct access to the wards; this reduced the time patients needed to be in other departments.
- Due to the complex patient clinical needs on ward 29, access was needed to intensive expert speech and language therapists. However, it was highlighted on the trust's risk register that there was a lack of specialists and there was a risk that patients were not able to meet their rehabilitation potential. Control measures were in place, for example, the head of the department oversaw the clinical practice of a graduate on the ward.
- We asked all the medical teams regarding medical outliers who confirmed that it was rare to have medical outliers on their wards.

Meeting people's individual needs

- Visiting hours on some of the wards were flexible to meet the needs of the patients and their condition.
- There was a range of clinical nurse specialists who supported patients in a range of different settings.
- Hospitality rooms were available for relatives to stay which were easily accessible.
- Patients said they were offered a choice of food and regularly offered drinks. Patients were offered alternative choices to the food menu and were provided with snacks during the day.
- Face to face interpreters were available and there was access to a language line for rare languages. There was also access to British Sign Language (BSL) interpreters.
- Staff informed us they had recently had to use the service for patients and relatives who spoke Russian and Polish.
- A clinical psychologist and learning disability specialist nurse supported those patients with particular needs. Staff were aware of the learning disability passport and how to access this. Patients with learning disabilities were highlighted as part of the safety brief to identify if further support was required. We observed this element within the safety brief during our inspection.
- The learning disability liaison nurse provided training for staff and the trust was planning to facilitate a mental health and learning disability study day in July 2016. Online training was also available.
- The wards areas were spacious and accessible for people with limited mobility and who used a wheelchair. Wheelchairs were available within the areas, when required and disabled toilets were available.
- One patient with physical disabilities could not use the nurse call system due to problems with their hands. The unit contacted engineering and the buzzer was adapted for their needs. Therapists were very flexible to meet the needs of those patients who required additional support.
- In the last 12 months there had been no mixed sex breaches reported by the Medicine Health Group. CMU was a mixed sex area due to the level of patient need, however where possible they tried to maintain the same sex in each bay area. At the time of inspection males patients were in the bay areas and female patients were in the cubicles.
- The trust had a dementia strategy. Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This is a national scheme that teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- Wards had dementia friendly signage and were decorated accordingly. Some staff took on a dementia friendly role and felt passionate about this responsibility; this included encouraging others to learn more about dementia. Wards had access to activities for patients living with dementia such as twiddlemuffs, photo boxes and memory pictures. We also observed on the ward information regarding dementia and contact numbers for support.
- Dementia training and education was not part of the trusts statutory or mandatory training programme. However, there was a dementia and delirium policy available to support staff to care for patients with dementia and a dementia screening tool was in use.

Medical care (including older people's care)

Learning from complaints and concerns

- Information submitted by the trust showed the trust received 855 formal complaints between April 2015 and April 2016. The average number of days taken to close a complaint was 36. Forty six (5.4%) of complaints were re-opened.
- Information provided by the trust identified in November 2015 at the Medical Health Group governance group, there were a number of complaints that had been open for 40 days; an update was requested and the trust identified this was due to waiting for responses from professionals. The trust's gold standard for completing complaints was 25 working days; however complex complaints were assigned a timescale of 40 or 60 days to complete.
- The most common issues complained about were all aspects of clinical treatment which included, care provided, attitude of staff and management of a patient's condition. The staff group most often complained about was medical staff which accounted for 83% of complaints involving staff.
- There were 31 complaints submitted to the trust specifically relating to oncology (3.6%) and 29 relating to cardiology (3.4%). These specialties were in the top 10 most complained about.
- We asked staff on the wards about complaints and they could remember specific complaints which were dealt with appropriately, for example communication issues and issues with medication. Staff knew the procedure for complaints and how to manage and deal with them.
- During the inspection we reviewed a response letter to the complainant which included a copy of the 'being open' report which was used to document issues raised at a meeting with the trust and complainant. The response letter highlighted the issues raised and an apology for the distress and upset caused.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. However, we saw limited information displayed in clinical areas (such as posters or leaflets) setting out the complaint process and explaining to patients how they could raise concerns.

Are medical care services well-led?

Good

In 2014 we rated well-led as 'Requires improvement'. In 2016 the service had improved and was rated 'Good' for well-led because:

- There was a clear vision and strategy for the medicine health group with an operational plan on how this would be delivered.
- Governance and risk management systems were in place to monitor and act on risks.
- The majority of staff enjoyed work and felt proud of their ward.
- There was an open and honest culture at the hospital.

However we also found:

- Due to staffing levels, ward managers were needed to provide clinical care on the ward and did not always have the capacity to allow time to be taken to focus on the leadership of their ward.
- Each ward was audited to ensure the correct level of patient care was provided, although timescales were not always adhered to.

Vision and strategy for this service

- The trust had developed a five year strategy 2016 – 2021; the strategy referenced recommendations and defined long tem goals and plans. Some of the aims of the strategy were the provision of care, workforce and financial sustainability.
- The trust had a set of values and staff we spoke with were familiar with these values. The values were identified as care, honesty and accountability. Each section identified expectations that patients and relatives should and should not see. Staff found the trust values to help focus staff on the behaviours expected.
- The trust focused building on their vision and adopted seven long terms goals which they felt when achieved will make three elements – great staff, great care and great future. This logo was used as part of their branding.
- The trust had a medicine Health Group operational plan for over a five year period.

- Within the oncology department there was a ten year plan with the expansion of beds to be available at the hospital.
- We met with the senior medical care team who articulated the vision for the Health Group. They were aware of the issues and plans were in place to meet the demands and needs of the service.
- The trust worked in partnership with local NHS trusts and commissioning groups to develop a nursing and midwifery strategy.

Governance, risk management and quality measurement

- Within the Medicine Health Group an Integrated Governance Committee was held monthly. This meeting had a set agenda and looked at incident management, serious incidents, risk register, current audit plan and complaints.
- As part of the inspection we reviewed minutes of meetings. In the medicine group integrated governance committee January 2016 minutes it identified there were a number of overdue serious incident actions. It was reported at the November meeting that it was agreed with commissioners that all overdue actions would be completed and closed by the end of January 2016. There were 51 actions, 22 of which became overdue at the end of December. Members of the executive management team reviewed serious incidents at weekly meetings. It was confirmed at the inspection that the overdue actions had now been completed.
- There was a risk register in place that reflected the current risks to the operational effectiveness of the medicine group. These risks were identified at the time of the inspection as current risks. The risk of nurse staffing establishments was highlighted on the medicine Health Group risk register and controls were put in place to minimise the risk. These included twice daily safety briefs, regular discussion with bank / agency staff to improve the fill rates including block bookings and an action plan monitored by the Health Group.
- The trust were aware that they had not met their target in relation to nutrition and hydration outlined in their Quality Account document. The 3Gs nutrition and hydration audits on some wards had been assessed as inadequate. This was not included within the medicine groups risk register to identify any controls in place to reduce the risk.
- Audits were not always completed in the timescales agreed although the trust had an audit programme in place.

Leadership of service

- Each Health Group had a structure of medical, operational and nurse directors. These then linked into the chief operating officer and executive team.
- The Health Group leadership team had recognised the need to develop effective leadership at all levels and this was identified on the risk register. Leadership development for service leaders and the introduction of the 'Great Leaders' programme for middle managers were control measures in place. Ensuring charge nurse competency and appropriate training for staff were also identified as control measures.
- Nurse directors met with the chief nurse every Tuesday and would alert the chief nurse to any major issues as they arose.
- Wards and departments carried out individual fundamental standards audits (3Gs – great staff, great care, great ward). During 2015/2016 medical wards had been rated as outstanding, good, requires improvement and inadequate. The trust was open and displayed the findings, positive and negative, detailing what they needed to improve with in each of the areas and also what worked well. These were displayed on the wards we visited.
- The majority of staff were aware of the executive trust team and identified the chief nurse had been on wards, engaged with staff and was approachable.
- Due to not attaining planned levels of nursing staff, some ward managers spent their management time on the ward providing nursing care.
- Staff felt their immediate line managers were approachable and ward managers were open and transparent.
- Some teams had team meetings were staff felt they could raise issues, however these were not regular due to staffing constraints.

Culture within the service

- All new starters received professional and cultural transformation (PaCT) training. Also current members of staff also completed the training. This training was for staff to understand the expectations of them working within the trust.

Medical care (including older people's care)

- We asked staff about bullying and all staff reported they had not seen or experienced any bullying. Some staff that had worked for the trust a period of years felt there had been positive shift in trust culture where improvements had been made.
- Staff felt they could raise concerns about patient safety to their immediate managers and they would listen. Staff gave positive feedback regarding the culture in the organisation.
- Staff often completed extra shifts on the wards they worked as they liked where they worked.

Public engagement

- A draft patient experience strategy which included medical care services was in the process of being reviewed by stakeholders and the public and patients council. The final version of the strategy was due to be presented to the trust board for approval in September 2016.
- The NHS Friends and Family Test (FFT) for Castle Hill Hospital showed a response of 29%; this was higher than the England average response rate.
- The trust worked with charities and joint initiatives were completed to raise awareness of rehabilitation issues.
- Staff on ward 30 had been nominated by patients and friends for a people award dignity in care 2015.

Staff engagement

- The trust had developed a 'People Strategy' in 2016. Some of the aims of the strategy were recruitment and retention and innovation, learning and development. Senior managers told us that staff had been involved in the all the strategies developed. We asked some staff about the strategies and they were aware of them.
- The trust looked at the four Health Groups they currently had and wondered if the groups were too large and potentially looked at creating a new structure of seven groups. A consultation period was created and staff were asked their opinion, the consensus from the majority of staff was that they preferred the four Health Groups. The trust remained with the four original Health Groups.
- The trust adopted a golden hearts award where staff were nominated for various awards for recognition. We were told some staff had received individual awards.
- Staff worked well on the wards and worked as part of a team and shared an understanding for each other's roles. Many staff enjoyed their job and found it rewarding even though at times they felt overstretched in their role.
- The friends and family test showed that 72% of staff would recommend Castle Hill Hospital for care and 56% recommended the hospital as a place to work.

Innovation, improvement and sustainability

- A number of wards were trialling the use of new types of roles to help and assist and release registered nursing time. These included ward personal assistants, discharge facilitators, ward hygienists and nutrition care apprentice.
- The therapists on ward 29 were involved in an exercise research study for patients with brain tumours.
- Staff were keen to progress research projects to benefit patient outcomes and raise the profile. We were told that innovation was encouraged by the trust. Ward 29 had the aspiration to achieve a level 2a status on data submission to the UK rehabilitation outcome collaboration.
- The trust will be hosting the British Society of Rehabilitation Medicine conference in November 2016.
- There was international recognition for the Haemophilia Centre based within the Queen's Centre for Oncology and Haematology as it was awarded European Haemophilia Centre status in June 2015.

Surgery

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

Information about the service

Castle Hill Hospital (CHH) was part of the Hull and East Yorkshire Hospitals NHS Trust. The Surgery Health Group provides a range of surgical services for the population of Hull and surrounding areas.

On this site the Surgery Health Group provide elective treatments for different specialities such as cardiothoracic, ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, spinal, orthopaedics, colorectal, upper gastro-intestinal, urology. It also provides acute non-elective urology and cardiothoracic services.

The surgery service has eight wards surgical at CHH with 199 inpatient beds. The hospital has fifteen theatres, four-day surgery theatres and two clean procedure rooms.

Between January 2015 and December 2015 the Surgery Health Group carried out 57,579 surgical spells, which placed it in the top quarter of all NHS trusts nationally. Sixty-one percent of procedures were carried out as a day case with 34% elective admission and 6% emergency admissions.

During our inspection, we spoke with 42 members of staff including nursing, medical and allied health professionals as well as 27 patients and two relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 20 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the Surgery Health Group.

We attended a number of staff focus groups and observed care being delivered on wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI) tool. SOFI is a way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust. We carried out unannounced inspections on 9th June and 11th July 2016.

A comprehensive inspection of CHH was carried out in February 2014; all five domains were inspected for surgical services. Safe and Well led were rated as requires improvement and effective, caring and responsive were all rated as good. The service overall was rated as requires improvement.

A focused inspection was carried out in May 2015. Two domains were inspected, for surgical services Safe was rated as inadequate and well led was rated as requires improvement. The service was rated Inadequate overall. The main issues at this inspection were:

- A number of Infection Prevention and Control (IPC) concerns in relation to the environment and compliance with specialised ventilation guidance within theatres and orthopaedic patients not being “ring fenced”.
- Concerns over the number of suitably skilled and experienced staff working in surgical wards.
- No clinical strategy for the Health Group.
- A backlog of complaints and incidents within the Health Group requiring investigation.

The trust was not meeting the overall referral to treatment (RTT) performance standards.

Surgery

Summary of findings

In 2015 we rated surgical services at CHH as 'Inadequate'. Following the 2016 inspection we rated surgical services at CHH as 'Requires improvement' overall because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated, were not always escalated for medical review.
- From our observations it was apparent the five steps to safer surgery checklist, was not embedded as a routine part of clinical roles.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff. In June 2016 ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. We found that nursing staff did not always complete accurately the falls and dementia risk assessments. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored red for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance standards for treatment and cancer standards.
- The senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

However,

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- Policies for the Health Group, which we reviewed, were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- The Short Observational Framework for Inspection (SOFI), we carried out showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.

Surgery

Are surgery services safe?

Requires improvement

In 2015 we rated safe for surgical services at CHH as 'Inadequate'. Following the 2016 inspection we rated surgical services at CHH as 'Requires improvement' for safe because:

- We had concerns over the escalation process of deteriorating patients; the systems used were not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated, were not always escalated for medical review
- We had concerns regarding the effectiveness of the five steps to safer surgery checklist, from our observations it was apparent this process was not embedded as a routine part of clinical roles.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. Within nursing, safer staffing levels were not being met. The trust recognised this was an issue and had twice-daily safety briefings to minimise the risks to patients. Within medical staffing there were gaps in the junior doctor's rota, especially overnight; this was highlighted on the risk register.
- From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of elective orthopaedics patients by senior medical staff. From medical notes, we reviewed and staff we spoke with we did not see an effective process to ensure clinical review of orthopaedics patients by senior medical staff. In June 2016 ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds.
- We found that nursing staff did not always complete accurately the falls and dementia risk assessments.

However,

- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.
- The health group was meeting the trust compliance target (85%) for mandatory training. Training data we reviewed showed an overall training compliance rate for the Surgery Health Group of 85.1%.

Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event. No never events had been declared within the Surgery Health Group at this hospital.
- Serious incidents are incidents that require further investigation and reporting. Twenty three serious incidents (SI) were reported; within the Surgery Health Group during the reporting period May 2015 to April 2016. Themes from serious incidents reported included surgical procedure issues, treatment delays and pressure ulcers. We reviewed four serious incident reports and noted the recording of duty of candour discussions, recommendations and further learning identified as appropriate. One serious incident we reviewed was due to be reviewed six months after completion, to ensure the new practices recommended were embedded.
- We reviewed incident data supplied to us by the trust that showed surgical wards and departments reported 2,518 incidents from May 2015 to April 2016. Reported incidents we reviewed showed two graded as death, nine graded as severe harm, 57 as moderate harm, 496 graded as low harm and 1,954 graded as no harm/ near miss.
- The Surgery Health Group reported the second largest number of incidents in the trust (23.4%). Reported incidents showed the top three categories of incidents reported was patient accident at 28% (713 reports), access, admission, transfer, discharge (including missing patient) were 13% (329 reports) and treatment and procedure 11% (280 reports). Staff we spoke with were aware of the top three incidents.
- In 2015, the trust was asked to take action to ensure, that all incidents were investigated in a timely manner. Data we received from the trust in February and March 2016 shows a backlog of 168 incidents required review. We discussed this backlog with the senior management team and they informed us of the work to reduce the backlog, and at the time of the inspection, the Health Group had reduced the backlog to 28 outstanding incidents to review.

- Nursing and medical staff we spoke with were aware of the reporting system and staff could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. The majority of staff we spoke with said that they received feedback following completion of incident forms.
- Nursing and medical staff we spoke with said that learning from incidents was shared internally through safety briefs during shift handovers, quality and safety bulletins, internal emails and lessons learned newsletters. Themes within the newsletters and bulletins we reviewed included new medications, changes to radiology results notifications, falls, blood transfusions and incident reporting.
- There was evidence of changes in practice from incidents. For example, there had been an incident in another heath group with alcohol hand gel; staff we spoke with were aware of this incident and had taken individual ward based actions to identify solutions.
- The senior management team held bi-weekly meetings with ward managers to discuss incidents and actions taken.
- Mortality and Morbidity meetings were held within individual specialities, no specific overall mortality meeting was held for the Health Group. The senior management team spoke with us about the trust Mortality Committee and the governance group providing information into this group; however, from governance and business minutes we reviewed it was not apparent that mortality discussion was held at the Health Group's governance or speciality business meetings. The lack of a forum to discuss mortality and morbidity within orthopaedics was identified in December 2015 as a risk. In June 2016 the Health Group agreed to remove this from the register; however medical staff had challenged this. Within the Health Group strategy it was recognised that a robust mortality and morbidity team review system was required. The senior management team informed us that a new system of case note review mortality meetings was been introduced. Staff from within the Health Group had received training and the centralised system was due to be implemented from September 2016.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of duty of candour requirements and described it as being open and honest with patients when incidents occurred, they provided examples of when patients were cancelled having open discussions with the patient about the reasons for cancellation and when patients had acquired pressure damage whilst in hospital.
- Data we reviewed showed that within the Surgery Health Group duty of candour requirements had been declared on 16 occasions during 2015/2016. The senior management team provided us with examples about its use, for example an increased incidence of pressure ulcer development within the Health Group. Staff recorded duty of candour discussions on the investigation reports and staff said this was also recorded on the incident form and medical notes.
- Response letters to complaints included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots) and catheter and urinary tract infections (CAUTI's).
- Information from the safety thermometer data was displayed in all areas visited.
- In the Health Group during the reporting period, March 2015 to March 2016 there had been 35 pressure ulcers, six falls with harm and 15 CAUTI's.
- The rate of new pressure ulcers reported was highest in March 2015, following this period rates were variable with no trends identified.
- The Surgery Health Group had reported six falls with harm; these had all been reported from September 2015.
- The rate of urinary tract infections reported in patients with a catheter showed a decreasing trend between October 2015 and February 2016.

- Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed March 2016 showed 77.9% of patients received the appropriate assessment of risk. The trust had implemented a new patient administration system and the trust reported that data capture issues were causing low level compliance issues.

Cleanliness, infection control and hygiene

- In 2015, the trust was asked to take action to ensure the results of IPC audits were reviewed especially on wards and theatres. The trust was also asked to ensure compliance with theatre engineering performance measures and annual servicing of ventilation for all theatres. Since the previous inspection, orthopaedic patients were being segregated appropriately and the ward managers were able to discuss results and actions as a result of infection prevention and control audits.
- Infection prevention and control information was visible on all wards we visited; this information included the number of days since last clostridium difficile (C.Diff) infection and methicillin resistant staphylococcus aureus (MRSA) isolate.
- The trust reported zero cases of hospital acquired MRSA July 2015 to April 2016. The trust reported 46 cases of hospital acquired clostridium difficile (C.Diff) in the reporting period April 2015 to April 2016 this was lower than the agreed maximum threshold of 53 cases.
- The trust had a policy for screening surgical patients for MRSA. Emergency and elective patients undergoing surgical procedures and fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening and noted 75% compliance against a target rate of 100% during the reporting period April 2016 to June 2016
- At the time of the inspection, the trust did not undertake audits of the MRSA and C.Diff policies.
- Wards and departments were visually clean and we saw ward cleanliness scores displayed in public corridors.
- We saw staff washing their hands, using hand gel between patients and staff complying with 'bare below the elbows' policies.
- Hand hygiene audit data we reviewed showed 97.2% compliance in the reporting period April to June 2016. However, only two wards and three theatres submitted data, out of these only one area submitted data every month. The trust had recognised a reduced compliance with the audit, and from July 2016 had introduced a new five moments audit tool and IPC ownership tool.
- During the inspection, we saw hand hygiene compliance data displayed on the wards and departments we visited. Following a serious incident the trust had taken a decision for wards to risk assess the provision of alcohol gel at patients' bedsides; some wards had made the decision following the risk assessment to provide personal issue alcohol gel to staff. Soap dispensers we reviewed were in good working order.
- All patients were provided with hand hygiene wipes to clean their hands prior to meal service.
- During the inspection, we observed good compliance with IPC policies for example rooms were available for the isolation of patients, and patients requiring isolation were isolated.
- Staff working on the elective orthopaedic wards spoke with us about being ring fenced for elective orthopaedic patients only to prevent infection as per best practice guidance.
- The hospital participated in national surveillance projects for Knee replacement October to December 2015 and cardiac surgery January to March 2016. Data we reviewed from the reporting periods showed a similar level of surgical site infection when compared with national hospital data for knee replacement. The hospital performed better that all hospitals data in cardiac surgery (non CABG) hospital 0% infection rate and 1.5% national all hospitals rate.
- Environmental cleaning schedules were available and displayed in public areas. We reviewed patient led assessment of the care environment (PLACE) results for the trust and noted 96% slightly below the 98% England average for 2015.
- The infection prevention and control (IPC) team delivered training both face to face and via e-learning. IPC training compliance rates for the Surgery Health Group were 75.7% with a trust target of 85%.
- The trust had completed a review of clinical areas undertaking operating procedures and classified them as ward, operating or clean room standards.
- Specialised ventilation isolation rooms were available on ward 27 for patients with communicable diseases.

Environment and equipment

- The wards and the majority of departments we visited appeared well maintained. One of the areas used for day surgery required refurbishment and did not appear well maintained; floors and walls were damaged and shelving units were not sealed to prevent contamination with body fluid spillages.
- Equipment we reviewed was stored appropriately and had been electrical safety tested.
- In the majority of occasions, for the resuscitation equipment we checked staff had recorded that checks were complete. All resuscitation equipment we reviewed was stored appropriately and within expiry date. We checked three emergency trollies in main theatres they did not have the same equipment stored in each trolley, the resuscitation council recommends that resuscitation equipment and layouts be standardised throughout organisations.
- Staff we spoke with said that there were adequate stocks of equipment and we saw evidence of good stock rotation.
- During the inspection, we observed a laser in use, in theatre 10; staff we spoke with had little knowledge of the policy, responsible person or environmental protection requirements.
- We reviewed the trolley used for difficult airway access within the day surgical unit and noted that it was difficult from visual observation to identify what equipment was single use or how it was decontaminated. This did not reflect recent improvements suggested by the Difficult Airway Society. It is recommended by the difficult airway society to have clearly and concisely labelled drawers they suggest downloading images to label difficult airway trolley drawers, to enable easy access to equipment in emergency situations.

Medicines

- On surgical wards we visited medicines were appropriately stored, with access restricted to authorised staff. On the majority of occasions, staff prescribed and administered medicines appropriately.
- Controlled drugs were appropriately stored; administration records were maintained; however, on most areas visited daily balance checks were not performed in line with the trust policy.
- From prescription charts we reviewed, medical staff did not always follow the trust procedure and safe practice when cancelling a prescribed medicine. Pharmacists had checked the majority of charts we reviewed checks included ensuring patients were prescribed the same medications they had been taking at home, unless this was no longer appropriate.
- Emergency medicines were readily available and they were found to be securely stored and in date.
- The majority of medicines fridges were secure; staff monitored and maintained temperature records in most areas.

Records

- Paper records were available for each patient that attended the wards or department; the trust used a computerised patient administration system, however most records and patient assessments were still paper based.
- Electronic boards were available on all wards visited, which provided access to staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans.
- Ward 15 was participating in a trail of electronic observations recording, via a tablet computer, staff we spoke with said that the trial was improving access to information and documentation.
- We reviewed 20 sets of medical and nursing care records whilst on site and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of the review or administration of medication as per compliance with trust policy and professional standards.
- Patient records were stored in notes trollies that were able to be locked, or where stored in secure areas.
- The wards and departments used risk assessments for falls and pressure damage prevention. Records we reviewed showed that on the majority of occasions theses were completed accurately.
- Completion of venous thromboembolism (VTE) assessment was noted to be 77.9% for March 2016 lower than the trust compliance rate of 100%.
- Individualised patient care plans were used for patients these were used as part of the assessment process to detail the care needs of the patient.
- Ward quality assurance audits were carried out on a monthly basis, five sets of notes were audited each week and areas audited, these included reviews of tissue viability, IPC and patient experience records.

Safeguarding

- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Staff we spoke with were able to describe their roles in relation to the need to report and take action as required when safeguarding issues were identified.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by refresher training. We reviewed safeguarding training compliance rates for July 2015 to April 2016 and they showed 84.6% compliance with a trust target of 85%.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e-learning programme.
- The trust target for mandatory training completion was 85% compliance; training data we reviewed showed an overall training compliance rate for the Surgery Health Group of 85.1%.
- Individual levels of compliance for training ranged from 82.5% to 92.1%.
- The Surgery Health Group human resources team provided a rag rated spreadsheet to ward managers on a quarterly basis showing levels of compliance.
- New staff received a corporate and a Surgery Health Group induction, which included some aspects of their mandatory training.
- New or junior medical staff received a corporate induction and departmental induction-training programme.

Assessing and responding to patient risk

- In 2015, the trust was asked to take action to ensure use of the best practice guidance, such as the safer steps to surgery checklist.
- The hospital did undertake the 'Five steps to safer surgery' procedures including the World Health Organisation (WHO) safety checklist. The hospital demonstrated compliance with the safety checklist via audit, with five sets of notes reviewed every month, for every theatre. Results we reviewed showed 100% compliance, however an internal audit report provided to us by the trust reported 54% compliance in the reporting period November 2015 to January 2016. The report was completed for 50 patients in most specialities, a recommendation from this report (published in March 2016) was to re-audit one month later and set up a working group to review the form. Post the inspection, the trust confirmed that a working group had not been developed and no further audit had been completed. A new theatre assurance tool had been developed since the internal audit results and the results from June 2016, showed 100% compliance for the WHO audit compliance.
- During the inspection, we reviewed five sets of surgical notes containing WHO checklists and we observed two occasions when WHO checklists were completed. On the two occasions the checklist were completed; however from our observations it was apparent the completion was undertaken without effective involvement of the whole clinical team, for example sign in and final briefing had no input/involvement from the operating surgeon. No verbal communication was apparent for sign in on both occasions no verbal communication occurred on the appropriate use of antibiotic prophylaxis, pre-operative warming, blood glucose control or VTE risk assessment, this should occur in the time out step .
- We had concerns over 15 incident reports we reviewed May 2015 to March 2016 where missing needles and sutures were reported post operatively and incorrect swab counts. We highlighted our concerns at the time of the inspection and the senior management team spoke with us about a new theatre assurance tool. Results from June 2016, showed 100% compliance for the WHO audit compliance.
- The trust used the national early warning score (NEWS) tool; surgical areas used a paper based version to record the early warning score. Nursing staff identified deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with were able to articulate the clinical condition of a deteriorating patient, however did not appear to have consistent knowledge of the actions required to escalate a deteriorating patient for medical staff review. The trust carried out internal audits of the NEWS scores and we noted on average a 96.8% compliance that appropriate action was taken for NEWS scores 7 or above in the reporting period January 2015 to February 2016.Audit data from April 2016 to June 2016 showed 100% compliance for most areas. Within the Health Group strategy, it had been recognised that the development and delivery of improved identification and management of deteriorating patients was required.

- From notes we reviewed we did not see effective escalation of all deteriorating patients. From seven sets of notes reviewed, from patients that had deteriorating early warning scores documentation of escalation and review was only in available for two patients. In five patients that had deteriorated, action or escalation was not apparent. The implementation of the early warning scoring system did not support the process for early recognition and early intervention of patients who were becoming unwell. From medical notes we reviewed one orthopaedic patient had deteriorated this had been escalated and the patient had been seen by the critical care outreach team, however no documentation occurred in regards to a medical review until seven days post the deterioration.
- We reported our concerns about the escalation of deteriorating patients to the trust at the time of the inspection. Post the inspection the trust said they were planning to implement e-observation packages as finances became available.
- We had concerns over consultant review of elective orthopaedic patients during June 2016. Evidence we saw showed that ward rounds had only occurred on four out of 29 occasions, board rounds had occurred on two further days; however patients are not seen during board rounds. The senior nursing team had highlighted this to the clinical director and had commenced completion of a safety cross to highlight the issue. We discussed this with the senior management team who informed us that consultant job planning reviews had been undertaken and that improvements would be made post September 2016, No formal protocols were in place to allow nursing staff to discharge patients without medical staff review.
- Staff were aware of escalation procedures for issues of concerns on their wards or departments.

Nursing staffing

- In 2015, the trust was asked to take action to ensure that there are at all times sufficient numbers of suitably skilled and experienced staff.
- At the time of the inspection, surgical wards and departments had 814.6 WTE registered nursing posts and 752 WTE unqualified nursing posts. We reviewed vacancy rates and this showed a 7.6% vacancy rate. All surgical wards we visited had vacancies.
- The trust used the safer nursing care tool to asses nursing staff requirements per ward and department, per shift.
- The surgical wards displayed planned and actual nurse staffing levels for each shift. The trust-planned nurse to patient ratios was 1:8 day shift and 1:10 night shift for all surgical wards.
- Prior to the inspection, we reviewed the safer staffing report May 2016 for surgical wards, and on average there was an 80.5% fill rate for registered nursing RN staff per day shift and 88% fill rate for night shift. For care staff the average fill rates were 80.8% day shift and 103% for a night duty. Data we reviewed ranged between 91% to 48% average fill rate for RN day shifts and 75% to 103% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 189 registered nurse shifts reviewed, we saw that 70 shifts were staffed at below the established levels. Staffing levels we reviewed on wards 8, 10 and 11 all showed periods of registered nurse staffing levels falling below the established levels.
- The Surgery Health Group used bank and agency staff to improve staffing levels; we reviewed use of bank and agency staff and noted 1.3% agency usage.
- Most of the wards we visited had below planned staffing levels overnight. The majority of the staff we spoke with said that when the rotas did meet their planned numbers, staff on duty were moved overnight to improve staffing levels on other areas. We had concerns over the staffing levels on ward eight overnight as they had only one nurse for that area on three out 21 occasions. They were supported by nurses from the adjacent ward at these times.
- We had concerns about the staffing levels within the high observation bay HOB. During the inspection, we reviewed staffing rotas for HOB units on ward 10 and ward 11, we spoke with staff working in the areas, and we found that although staff were clear about the staffing levels required 1:4 registered nurse to patient ratio, they were not always able to maintain these levels. During the inspection, we saw one registered nurse to four patients; however, when reviewing 126 registered nurse shifts the ward staffing level was below establishment on 62 occasions. On these occasions, staff were not able to demonstrate how they maintained a 1:4 ratio in the HOB and a 1:8 ratio for the rest of the

ward. When we asked staff for the protocol or policy for the HOB units, they were not aware of one, however post the inspection the trust provided one which stated the staffing level is agreed as a 1:4 ratio.

- The Surgery Health Group was actively recruiting to vacant posts, both local and international recruitment events had been undertaken, an intake of new registered nurses from the local university were due to commence employment in September 2016.
- Twice daily safety brief reviews took place each day across the hospital, the purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Ward co-ordinators attended safety briefings. Prior to making decisions discussions were held around the skill mix, harm rates of pressure sores, falls and infection status, availability of other staff. Staff were often moved from their substantive area because of these discussions.
- The trust had recently developed new roles to support the nursing ward teams. These included ward personal administrators, to help ward sisters with ward administration duties, discharge facilitators and ward hygienists. All surgical wards had access to these members of staff. Staff we spoke explained the difference these roles had made, especially discharge facilitators and ward administrators.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that patients' clinical conditions were discussed and levels of support or risks were identified.
- We reviewed planned vs actual hours for allied health professionals within the Health Group; these were similar for qualified and unqualified staff.
- Within theatres at this hospital, 16 WTE Operating department practitioner post and 24.6 WTE junior qualified nurse posts were vacant.

Surgical staffing

- For all surgical specialities a consultant is present on site 8am until 6pm Monday to Friday. Acute general surgery had consultant presence 8am until 1pm weekends and bank holidays and trauma had consultant presence 8am until 6pm weekends and bank holidays.
- On-call cover was provided for a 24-hour period, one resident foundation level two doctor was available overnight; two registrars were present on site until 8pm, overnight two non-resident registrars were available on an on-call basis.
- We found that the medical skill mix was similar to the England average for consultants at 43% (England average 41%), registrar group 37% (England average 37%), and junior doctor level 14% (England average 12%). Middle career level was lower than the England average at 6% (England average 11 %).
- At the time of the inspection, surgical wards and department had 372 WTE surgical medical staff, 152.5 WTE consultants and 190.1 WTE junior doctor and middle grade posts. We reviewed vacancy rates and this showed 12 WTE surgical consultants, 14.73 WTE junior doctor vacancies, and three WTE middle grade posts. The senior management team spoke to us about the gaps in the junior doctor's rota, especially overnight; this was also highlighted on the risk register. During and post the inspection the trust confirmed that 89% of all junior doctor posts had been filled for the new August intake.
- Some junior medical staff we spoke with highlighted concerns over the workload within some surgical specialities. On two different occasions staff spoke with us about gaps in overnight surgical cover, they provided us with dates of when there had been no foundation level two cover on site however the trust confirmed there were locum staff on duty.
- The Surgery Health Group used locum staff to improve staffing levels; we reviewed use of locum staff during the reporting period of April 2015 to March 2016 and noted 7.8% agency usage.
- Some junior medical staff we spoke with said that formal handover in the morning did not take place. The hospital at night team did handover to medical staff any patients of concern overnight.
- Formal medical handovers took place twice a day with informal handovers occurring as shifts changed or as patients conditions deteriorated, we were unable to observe these during inspection.

Major incident awareness and training

- The trust had a major incident and business continuity plan. This was available to staff on the trust intranet.

- A recent live incident had led to the business continuity plan being activated. The trust had evacuated a group of patients due to a fire in a nearby theatre. The senior management team spoke with us about being proud of how the staff worked in that situation.
- Staff we spoke to had an awareness and understanding of their roles in major incidents.

Are surgery services effective?

Requires improvement

The effective domain was not inspected during the 2015 inspection, in 2014; we rated surgical services at CHH as 'Good' for effectiveness. Following the 2016 inspection, we rated surgical services at Castle Hill Hospital as 'Requires improvement' for effectiveness because:

- National audit performance was variable; the emergency laparotomy organisational audit 2015 scored worse than the national average (0-49%) for six out of 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- The majority of fluid balance charts we reviewed on ward 8 were not maintained accurately

However,

- Policies for the Health Group we reviewed were up to date and based on national guidance.
- We observed good multidisciplinary working between physiotherapy teams, dietitians, and ward staff.

Evidence-based care and treatment

- We saw patient's treatment was based on national guidance, such as from the National Institute for health and care Excellence (NICE), the Association of anaesthetics, and from the Royal College of Surgeons.
- The department measured compliance with national guidelines. Data we reviewed from March 2016 showed that one clinical policy and one clinical guideline were overdue for review, and all procedure documents were compliant.
- We saw evidence of discussions in accordance with the National Confidential Enquiry into Patient Outcome and death (NCEPOD) guidelines.
- Policies were stored on the trust intranet and staff we spoke with, said they were able to access them.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery, examples of these included gastro surgery and elective orthopaedic joint replacements.
- The hospital participated in both the bowel cancer audit and lung cancer audit 2015. CHH did not undertake emergency surgery to patients with fractured neck of femur (hip joint) so did not provide data to the national hip fracture audit 2015.
- The Health Group had a local audit programme and these were discussed during audit sessions for the Health Group.
- Wards and departments we visited took part in local compliance audits of infection prevention and control practices, medication and documentation. These audits were called (3G inspections) and had been conducted during 2015/ 2016. The outcome was that the surgical wards had been rated as outstanding (none), good (four), requires improvement (12) and inadequate (one).

Pain relief

- We saw that patients were offered pain relief. Patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Staff used a pain-scoring tool to assess patients' pain levels; staff recorded the assessment on paper records.
- Some surgical patients received intravenous patient controlled pain relief trust post-operatively.

Nutrition and hydration

- We saw patients were offered drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes by using validated nutritional risk assessment documentation. Documentation we reviewed showed good levels of completion.
- We observed two meal services on ward 8 and 15 and noted all patients requiring support with feeding received this within five minutes of being provided with warm food,
- Patients had access to fresh water where appropriate. Fluid balance charts we reviewed were not always accurately completed, four out of six charts we reviewed on ward 8 had gaps in recording and daily totals were not added up, meaning staff were not aware of patient's daily intake of fluid.

- The trust staggered theatre fasting times, however, because of list overruns some patients we spoke with did fast for longer times than planned. The trust did not undertake internal fasting audits.
- A snack menu was available on all surgical wards. This provided patients with additional food between meals such as cakes, yogurts and ice creams.
- Staff we spoke with said they could access hot meals out of hours, for patients who had been to theatre or required a hot meal if they were unable to go to theatre.

Patient outcomes

- At the time of the inspection, the trust was classified as a mortality outlier with the Care Quality Commission for cardiac artery bypass graft. This means that performance within these two areas was outside of the expected range of performance; the trust had investigated the reasons for this and provided the commission with an action plan.
- At Castle Hill Hospital, the risk of readmission following elective surgery was worse than the England average in cardiothoracic surgery and was better than the England average in urology and colorectal surgery. Non-elective surgery readmission rates were worse than the England average in colorectal surgery and about the same in urology and lower in ear, nose and throat.
- The national bowel cancer audit (2015) showed worse than England average performance for the three indicators, including data completeness and review by a clinical nurse specialist. Laparoscopic surgery rates showed that this was only attempted on 24% of occasions, which was worse than the England average of 57%. No action plan was available detailing improvements required.
- We found that the emergency laparotomy organisational audit 2015 showed that the trust scored worse than the national average for four out of the 11 outcome measures including consultant surgeon review within 12 hours of emergency admission, preoperative review by consultant surgeon and anaesthetist and a consultant anaesthetist presence in theatre. The trust scored green in three-outcome measure and that was for direct postoperative admission to critical care. The remaining four outcome measures all scored amber. We reviewed the trust action plan for the audit and noted actions for further implementation of the laparotomy pathway and a resources review. It did not include any actions to improve patient access to consultants.
- The lung cancer audit (2015) showed better performance than the England average results for both discussion at a multidisciplinary team meeting (97% for the trust, compared with 93.6% England average) and the percentage of patients seen by a clinical nurse specialist which was 83.9% compared with 78% England average. However, the percentage of patients receiving surgery was lower 13.5% than the England average 15.4 %. We requested to review the trust action plan for the audit, an action plan was available, and these detailed two actions including a further audit, and it did not include actions for the recommendations in the report.
- The trust participated in the national hip fracture audit; however, CHH did not undertake emergency surgery to patients with fractured neck of femur (hip joint) so did not provide data to the national hip fracture audit 2015.
- Patient reported outcome measures (PROMs) showed that the trust performed better than to the England average for both groin hernia indicators, three varicose vein indicators and one hip replacement indicator. It performed worse than the England average for two of the three knee replacement indicators.
- The Surgery Health Group monitored there performance against a range of clinical indicators via a performance dashboard. This data included compliance with NICE guidance and national audits.
- The orthopaedic department had recently commenced one-day hip and knee replacements, patients were admitted to hospital early in the morning, operated on, post-operatively recovered, mobilised and discharged within approximately 14 hours. An admission and patient selection protocol was available. Early patient outcomes were positive, however at the time of the inspection this procedure had only been undertaken on a small number of patients.

Competent staff

- The Health Group had an internal appraisal target to achieve 85%. Appraisal records we reviewed showed that within the Health Group in May 2016, 87.7% of staff had an up to date appraisal. Data for medical staff appraisals was not available.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.
- Staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.

- Staff we spoke with on cardiothoracic surgery said that during induction they received training on using the specialised ventilation isolation room located on their wards.
- Nurse practitioner roles (nurses with extra training and skills) had been developed on cardiothoracic surgical wards, these nurses carried out pre-assessments on patients and were able to triage and take referrals from other hospitals.
- We saw evidence of on the ward educational sessions being provided on ward 27 for epidural training.
- We observed new starters on ward 16 being buddied with an experienced member of staff to provide support.

Multidisciplinary working

- There were established multidisciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed. Whilst on the wards we saw staff working with the tissue viability team and the diabetes specialist team.
- Referrals were sent to the dieticians from the Surgery Health Group, however due to vacancies within the team referrals received were being prioritised for clinical need some patients that required seeing a dietician prior to discharge did not always manage to be seen, however a letter was sent to the GP explaining this.
- Occupational therapist and physiotherapists held daily meetings with the orthopaedic wards. They also attended ward rounds, to review progress or discharge arrangements for the patients
- Staff within the Surgery Health Group said that they had positive working relationships within the multidisciplinary team. Physiotherapy staff said that they felt part of the ward team.

Seven-day services

- On-site medical cover was available seven days a week.
- Registrars or foundation level two junior doctors reviewed patients on admission.
- Surgical wards and departments had access to diagnostic and radiology services 24 hours, seven days a week to support clinical decision making.
- Access to occupational therapy was available Monday to Friday and physiotherapy services were available six days a week, with emergency cover on a Sunday.
- Pharmacy staff were available six days a week and an on- call service was available out of hours.

Access to information

- Staff recorded information about patients in paper format and on a computer based patient administration system.
- Handover reports were electronic and contained relevant information.
- Discharge summaries were prepared for the GP, records we reviewed showed these contained relevant information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed clinical records and observed that patients consented to surgery in line with trust policy and department of health guidance.
- Nursing and medical staff obtained consent via both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining consent before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff said they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff told us that where this was not possible and due to the nature of the surgery required staff had to make best interest decisions to enable lifesaving treatment to proceed; staff said that these decisions were documented within care records.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Training records for the Surgery Health Group showed 86.6% of staff had undertaken mental capacity training against a trust target of 85%. Deprivation of liberty safeguards training was completed by 84.6% of staff.
- Consent audits were carried out, results were disseminated, and recommendations with deadlines were made.

Surgery

- The trust held all paperwork relating to MCA on the intranet, staff we spoke with were aware of how to locate assessment information and record best interest decisions.

Are surgery services caring?

Good

In 2014, we rated surgical services at CHH as 'Good' for caring; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgical services as 'Good' because:

- Patients we spoke with provided consistently positive feedback about their inpatient stay.
- Short Observational Framework for Inspection (SOFI) we carried out through our observations showed that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- Staff we observed and spoke with were highly motivated and inspired to offer care that was kind and prompted patients' dignity.
- Relationships we observed between patients and staff were strong, caring and supportive.

Compassionate care

- We spoke with 27 patients and two relatives, during the inspection. We observed positive interactions between patients and staff. All patients we spoke with were happy with the care they received; they said that they felt happy, confident and safe during this admission. Patients we spoke with also said that staff were very responsive to their needs.
- Patient- led assessments of the care environment (PLACE) for the trust showed privacy, dignity, and well-being scored 81%, which was below the 86% England average level and dementia care.
- The NHS Friends and Family test (FFT) is a national survey that measures' satisfaction with the healthcare the patient has received. The response rate was 25%, which is lower than the England average of 31%. However, a higher proportion of patients who would recommend the service. Wards and departments we visited displayed their friends and family results. Wards and departments we visited displayed their friends and family results.
- During the unannounced inspection, we carried out two SOFI assessments. Through our observations, we saw that the majority of patient mood states were positive or neutral and interactions with patients were positive.
- Patients on the wards we visited appeared happy and relaxed, all had drinks and call buzzers located within easy reach. Patients we spoke with said that staff did not take long to answer call bells. During the inspection, we did not hear call bells ringing for long periods.
- We observed staff closing curtains/doors whilst delivering personal care. Patients we spoke with said that the environment in the hospital improved their experience as they had more privacy.
- We reviewed comments received by the trust from patients all comments we received were positive about surgical wards and departments.
- During the inspection, we overheard a positive, patient centred episode of care being delivered a nurse on ward 10 was helping a patient with hygiene needs; they explained all their requests to the patient in a clear, positive and kind manner. Assistance provided was at a pace appropriate to the patient, with consent for the next steps being gained.
- Staff we spoke with were highly motivated to deliver good quality patient care. We observed a positive, caring and supportive relationship between patients and staff.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they knew who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients with stoma were encouraged to complete their own fluid balance records.
- Patients we spoke with were all aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

Emotional support

- A multi-faith chaplaincy service was available within the trust and during the inspection.

Surgery

- Clinical nurse specialists were available within surgery and attended the wards to provide support and advice to patients and staff.

Are surgery services responsive?

Requires improvement

In 2014, we rated surgical services at CHH as 'Good' for responsive; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgical services at CHH as 'Requires improvement' for responsiveness because:

- Patients were not always able to access services for treatment in a timely or effective manner. The trust did not meet national performance indicators for treatment and cancer indicators. A local trajectory for the trust to achieve 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted RTT data and cancer standards was above the agreed local trajectory for both April and May 2016.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter 2, 2015.The trust cancelled 177 patients' operations March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.

However,

- There was evidence of good practice in order to meet the individual needs of patients.
- The trust's policy was to close all complaints within 40 days, each Health Group had a target of 95% to achieve this deadline, within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data which was 30% closure.

Service planning and delivery to meet the needs of local people

- The Surgery Health Group provided elective treatments for different specialities such as cardiothoracic, ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, spinal, orthopaedics, colorectal, upper gastro-intestinal, urology. It also provided acute non-elective urology and cardiothoracic.
- The Health Group had taken into account local transformation plans and commissioning decisions when creating their strategy.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients, incomplete pathways were set at 92%.
- The trust performance of meeting referral to treatment times (RTT) for patients admitted for treatment within 18 weeks of referral was below the national standard of 92%. Trust data from April 2016 showed that 86% of patients were being admitted within the 18 weeks from referral. Speciality specific data showed that no surgical specialities were meeting the incomplete standard, data we reviewed ranged between 53.3% to 90.1% performance to March 2016.
- A local trajectory for the trust to achieve the 92% had been agreed with the commissioners and NHS improvement and recent data supplied by the trust showed that the admitted RTT data was above the agreed local trajectory for both April and May 2016.
- We reviewed performance against the cancer indicators and noted that three cancer standards were not achieved by the trust in February 2016, these were the 31 day drug standards, the 62 day standard and the 62 day screening standard
- A local trajectory for the trust to achieve cancer indicators had been agreed with commissioners and NHS improvement and recent data supplied by the trust showed that performance was above the agreed local trajectory for both April and May 2016.
- The trust reported to us the data management issues since the implementation of the new patient administration system from June 2015 had affected data collection. The trust was carrying out internal verification of patients on the list and clinical reviews of waiting patients to ensure patients did not come to harm during the waiting list process.
- Theatre usage was 77.1% for day surgery and above 81.5% for main theatres December 2015 to February 2016. The data ranged from 61.4% to 94.5% usage in the same period.

Surgery

- Elective theatre lists were available six days a week and emergency theatre lists were available seven days a week. Services shared access to theatres for emergencies overnight and at weekends.
- The percentage of patients whose operations were cancelled and who were not treated within 28 days was consistently better than the England average from April 2013 to December 2015. However, the percentage of patients whose operations were cancelled and who were not treated within 28 days between March 2015 and December 2015 was higher 3.8% than the equivalent period a year early 2.4%. Two surgical patients that had their operation cancelled by the trust for non-clinical reasons in March 2016 and were not re-appointed within 28 days.
- Cancelled operations were higher as a percentage of elective admissions than the equivalent England figure for all quarters from April 2014 to December 2015, apart from quarter two, 2015.The trust cancelled 177 patients' operations from March 2016 to May 2016, the trust were unable to break this down into clinical and non-clinical cancellations.
- Average length of stay data was similar (3.4 days) to the England average (3.3 days) for all types of elective admissions.
- Non-elective average length of stay performance was about the same 5.1 days as the England average. However, per speciality data showed a lower than the England average length of stay for plastic surgery and upper gastrointestinal surgery and a longer length of stay for trauma and orthopaedics.
- Pre- assessment services including blood tests and screening was scheduled to take place as near as possible to the time of listing to prepare the patient adequately for operation.
- The majority of patients requiring elective surgery were admitted into the hospital via a surgical admissions lounge prior to being transferred to theatre. Patients would be prepared for theatre and consent would be gained.
- During the inspection, no wards had medical patients located on them (medical outliers).

Meeting people's individual needs

- The wards and departments were accessible for people with limited mobility and people who used a wheelchair.
- The department reviewed each patient's needs on admission, or during pre-assessment in regards to earing difficulties.
- Translation services were available for people whose first language was not English. Staff we spoke with said that this service was very responsive and if consent was being gained, there was access to staff that would visit the hospital and interpret face-to face.
- Patients with particular needs were identified to staff at the ward safety briefings, for example, learning disabilities, mental health and dementia.
- A lead nurse for learning disabilities was available in the trust, staff working within the wards were aware of how to contact the lead nurse. Families of patients with learning disabilities were supported to stay with patients. Staff working within the Surgery Health Group provided examples of when they had used learning disability passports, supporting patients with a learning disability through the admission, by referral to learning disability specialist nurse and by accommodating relatives to stay with patients.
- Healthcare assistants on the majority of occasions provided one to one observation of vulnerable patients.
- A vulnerable adult link nurse was available within theatre recovery, carers and parents were allowed into the recovery area.
- The department used a butterfly symbol to support people living with dementia, we saw some areas that were decorated in a dementia friendly way for example coloured signs on toilet door or clocks in rooms. However, no specific areas were identified on the wards to be dementia friendly. Staff we spoke with on ward 15 were knowledgeable about the needs of patients living with dementia. Staff we spoke with on ward 15 showed us "reach out to me" forms to complete for patients living with dementia.
- Basic information for staff about patients was identified on boards behind the bed's, for example the butterfly symbol and acronyms for mobility and dietary requirements and support.
- There were links between specialist nurses and ward staff to ensure continuity of care and support for patients.
- Specialised equipment required for bariatric patients was available. Commodes, chairs and beds were all

available as this site provided planned bariatric surgery. A specialist bariatric nurse had been recently appointed to improve knowledge and pre and post-operative education of staff and patients.
- Discharged patients were given the ward contact number following discharge to contact staff if they have any concerns post-operatively.
- Relevant information to patients on that ward area was displayed on the walls of corridors of wards we visited, such as discharge information, learning disability and butterfly dementia scheme.
- A range of leaflets were available for patients within surgical wards and departments e.g. prevention of pressure ulcers, venous thromboembolism prevention and information for a patients discharge.

Learning from complaints and concerns

- The trust had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS).
- There were 217 complaints received within the Health Group April 2015 to February 2016. The top three complaints were associated with treatment received (145), delays, waiting times and cancellations (27) and attitude of staff (19).
- The trust's policy was to close all complaints within 40 days; each Health Group had a target of 95% to achieve this. Within surgery 72% of complaints were closed within the timescale, lower than the target but a significant improvement on the 2014/ 2015 data, which was 30% closure.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.
- Staff talked to us about changes in practice that had occurred post a complaint, for example improved patient information leaflets.
- Complaints were shared with staff via team meetings and individual conversations.

Are surgery services well-led?

Requires improvement

In 2015, we rated surgical services at CHH as 'Requires improvement'. Following the 2016 inspection, we rated surgical services at CHH as 'Requires improvement' overall because:

- The senior management team had appointed substantive roles within the Surgery Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.
- We had concerns over the response and support offered from the site co-ordination team to staff shortages in the Health Group and periods of understaffing.
- We had concerns over the assurance required for the closure of items from the surgical risk register. We saw evidence of items being closed and clinical staff raising concerns over the closure as in their opinion the risks had not been mitigated.

However,

- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust values and strategy.
- We found an improved staff culture within the hospital, staff we spoke with said this had improved.
- The trust had recently commenced on the day hip and knee replacement operations to improve patient experience and flow.

Vision and strategy for this service

- In 2015, the trust was asked to take action to ensure there is the development of a long-term clinical strategy for the Surgery Health Group. Since the last inspection, the Health Group had developed a five-year strategy 2016- 202. The strategy referenced national reports and recommendations and was aligned to the trust values and strategy. Aims within the strategy included the provision of safe and effective care, delivering key standards and improved productivity and efficiency.

- Staff we spoke with working in the clinical areas were not aware of the Health Group vision and strategy; however this document was a recent development, they were aware of the elective/ emergency split between sites and they could articulate the values of the trust.
- We reviewed the surgery operational plan; which identified vision and goals. These included the separating of elective and non-elective activities, ensuring that patients were treated" in the right place, at the right time, by the right people, first time and within budget".

Governance, risk management and quality measurement

- The Surgery Health Group had a clear management structure; a new operations director had commenced employment in the days prior to the inspection. All management posts were now filled with substantive staff. This new structure required further time to be established and embedded.
- The Health Group held governance meetings; we reviewed four sets of board meeting minutes and noted discussion of risks and incidents. There was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed.
- There was a risk register in place. Risks for the Surgery Health Group were discussed at the integrated governance meeting; medical and nursing staff attendance at these meetings was good. Items requiring escalation to the Operational Quality Committee were clearly identified. The risk register reflected current risks relevant to the operational effectiveness of the department. Data we reviewed from February 2016 showed four high risks, 39 medium risks and 21 low risks identified.
- However, we were unable to identify effective documentation of discussions around gaining assurance and removing risks from the register. Five risks had recently been identified by the Health Group to be removed from the register following a meeting. However, from written communications from the clinical teams, it was apparent that assurance was not available for four of these risks and discussions were ongoing between clinical teams and management.Audits had been completed within the Health Group to provide assurance on key performance measures e.g. the WHO checklist, NEWS completion, infection prevention and control, medicines management, documentation and theatre productivity issues. We saw that on the majority of occasions for NEWS and WHO checklists, 100% scores for the audits had been recorded, however during the inspection we did not see evidence that the clinical practice required to produce 100% audit scores was embedded. Within theatres a new theatre quality assurance audit tool had been developed; this audit had only just commenced and required a further period to assess the impact of the audit results on compliance.
- The senior management team said their main risks for the Health Group were staffing, junior doctor cover overnight, RTT and cancer standards performance. These were all issues identified on the current risk register.

Leadership of service

- The Surgery Health Group had a new senior management structure. Staff commented that they were pleased that there was now a stable, permanent workforce after having interim roles for some months. The senior management team recognised that they needed more time to develop and become fully effective in their roles.
- From our discussions with staff, the majority of staff said that senior leadership was good and staff felt listened too. All staff we spoke with were positive about the support offered from the ward managers.
- From our discussions with staff, the majority of nursing staff said that senior leadership was good and staff felt listened too. Most of the nursing staff we spoke with expressed concern about the response from some of the senior nursing staff working in the site co-ordination team. They provided examples of staff being moved from their substantive ward areas to ease periods of understaffing in other areas. Staff we spoke with said that when they expressed concern about leaving the substantive area with low staffing levels they did not always feel supported and listened too.
- Most of the wards we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies. Minutes of the meetings we reviewed on ward 27 showed good attendance and action plans from incidents were shared at these meetings. Surgical admissions lounge included guest speakers, incidents and local issues. The ward manager on ward 16 had recently arranged health care assistant meetings. To encourage suggestions, access and improve feedback to staff of all grades.

Surgery

- The majority of staff we spoke with said that the executive team were visible on the wards and departments.
- Staff sickness in the Health Group was 3.3% in May 2015, which was lower than the target of 3.9%.

Culture within the service

- At ward level, staff we spoke with described the culture as improving; they highlighted the past issues with regards to bullying; however, they said that things had improved since the new executive team had been in post.
- The majority of staff we spoke with described the culture at ward level, as good. However, junior medical staff working within a surgical speciality highlighted to us concerns over bullying within their department, the human resources team was aware of and was dealing with the issues.
- The majority of staff we spoke with spoke about their colleagues in a positive manner.
- In the majority of occasions, we found staff morale within surgical wards and departments as good.
- Staff spoke with us about feeling able to raise concerns and feeling listened too by their immediate senior team.
- In the previous year the trust had a Yorkshire and Humber trainee survey 2015 undertaken which highlighted concerns of doctors in training; these concerns included low morale, bullying and a lack of support to trainees. The senior management team had responded to this report by reviewing rotas of on-call foundation level staff and improving support mechanisms.

Public engagement

- The NHS Friends and family test (FFT) had a response rate at ward level of 25%, which is lower than the England average of 31%. Feedback from the FFT for ward 27 included patients not being seen by the same registrar in clinic on each occasions, the department had worked to improve continuity and to ensure where possible the same member of the medical team were seen during appointments.
- Wards we visited had "you said we did boards" which highlighted actions taken because of patient feedback.

Staff engagement

- Department managers spoke with us about an "open door policy" for staff to discuss issues with them.
- The Surgery Health Group had scored the second highest score for staff engagement on the 2015 staff survey.
- The trust held a yearly 'Golden Hearts' award ceremony to recognise great work from staff. Staff working within the Health Group had recently been awarded the Golden heart.
- Staff had been involved in choosing the new values for the organisation of care, honesty and accountability.

Innovation, improvement and sustainability

- Staff we spoke with were proud of the modernisation of the workforce, in relation to the new ward support roles developed over the last year.
- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.
- The orthopaedic department at CHH had recently commenced day case joint replacement operations, two total knee replacements and one total hip replacement had been carried out in May 2016.
- The Gastroenterology department received a national award for introducing a service to support liver research in the community.
- The colorectal team had introduced a nurse led two-week wait clinic to increase available capacity.
- Both staff and patients highlighted to us the ward manager of ward 10 and ward 16, staff and patients we spoke with spoke fondly about the support and leadership of these managers.

Critical care

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

Information about the service

Hull and East Yorkshire Hospitals NHS Trust provides critical care services at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH). The Surgery Health Group manage the service.

There are two intensive care units (ICU) at CHH. ICU1 has 12 beds and is a cardiothoracic critical care unit and ICU2 has 10 beds and is a general critical care unit. The units area adjacent to each other on the same floor and are staffed to care for six level three patients (who require advanced respiratory support or a minimum of two organ support) and 13 level two patients (who require pre-operative optimisation, extended post-operative care or single organ support) across the floor.

Intensive Care National Audit and Research Centre (ICNARC) data for ICU1 showed that between 1 April 2015 and 31 December 2015 there were 641 admissions with an average age of 67 years. Nineteen percent of patients were non-surgical, 79% planned surgical and 2% emergency or urgent surgical. The average length of stay on ICU1 was three days.

Intensive Care National Audit and Research Centre (ICNARC) data for ICU2 showed that between 1 April 2015 and 31 December 2015 there were 481 admissions with an average age of 64 years. Twenty four percent of patients were non-surgical, 70% planned surgical and 6% emergency or urgent surgical. The average length of stay on ICU2 was three days.

A critical care outreach team provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The team is available 24 hours a day, seven days a week.

The critical care service is part of the North Yorkshire and Humberside Critical Care Network.

A comprehensive inspection was undertaken in February 2014. We rated safe, effective, caring, responsive and well led as good. The service was rated as good overall.

During this inspection we visited both units. We spoke with six patients, two relatives and 23 members of staff. We observed staff delivering care, looked at four patient records and three medication charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

In 2014 we rated critical care as 'good' across all domains. Following the 2016 inspection the service was rated as 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, staffing in the critical care outreach team, the frequency of the consultant on call rota and less than the 50% standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified risks to the service that were not on the risk register. We were concerned about the out of hours medical cover at CHH and the impact of the trust's reconfiguration of services. There was a lack of recognition of this or forward planning from the Health Group management team or executive team to mitigate the risks.
- Controls for some of the risks that had been identified were limited and unsustainable and there was not clear evidence or assurance of escalation of the risks beyond the Health Group. Staff gave us examples of a lack of action on some of the risks on the risk register.
- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts to cover CHH. Some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place which was not in line with guidelines for the provision of intensive care services (2015).
- Junior medical staff that worked on ICU2 out of hours did not have skills in tracheostomy and epidural management. Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units. The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015). Patients did not have access to formal psychology input following critical care.
- The service had limited formal mechanisms for collecting patient or relative feedback.

However;

- Patient outcomes were the same as or better than similar units and care and treatment was planned and delivered in line with evidence based guidance, standards, best practice and legislation.
- The service showed a good track record in safety. There had been no never events, or serious incidents.
- There was clear nursing and medical leadership on the units and in the critical care outreach team and it was clear that staff had confidence in the units' leadership.
- We observed patient centred multidisciplinary team working.

Critical care

Are critical care services safe?

Requires improvement

In 2014 we rated safe as 'good' and in 2016 it was rated 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014, for example, the frequency of the consultant on call rota and staffing in the critical care outreach team. Medical staffing was not in line with guidelines for the provision of intensive care services (2015) as some patients were not seen by a consultant within 12 hours of admission and twice daily ward rounds did not take place. Junior medical staff that worked on ICU2 out of hours did not have skills to manage potential risks associated with tracheostomy and epidural management.
- The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 79-91% in the day and 84-92% at night. This meant that planned staffing levels were not consistently achieved. The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team.

However;

- The service showed a good track record in safety. There had been no never events, or serious incidents. Staff understood their responsibilities to raise concerns and report incidents.
- The number of staff in the service that had completed mandatory training was above the trust's target.

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between May 2015 and April 2016.
- There service reported no serious incidents between May 2015 and April 2016.
- The units reported 46 incidents between 1 January and 31 March 2016, 70% of these were graded as no harm and 30% as minor harm. Themes of the minor and no harm incidents were skin damage, restraint of patients, for example, using mittens for patients' own safety and medication administration.
- Staff reported incidents using an electronic system. They were aware of what to report as an incident and how to report it.
- Staff could identify on the form when an incident involved a patient that had been referred to the critical care outreach team so a copy was sent to the critical care outreach lead.
- Senior staff had completed training to investigate incidents and shared information from incidents by email and at team meetings.
- Cross site critical care mortality and morbidity meetings were held monthly. The trust provided an example of the record from the meeting. Minutes included any clinical action needed and lessons learnt from the review by the responsible staff member. Junior medical staff were encouraged to attend these meetings. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust included the process for duty of candour in the 'Being Open when Patients are Harmed' policy.
- A member of staff gave us an example of when they had applied the duty of candour after a patient developed pressure damage on the unit.
- The trust had a duty of candour intranet site to provide information for staff.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism.

- The units displayed some of the safety thermometer information so it was visible to staff and visitors. The incidence of pressure ulcers and falls was on display; however, the other components of the safety thermometer were not displayed.
- Data for ICU1 from July 2015 to May 2016 showed 100% harm free care on the day the data was recorded.
- Data for ICU2 from July 2015 to May 2016 showed between 88% to 100% harm free care on the day the data was recorded.

Cleanliness, infection control and hygiene

- Infection control information was displayed to visitors prior to entering the unit.
- All areas on the unit were clean and tidy.
- All equipment was visibly clean and was labelled with the date it had been cleaned.
- ICNARC data showed ICU1 had 4.5 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was higher than similar units.
- ICNARC data showed ICU2 had 3 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was about the same as similar units.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Infection control training information provided by the trust was not site specific. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 86.8% of registered nurses, 83.3% of estates and ancillary staff, 81.3% of additional clinical services staff and 54.6% of administrative and estate staff had completed infection control training.
- Staff completed infection prevention and control audits. Information provided by the trust for November 2015 showed 94% compliance in ICU1 and 94% compliance in ICU2. The results showed concerns about sharps, cleaning checklist and staff's awareness of the five moments of hand hygiene, however, no comparative results or action plan were provided.
- At the time of our inspection the units displayed ward cleaning audit information from July 2016. This showed 98.5% compliance on the cleaning audit and 100% compliance with the hand washing audit.
- Records for flushing taps to prevent legionella were kept and complete.
- The units had facilities for respiratory isolation.

Environment and equipment

- The unit was secure; access was by an intercom.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.
- Staff checked the defibrillator and other emergency equipment daily. Records for this were complete.
- Disposable items of equipment were stored appropriately. We checked over 55 pieces of equipment; only one piece of equipment was out of date. The nurse in charge removed it and informed us this piece of equipment was no longer used
- The service kept up to date environment and equipment maintenance records.
- We checked over 20 pieces of electrical equipment; all of them had up to date safety test stickers on.
- Staff received training on the use of equipment and gave an example of a new piece of equipment being brought onto the unit and the manufacturers providing training on its use. We saw evidence of equipment training in team meeting files.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- There were some medications stored in the top drawer of the resuscitation trolley which was not locked. Staff on both units told us there were plans to have an easy release lock fitted to the drawer.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- We reviewed three medication records. Two had been completed and in line with national and trust guidance; on one record the staff signature was illegible.

- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely and all components of the record were in one place.
- Medical staff completed a daily critical care assessment form that met the National Institute of Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals). However, the document did not have date, version or review date on.
- Nursing documentation included care bundles and quality and safety checklists. Staff explained how these were used, however, we found numerous occasions where the quality and safety checklists were not completed at night time. We raised concerns about this with senior staff during our inspection.
- During our unannounced inspection we checked four quality and safety checklists. Two of these were complete; three night time checks had not been documented in 14 days on the other checklists. This showed practice had improved following our initial inspection.
- Medical documentation did not record that care was delivered in line with guidelines for the provision of intensive care services (2015). For example, records showed evidence of a consultant ward round once a day rather than the recommended twice a day and there was not always a record of a consultant review within 12 hours of admission to critical care.
- Information governance training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 81.8% of registered nurses, 90.9% of support staff and 70% of administrative and estate staff had completed information governance training.

Safeguarding

- Staff were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Safeguarding training information provided by the trust was not site specific and did not provide detail on the level of safeguarding training. The trust target was 85%. However, in the service 0% of scientific, therapeutic and technical staff, 89.2% of registered nurses, 81.8% of support staff and 80% of administrative and estate staff had completed vulnerable adults training.
- In the service 0% of scientific, therapeutic and technical staff, 87% of registered nurses, 90.9% of support staff and 80% of administrative and estate staff had completed safeguarding children training. The trust target was 85%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and fire training. Annual updates of mandatory training topics were planned into team meetings.
- Mandatory training information provided by the trust was not site specific. Overall compliance with mandatory training in the service was 86.8%. This was better than the trust target of 85%.
- Resuscitation training information provided by the trust was not site specific. The trust target was 85%. However, in the service 71.3% of registered nurses and 50% of support staff had completed resuscitation training.

Assessing and responding to patient risk

- The critical care outreach team was available 24 hours a day, seven days a week. The team consisted of senior nurses who were supported by a consultant intensivist for one session a week. They supported patients stepped down from critical care and reviewed patients alerted to them through the NEWS referral system. The team also supported patients nursed on wards with tracheostomies, delivered non-invasive ventilation outside of critical care units and were a member of the cardiac arrest team.
- Staff on the wards told us they had a high regard for the service provided by the critical care outreach team.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team responded to 4671 referrals across both HRI and CHH. That was on average 13 referrals a day.
- Information provided by the trust showed that, between May 2015 and May 2016, the critical care outreach team followed up 1407 patients from ICU1 and ICU2. That was on average four patients a day.

- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- Records reviewed included risk assessments for VTE, pressure areas and nutrition. Staff had completed these in all the records we reviewed.
- Two beds on ICU1 were for post anaesthetic ventilation (PAVU) and four beds were dedicated for cardiothoracic cases.
- The junior doctors, who were the only member of medical staff based on ICU2 overnight, had not had training in the management of a dislodged tracheostomy or in epidural care.
- The junior doctor on ICU1 and the anaesthetic trainee on ICU2 were part of the cardiac arrest team.
- Advanced Critical Care Practitioners (ACCP's) had basic airway skills and assisted in intubation. There was not always an ACCP on duty overnight.

Nursing staffing

- Nurse staffing met the guidelines for the provision of intensive care services (2015) minimum requirements of a one to one nurse to patient ratio for level three patients and a one nurse to two patients ratio for level two patients.
- The units displayed the planned and actual staffing figures. One of the days of our inspection the planned number of registered nurses was 16 for the early, late and night shifts, however, the actual number on duty was 12 on the early shift, 13 on the late and night shifts. The actual number of support workers on duty was the same as the planned number.
- The planned staffing figures included two supernumerary clinical co-ordinators, one based on each unit. This was in line with the guidelines for the provision of intensive care services (2015).
- The service had 50 whole time equivalent (WTE) registered nurse vacancies in April 2016. This was recorded on the risk register, recruitment was underway and the divisional nurse manager was undertaking a workforce review.
- The trust provided information on staffing levels for the six weeks prior to our inspection. The units used a step up and step down model to allow flexibility in staffing according to the demand, however, fill rates on the unit for registered nurses were between 79-91% in the day and 84-92% at night. This meant that planned staffing levels were not consistently achieved. Senior staff and the coordinator planned staffing across both sites according to each units capacity.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the transfer team which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. The critical care outreach lead had written a standard operating procedure for the suspension of the critical care outreach service; this had not been ratified at the time of our inspection. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- The critical care outreach team generated an electronic handover document.

Medical staffing

- Critical care had a designated clinical lead consultant. Cardiac critical care had a clinical director.
- The consultant establishment in critical care was 16 WTE. At the time of our inspection the service had four vacancies and one consultant on maternity leave. The 11 consultants in post covered the rota which resulted in a more than one in six on call frequency.
- The units met the requirements of the guidelines for the provision of intensive care services (2015) for medical staffing between Monday and Friday 8am to 6pm. Care was led by a consultant in intensive care medicine and the work pattern delivered continuity of care. The consultant to patient ratio did not exceed the recommended 1:8 to 1:15.
- There was no documented evidence that consultants completed twice daily ward rounds which was not in line with the guidelines for the provision of intensive care services (2015).
- One anaesthetic trainee doctor and one junior doctor were based on the units overnight. The anaesthetic trainee was based on ICU1, if they were called away, for example, to theatre one of the consultants on call came in to the hospital.
- The service employed trainee Advanced Critical Care Practitioners (ACCP's). Three were due to qualify three months after our inspection; an additional two trainees were due to qualify in 2017. Three more trainees and

one qualified ACCP were due to start in the service three months after our inspection. The ACCP's were not part of the junior doctor rota. The aim was for one ACCP to be based on the units on every shift.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans and completed regular table top exercises.
- Staff knew how to access the major incident and continuity plans on the intranet.

Are critical care services effective?

Good

In 2014 we rated effective as 'good' and this rating was maintained at the 2016 inspection because:

- Care and treatment was planned and delivered in line with current evidence based guidance.
- Patient outcomes were in line with or better than similar units.
- We observed patient centred multidisciplinary team working.
- The units had a teacher trainer in post and staff were supported to maintain and develop their professional skills.

However;

- Only twenty five percent of nurses had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%.

Evidence-based care and treatment

- The units policies, protocols and care bundles were based on guidance from NICE, the intensive care society and the faculty of intensive care medicine. Staff demonstrated awareness of the policies and knew where to access them.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The trust's tracheostomy care bundle and resources were in line with National Tracheostomy Safety Project guidance.
- The unit displayed a critical care and anaesthetic research board with poster presentations of research completed and information on current research trials that were underway.
- We observed staff on the ward round assessed patients for delirium.

Pain relief

- A pain management specialist nurse visited the units and reviewed patients and suggested treatment plans.
- ICU2 displayed a pain information board that contained information about the pain link team, pain assessment and scoring system.
- We observed staff on the ward round assessing pain and giving support to patients who required pain relief.
- Three patients told us their pain was well controlled, staff monitored their levels of pain and that additional medications were given promptly.

Nutrition and hydration

- Staff assessed patients' nutritional and hydration needs daily and acted upon the findings.
- We observed a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietician was not available.
- A dietician visited the unit daily. The dietician saw some of the elective patients pre operatively and advised on pre-operative nutrition.
- Halal and kosher meals were available and catering staff had received training regarding special dietary requirements.
- During our inspection we observed water was available and within reach for patients who were able to drink.

Patient outcomes

- We reviewed the Intensive Care National Audit and Research Centre (ICNARC) data for ICU1 from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 0.95. This was in line with similar units.
- ICU1 had a 0.7% unplanned readmission in 48 hours rate. This was lower than the 1.3% rate of similar units.
- We reviewed the ICNARC data for ICU2 from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 1.02. This was in line with similar units.
- ICU2 had a 0.7% unplanned readmission in 48 hours rate. This was lower than the 1.6% rate of similar units.

- The ICNARC data coordinators worked with clinical staff to collect additional information the service used for research and audit.
- The critical care outreach team collected patient outcomes in an electronic database.
- The trust provided a list of titles of projects on the units audit program. Topics included ICU delirium, six hour sepsis care bundle, inadvertent hypothermia in intensive care patients and record keeping.
- Senior nurses completed the trust's nursing quality metrics.

Competent staff

- Senior nursing staff had been allocated responsibilities; these included completing appraisals, managing sickness and clinical expert roles. Nursing staff had link nurse roles, for example, infection prevention and control, pain, pressure care and nutrition.
- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. However, information provided by the trust showed that at May 2016 89.9% of nurses and 100% of additional clinical services staff, estates and ancillary and administrative and clerical staff on the units had received an appraisal. This was better than the trust target of 85%.
- The units had a teacher trainer who was responsible for coordinating the education and training for staff. This met the recommendations of the guidelines for the provision of intensive care services (2015).
- Twenty five percent of nurses in the service had completed a post registration critical care qualification. This was lower than the minimum recommendation of 50%. All staff completed the national competency framework for adult critical care nurses as the first step towards meeting the post registration in critical care qualification recommendation.
- Staff within the critical care outreach team were working towards the national outreach competencies. Two staff in the team were completing an MSc and all staff had completed in-house advanced clinical skills.
- New members of nursing staff received an induction onto the unit, were allocated two mentors and had a supernumerary period.
- Simulation courses were available to staff, recent courses had been held on paediatric critical care and evacuation.
- Staff told us there were good opportunities to undertake further relevant training. Nursing staff had the opportunity to complete a management training course where they became the coordinator for six to eight weeks with band six support.
- We observed the ward round being used as a teaching opportunity. Junior doctors told us they received good support and teaching.
- The units displayed information about revalidation for nurses.
- Some clinical support workers had completed additional training and competencies to allow them to carry out interventions and care for patients under the direction of a registered nurse.
- The trust supported trainee ACCP's to complete an advanced practice module at a local university, advanced life support, faculty of intensive care medicine and non-medical prescribers training.
- The trust had recruited nurses with post-operative recovery experience but who did not have critical care training to work in PAVU. These staff had a supernumerary period to achieve set competencies including extubation. One new member of staff was working in this area at the time of our inspection. They told us that they had been well prepared for the role and supported by the teacher trainer and experienced critical care staff.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from occupational health and human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection.
- We observed members of the multidisciplinary team participate in the ward round; however, all members were not present for the whole ward round.
- Physiotherapists, a dietician and a pharmacist visited the unit daily.
- Nurses told us they could access occupational therapy and speech and language therapists when required. We saw in records that when staff made referrals to the multidisciplinary team such they responded promptly within 24 hours.
- Each unit had a full time ICNARC data entry coordinator.

- A member of staff told us of joint work regarding medicines management between nursing and pharmacy staff had a financial benefit.

Seven-day services

- A consultant intensivist was available seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A specialist critical care pharmacist visited the units Monday to Friday to check prescriptions and reconcile patients' medicines. The pharmacy was open seven days a week with a 24 hour on call service.

Access to information

- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital. A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.
- Staff had access to guidelines at every bed space and at the nurses' station.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- There was a trust information leaflet on Deprivation of Liberty Safeguards (DoLS) in the waiting room on ICU1. This explained the process for applying for a DoLS authorisation and what this meant for the patient.
- Staff we spoke with demonstrated some understanding of consent, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- MCA training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 91.3% of registered nurses and 50% of support staff had completed MCA training.
- DoLS training information provided by the trust was not site specific. The trust target was 85%. However, in the service 100% of scientific, therapeutic and technical staff, 88.3% of registered nurses and 25% of support staff had completed DoLS training.
- Senior staff had written an appendix to the trust restraint policy to make it applicable for critical care.
- Staff showed an understanding of restraint and explained the reasons and the process they would follow if they needed to use mittens or medication for a patient's safety.

Are critical care services caring?

Good

In 2014 we rated caring as 'good' and this rating was maintained at the 2016 inspection because:

- Patients were supported, treated with dignity and respect, and were involved in their care. Feedback from patients and relatives was positive about the way staff treated people.
- We observed all staff responded to patients' requests in a timely and respectful manner.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.
- A member of staff received a trust award in recognition of the care they provided.

However,

- There was no regular psychological support available to patients following critical care.

Compassionate care

- The unit did not carry out patient surveys. Thank you cards from patients and relatives were on display.
- We observed curtains being drawn around patients' beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- All staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- All the patients we spoke with told us they had received good care and did not have to wait for anything from staff. They did not have any suggestions for improvement

- One patient we spoke with had experienced difficulties in sleeping due to the noise level on the unit. Staff offered ear plugs and medication to assist with sleep.
- A member of staff on ICU1 received a trust award in recognition of initiating palliative care for a patient and arranging their discharge home. The nurse had received an award in recognition of this. Staff also arranged the transfer of a patient to a hospice for end of life care.

Understanding and involvement of patients and those close to them

- All the patients and relatives we spoke with told us they had been kept informed of the treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence on the ward round where staff spoke to patients in a way they could understand and involved patients in making decisions about their care and treatment including discharge planning.
- We observed staff explaining their care to patients prior to delivering it.
- Patients and relatives told us they thought the visiting arrangements were good.
- We observed staff using the cordless telephone so patients could speak to their relatives when they called the units.

Emotional support

- Staff provided the opportunity for a patient diary to be kept. Patients and relatives were invited back to a clinic to collect and review the diary with staff and visit the unit if they wished.
- The chaplaincy service visited the units daily and they were able to offer pastoral, spiritual and religious support.
- We observed staff on the ward round discuss the symptoms of delirium with a patient and reassure them about the cause and treatment for these. Staff empathised with the patient and gave them all the time they needed to talk.
- The spouse of a former patient on ICU at HRI had set up a critical care patient support group that was available to patients and relatives at both HRI and CHH. The group met regularly and offered telephone support.
- There was no regular psychological support available to patients following critical care. We found evidence that patients may benefit from psychological support as they suffered from intrusive and distressing thoughts and dreams. We informed senior staff about this at the time of our inspection.

Are critical care services responsive?

Good

In 2014 we rated responsive as 'good' and this rating was maintained at the 2016 inspection because:

- Access to care was managed to take account of peoples' need. The delayed discharge and out of hours discharge rates were better than similar units.
- There had been no patients ventilated outside of critical care in the last 12 months.
- The facilities and premises were appropriate for the services being delivered.
- Staff took account of and were able to meet people's individual needs.

However,

- The rehabilitation after critical illness service was limited and not in line with the guidelines for the provision of intensive care services (2015).
- There had been eight mixed sex accommodation breaches on ICU2 in the last 12 months.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision could be flexed to meet the differing needs of level two and three patients; however, at the time of our inspection the provision was limited by nurse staffing.
- The service had produced a patient and relative support information leaflet. This included advice about financial support, social care and support including mental health services and carers support. There was also information about the critical care support group.
- The rehabilitation after critical illness service was limited. Critical care outreach staff reviewed all patients who had been ventilated or in critical care for two or

more days following discharge, however, the frequency of the visit depended upon the team's capacity. There was no medical or multidisciplinary input to the follow up clinic.
- A visitors' waiting room was available outside the unit; a file was available with general information about the units and nearby accommodation. There was information on the walls about speaking to medical staff and accessing chaplaincy staff. A hot drinks machine was available.
- Staff could meet visitors in private by using the separate quiet room.
- Overnight accommodation for relatives was available.

Meeting people's individual needs

- Translation services were available to patients whose first language was not English. Staff knew how to access the service. During our inspection we observed the coordinator allocated a nurse to care for a patient of the same nationality to aid communication.
- Staff could access leaflets in different languages if required.
- Staff were aware of the butterfly scheme in use for patients living with dementia, however, reported that they cared for very few patients living with dementia. Staff told us they would invite carers or relatives to stay with the patient if required.
- Staff gave us an example of a patient with hearing difficulties was on the unit and their carer stayed to support the patient.

Access and flow

- The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient.
- Information provided by the trust showed that between March and May 2016 the average bed occupancy for ICU1 was 76.3%. This was lower than the England average.
- Between March and May 2016 the average bed occupancy for ICU2 was 101.3%. This was higher than the England average.
- Data provided by the trust showed in the last 12 months:
  - there had been 42 cancelled elective operations across both sites due to a lack of critical care capacity;
  - there had been no adult patients ventilated outside of critical care;
  - there had been eight mixed sex accommodation breaches on CICU2;
  - The ICNARC data for both units from 1 April to 31 December 2015 showed the unit had transferred 0.2% patients due to non-clinical reasons. This was in line with similar units and the network average.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the delayed discharge rate was 0.6%. This was lower than similar units' rate of 1.5%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 0.2%. This was lower than similar units' rate of 0.7%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the delayed discharge rate was 0.3%. This was lower than similar units' rate of 2.9%.
- The ICNARC data for ICU1 from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 0.7%. This was in line with similar units' rate of 0.8%.

Learning from complaints and concerns

- Staff were aware of the process for managing concerns and complaints and how to access it.
- The unit displayed information and leaflets on how to make a complaint.

The matron visited some patients on the ward following discharge from critical care. One patient raised concerns about the way some members of staff delivered care. The matron shared this feedback with staff who were then able to make changes to their practice.

Are critical care services well-led?

Requires improvement

In 2014 we rated well led as 'good' and in 2016 it was rated 'requires improvement' because:

- The trust had not addressed some of the issues raised from the comprehensive inspection in February 2014. We also found new issues around the identification, management and escalation of risks in the service.
- We identified risks to the service that were not on the risk register. We were concerned about the out of hours

medical cover and the impact of the reconfiguration of services. There was no clear evidence of forward planning from the Health Group management team or executive team to mitigate the risks.
- Staff gave us examples of a lack of action on some of the risks on the risk register. Controls for some of the risks were limited and unsustainable and there was not clear evidence or assurance of escalation of the risks beyond the Health Group.
- The service had limited mechanisms of collecting patient or relative feedback.

However,

- There was clear nursing and medical leadership on the units and in the critical care outreach team with the integrity, capacity and capability to lead the service effectively. It was clear that staff had confidence in the units' leadership.
- Staff were happy in their work and felt that the culture on the units was open and honest.

Vision and strategy for this service

- The Surgery Health Group strategy 2016 – 2021 was in draft at the time of our inspection. It set out objectives that were in line with the trust's vision, values and goals.
- The key priorities for critical care in the strategy were operational and focussed on nurse and medical staffing, the development of new advanced practitioner roles, reduction of cancelled operations and the completion of a demand and capacity analysis to highlight capacity constraints to the trust and the critical care network.
- The management team acknowledged organisational changes at trust level had an impact on critical care provision. These changes were mainly related to the move of almost all elective work to CHH. Elective maxillofacial and ear, nose and throat surgery were planned to be moved to CHH three months after the time of our inspection. The management team did not have a timescale for when elective neurosurgery and vascular surgery would move to CHH.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

- The service held monthly business team meetings that included multidisciplinary attendance. We reviewed minutes from these meetings; governance, ICNARC data, equipment and the risk register were some of the agenda items discussed. Following each meeting an action log was completed with timescales.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. The unit's risk register identified the following key risks: consultant vacancies, delayed discharges, cancellation of elective surgery due to nurse vacancies and risk to services and patient safety due to nurse vacancies. The risk register showed that limited controls were in place to mitigate these risks.
- During our inspection we identified risks to the service that were not on the risk register. At CHH we were concerned about the out of hours medical cover and the impact of the reconfiguration of services. There was no forward planning from the Health Group management team or executive team to mitigate the risk.
- In addition critical care outreach staffing and service suspension, lack of escalation of NEWS scores and the lack of compliance with guidelines for provision of intensive care services (2015), particularly lack of rehabilitation after critical illness was not clearly identified as a risk to patients who used the service.
- Staff gave us other examples of a lack of action on some of the risks on the risk register. Recruitment of consultants had not been actioned promptly, incorrect vacancies had been advertised and a block had been placed on locum consultant appointments. Due to the limited and unsustainable controls in place for some of the risks, for example, consultant staffing, we requested evidence from the management team of escalation of these risks to the executive team. The team provided copies of the Executive Management Committee risk register report and the Surgery Health Group report to the Operational Quality Committee and Health Group board; however, these did not give clear evidence or assurance of escalation of the risks.

Leadership of service

- Senior staff were visible and approachable. There was clear nursing and medical leadership on the unit and in the critical care outreach team.

Critical care

- It was clear from our conversations, observations and data we reviewed that staff had confidence in the unit's leadership. Most staff reported feeling supported by their teams and managers.
- During our inspection we saw examples of strong leadership at unit level; however, staff told us that senior managers from the executive team lacked understanding of the demand on the units and the capacity of critical care. Staff gave us examples of the reconfiguration of elective surgery work despite the challenge faced in medical staffing.
- Senior staff had completed the internal and external leadership training and received dedicated management time.
- The management team was very proud of all the staff and the patient care they provided.
- Senior staff attended regular cross site meetings as well as site specific meetings and the trust senior nurse forum.

Culture within the service

- Staff we spoke with told us they were happy in their work, felt supported, able to raise concerns and that the culture on the units was open and honest.
- Staff were proud of their teamwork and the care they delivered to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- We observed the nurse in charge offer support to a member of staff away from the patient's bedside after they had dealt with a challenging situation with on the unit.
- Senior staff had worked to reduce sickness in the service, information provided by the trust showed registered nurses sickness was 4% and other staff was 2.6%.
- Staff had access to a counselling service in the trust.
- Staff had completed professional and cultural transformation training and all staff who had worked in the trust for a long period told us the culture had improved and they were optimistic about the future.

Public engagement

- The units displayed thank you cards from patient and relatives.
- Comments slips and a suggestion box were available in the waiting room.
- A patient from HRI ICU and their spouse had set up a patient support group, the spouse had attended staff meetings to feedback their experiences, examples of changes introduced from this was for staff to let the patient know if they were leaving the room and changes to some staff's routines on a night shift.
- Staff had nominated the patient support group for a trust award.
- A member of senior staff visited patients on the ward to receive feedback from their stay. This feedback was collected informally at present and shared with staff at team meetings.

Staff engagement

- Regular staff meetings were held. We saw evidence in the minutes that incidents, training, clinical supervision and equipment were some of the topics discussed.
- ICU1 displayed a large staff notice board with information including mentorship updates, lesson learned, infection control, pressure ulcer prevention and nutrition.
- Staff gave us examples of changes that senior staff had made in response to concerns raised by staff. These included additional options being included in electronic rostering to allow some flexibility for staff and the movement of staff off the unit to cover other areas in the hospital.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- The critical care outreach team was part of a critical care outreach regional network forum to benchmark services and share best practice.
- The service had successfully recruited and retained advanced critical care practitioners (ACCP's). Feedback from the ACCP's on their role and training was very positive.
- The service had submitted a successful business case to use a new electronic clinical management system to collect ICNARC data and critical care outreach data to provide more real time data to understand activity.
- The teacher trainers had been shortlisted for a national nursing award and had been asked to write an article for a national nursing journal for their training courses.

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

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

Hull and East Riding Hospitals provided are at the end of life across a wide range of services, including surgical and medical wards (including wards for older people), accident and emergency, critical care and specialist services such as oncology at both Hull Royal Infirmary and Castle Hill Hospital which also incorporated the Queen's Centre for Oncology and Haematology. In addition, the chaplaincy, mortuary and bereavement teams also provided care at the end of life.

The trust employed a Specialist Palliative Care Team; this included nine specialist palliative care nurses and four consultants. The Specialist Palliative Care Team worked Monday to Friday 8am to 6pm. There was provision across both main hospital sites. The team were based at Castle Hill Hospital and provided a daily in reach model at Hull Royal Infirmary.

During 2015, the trust had 2386 in hospital deaths. The Specialist Palliative Care Team received 1386 referrals; this included 1043 cancer referrals and 343 non-cancer referrals.

During our inspection we visited seven wards at Castle Hill Hospital where care at the end of life was being provided, we spoke with eight patients and three relatives. We also spoke with 15 members of nursing and medical staff. We visited the mortuary and bereavement service and spoke with a member of staff from this team. In addition to this, we visited the chaplaincy team and spoke to three of the hospital chaplains.

The last comprehensive inspection of end of life care services at the hospital was in February 2014, we found the service to be good overall.

End of life care

Summary of findings

In 2014, we rated this core service as 'good' overall. Following the 2016 inspection we rated the service as 'Good' because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents. Mandatory training across most services was above the trust targets. Medicines were prescribed and administered safely in line with policy and staffing levels were appropriate for the services provided.
- People's care and treatment was planned and delivered in line with current evidence-based guidance. Information about people's care and treatment, and their outcomes, were routinely collected and monitored. Staff providing care at the end of life were highly skilled and competent. There was evidence of multidisciplinary working across all teams. The trust had recently employed more staff to be able to provide seven-day specialist palliative care nurse availability. Consent to care and treatment was obtained in line with legislation and guidance.
- Feedback we received from patients was consistently positive about the way staff treated them. We observed a number of staff and patient interactions during our inspection. We observed consistently caring and compassionate staff. Patients and their families were supported emotionally. We saw an initiative that had been implemented by the bereavement team that we thought was outstanding.
- Services were planned and delivered in a way that meets the needs of the local population. All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and patients' choice in relation to where their care was delivered was achieved. We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- All teams were aware of the trust vision and values. Whilst there was no trust end of life strategy at the time of our inspection, the Specialist Palliative Care Team (SPCT) were working collaboratively with other providers and using the national End of Life Care strategy to benchmark and influence the care and treatment they provided to patients. Robust governance, risk management and quality measurement processes were embedded. Staff told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board. We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused and we saw examples of innovation, improvement and sustainability.

End of life care

Are end of life care services safe?

Good

In 2014, we rated safe as 'Good' and this rating was maintained in 2016 because:

- Patients were protected from avoidable harm and abuse. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Managers shared the learning from incidents.
- All staff we spoke with were aware of their responsibilities and took a proactive approach to safeguarding.
- Mandatory training in most teams providing care at the end of life was above the trust targets however; in some teams, compliance with some subjects was lower than the trusts targets.
- The environments were fit for purpose and equipment was readily available.
- Medicines were prescribed and administered safely in line with policy.
- Staffing levels were appropriate for the services provided.

However we also found:

- Not all staff were up to date with mandatory training.
- Staff were non-compliant with the syringe driver policy in that four hourly checks were not being completed. However, following our unannounced inspection we found that the trust had taken immediate steps to address this including daily audits being undertaken by the Specialist Palliative Care Team (SPCT).

Incidents

- All staff we spoke with told us that they were encouraged to report incidents and that they were confident in the use of the trusts electronic reporting system.
- Staff told us that they received feedback after reporting incidents and we saw lessons learned publications that were produced by the trust each month and disseminated to staff. We saw these displayed in some of the wards we visited.
- There were low numbers of incidents involving patients at the end of life across all core services. Information provided by the trust indicated that 30 incidents involving patients at the end of life had been reported between May 2015 and May 2016. All of these incidents were graded as low or no harm. These included incidents such as deterioration in a patient's skin condition and concerns raised regarding the transfer of patients care.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour. We saw that following incidents, in other services, the trust apologised to the patients involved and their families. There had been no incidents requiring duty of candour for patients receiving care at the end of life however staff told us about being open and honest and apologising if things went wrong.

Cleanliness, infection prevention and control (IPC) and hygiene

- All areas that we visited, that were providing care at the end of life, appeared clean and well maintained. This included ward areas and the bereavement team offices.
- Personal protective equipment (PPE) such as gloves and aprons were available in all areas. Hand wash stations were available in the main foyer area of the hospital and also in each ward. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side wards. We saw staff using appropriate PPE and washing their hands before providing care to patients.
- Staff completed IPC training as part of their mandatory training programme. The trust target for this training was 85%.Overall trust compliance with this was 73%; however, we found that only 43% of staff from the SPCT were compliant with this training.

Environment and equipment

- Staff we spoke with told us equipment, such are syringe pumps and specialist mattresses, were readily available for patients. However, some staff referred to the 'bed policy' and said that they were concerned that when patients were transferred between wards, they had to be transferred on to a bed belonging to the admitting ward

rather than the beds being swapped. This meant that sometimes patients were transferred between beds. Staff told us that they were concerned that this could cause unnecessary pain or distress for patients.

- The trust used two types of syringe pumps. However, wards at this hospital only used one type of device. One palliative link nurse told us that they were the trainer for the type of device used in the area and as such provided training in the use of the pumps for other staff on the ward. We had concern about this because if staff were required to move wards they may not be trained in the correct use of the pump in use in that area.
- We visited the bereavement office at the hospital. The bereavement offices were clean, and tastefully decorated.
- The Human Tissue Authority (HTA) is a regulator set up in 2005 created by parliament; they are an executive agency of the Department of Health. The HTA regulate organisations that remove, store and use human tissue for research, medical treatment, post-mortem examination, education and training, and display in public.
- The HTA inspected the mortuary services for the hospital in September 2015 and deemed that the services provided by the hospital met the required standards for premises facilities and equipment. Maintenance and service records were kept for equipment, including fridges/freezers, trolleys, post mortem tables and the post mortem suite ventilation.
- The fridges in the mortuary had an electronic automated alarm system to alert staff if the temperature of any individual fridge rose above 12 degrees centigrade. Staff were available 24 hours per day in case of emergencies.

Medicines

- The trust had policies and procedures in place for the safe handling and administration of medicines. These included documents that related specifically to care at the end of life including the prescribing of 'just in case' medication boxes for palliative care and guidelines for the use of opioids in palliative care.
- The trust had a policy for the administration of medications via a syringe driver. During our inspection, we found that staff were not completing four hourly checks of the syringe driver and the infusion site in line with trust policy. We discussed this with the SPCT who told us that this issue had been raised in the past. We highlighted this to ward staff at the time of our inspection and found that some staff were unable to tell us how frequently the checks should be. We raised our concerns with the senior trust team.
- During our unannounced inspection, we looked at the charts on four wards and found that compliance with the four hourly checks had improved however; staff were still not fully complying with policy. The trust had taken steps to address our concerns including communication being sent to all wards and a member of the SPCT told us that they were completing a trust wide audit of this issue.
- A member of the SPCT explained that syringe drivers were always prepared to contain 24 millilitres of fluid and run at one millilitre per hour over 24 hours to ensure a standard approach trust wide and therefore maintain patient safety.
- Staff we spoke with explained that if a patient was going home they had to take them off the syringe pump and would arrange for a district nurse to visit the patients home to set up a new pump. We had concerns about this however; staff explained that they gave the patient a subcutaneous dose of their medications to ensure that they remained symptom free until the community nurses could re-establish the syringe pump.
- The SPCT nurses were not non-medical prescribers however, they liaised with medical staff from the wards caring for patients at the end of life to ensure that medications were adjusted when needed. We witnessed this taking place during our inspection.
- We checked the medication administration charts for seven patients receiving end of life care and found that all non-essential medications were discontinued as appropriate. We found anticipatory medications were prescribed in line with evidence based best practice. This included medications for pain, shortness of breath, restlessness, nausea and respiratory tract secretions.
- In addition we saw that medicines reconciliation had been completed on the medication administration charts.

Records

- We looked at the care records for seven patients. We found that documentation completed by members of the SPCT was completed fully and consistently across in all records. This included the patients' prognosis, symptom management and patients physiological, social, spiritual and psychological needs.

End of life care

- We saw comprehensive assessments of patients' needs and care plans in place to manage the risks. This meant that records were in line with national guidance and processes were followed which helped keep people safe however, we looked at ten food and fluid charts and found that these were not fully completed for any of the patients.
- Family involvement was clearly documented in the records reviewed.
- The trust used an intentional rounding tool; we saw that these were in place in all records we reviewed.

Safeguarding

- Staff told us that they completed safeguarding training as part of statutory mandatory training. The team members of the SPCT (medical, nursing and the MDT coordinator) were 86% compliant with vulnerable adult's level 1 and safeguarding children level 2 training. This was above the trust target of 85%.
- Mortuary and bereavement office staff were 100% compliant with vulnerable adults and safeguarding children training. This was above the trust target.
- The chaplaincy staff were 57% compliant with vulnerable adults and safeguarding children training which was below the trust target.
- Nursing staff, we spoke with about training told us that they had completed safeguarding training and were able to describe the process they would follow if they had a concern or needed to raise an alert.
- Staff also said that they knew how to access safeguarding policies and procedures via the trust intranet.

Mandatory training

- The trust target for completion of statutory and mandatory training compliance was 85%. Data showed overall compliance of 76% for the 14 members of staff in the SPCT; however, the team had newly appointed members of staff and staff who had returned after a period of absence.
- The team was above the trust target for major incident (100%), Fire training (86%) and Information Governance (86%) however, they were below target for Moving and Handling (71%), Safety (64%) and Resuscitation training (57%).
- Staff in the mortuary and bereavement service were 100% compliant with all training except for moving and handling which was 71%.
- Overall, the chaplaincy staff were 78.5% compliant with all training, which was below the trust target. Compliance for infection prevention and control training was 43%. Safeguarding children and vulnerable adults training compliance was 57%.

Assessing and responding to patient risk

- The trust used a recognised national early warning score tool (NEWS). These tools are designed to assist staff in the early recognition and response to a deteriorating patient.
- We saw these in use in all of the care records we reviewed, however the forms did not always have a guide for staff to refer to in the event of a patient needing escalation response, except on one ward where we saw a laminated guide in the care record which was stored in the same section of the notes as the chart.
- In most of the records for patients receiving end of life care, we saw that ceilings of care were identified and documented.
- We saw that risk assessment tools had been completed in the records we reviewed. This included venous thromboembolism (VTE), falls, pressure area, malnutrition, moving and handling and IPC. When a patient was identified as at risk, we saw that a care plan was created.
- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw that the trust had a safety alert management flowchart. We also saw details of safety alerts displayed on some of the wards we visited.

Nursing staffing

- There were nine (6.5 whole time equivalents - wte) clinical nurse specialists and a multi-disciplinary team coordinator (0.7wte) in the SPCT.
- There were no vacancies at the time of our inspection and there had been no bank or agency use between June 2015 and May 2016. Sickness levels within the team were predominantly low, the average being 3% between June 2015 and May 2016. There was no sickness for seven of the previous 12 months. This meant there was continuity in the service, which helped to keep patients safe.

End of life care

- The SPCT nurses were available Monday to Friday 08:00 -18:00. Out of hours, staff could contact the local hospice for advice.
- The hospice was also able to contact the regional on call consultant in palliative medicine for further specialist advice if required.

Medical staffing

- The trust employed four end of life care consultants (3.6 wte). The hospital had 1202 general, acute and critical care beds therefore this number was less than the national commissioning guidance for specialist palliative care which was one doctor per 250 hospital beds.
- The consultants worked across the trust and a local hospice.
- There had been no locum medical cover between June 2015 and May 2016. Sickness levels within the team were low. There was no sickness in the medical team in the previous 12 months except for November 2015 when sickness was 1.5%.

Major incident awareness and training

- NHS providers have a statutory obligation to ensure they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. We saw the trusts emergency preparedness, resilience and response (EPRR) business continuity plan 2015/16. This showed evidence of testing for staff available to respond with 30 minutes in the event of a major incident.
- Staff completed major incident training as part of the induction at the trust. 100% of the SPCT, bereavement, mortuary and chaplaincy staff had completed this training.

Are end of life care services effective?

Good

In 2014, we rated the services as 'Good' for effective. In 2016 the services were rated as 'Good' because:

- Patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patients were prescribed and administered pain relief in a timely manner.
- Information about people's care and treatment, and their outcomes, were routinely collected and monitored. This information was used to improve care.
- Staff providing care at the end of life were highly skilled and competent.
- There was evidence of multidisciplinary working across all teams and also evidence of collaborative working with other providers and the local authority. Referral processes were straightforward and staff did not raise any concerns about these.
- The trust had recently employed more resources to provide seven-day specialist palliative care nursing availability. This was planned to be implemented from September 2016.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. We saw evidence that patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However we also found:

- Although patients were assessed for risk of malnutrition, food and fluid charts were not always completed in line with policy. This meant that patients might not always receive appropriate support with food and fluids.
- The trust did not provide face-to-face access to specialist palliative care for at least the hours 9 am to 5 pm, Monday to Sunday and did not have any end of life care facilitators

Evidence-based care and treatment

- We saw that trust polices relating to care at the end of life had been developed based on national guidance such as that recommended by the National Institute for Health & Clinical Excellence (NICE).
- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the trust had developed guidelines for end of life care. Staff did not use a pathway but used the guidelines to develop an individualised plan of care for patients receiving end of life care. This was called the guidance for the management of the dying patient.
- The specialist palliative care nurses we spoke with told us that the guidance was based on the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. The new approach focussed on giving compassionate care and to move

away from processes and protocols. It recognised that in many cases, enabling the individual to plan for death should start well before a person reaches the end of their life and should be an integral part of personalised and proactive care.

- Information provided by the trust indicated that the SPCT managed patients on their caseload according to national and local guidelines as appropriate. Examples of these were the rapid discharge policy, the syringe driver policy, the Yorkshire and Humber palliative and end of life care groups: a brief guide to symptom management in palliative care, the DNACPR policy, NICE guidelines on opioids in palliative care, NICE guidelines on neuropathic pain and NICE guidelines on care of dying adults in the last days of life.

Pain relief

- We saw the results of an audit of 44 care records of patients receiving end of life care, which was undertaken by the SPCT in 2015.This showed that 26 (59%) of the patients reviewed had all key drugs prescribed whilst 18 (41%) had some or none of the key drugs prescribed. There were 12 (27%) patients who had a syringe driver in place; however, 20 (45%) patients had two or more injections in the previous 24 hours. This would suggest that a syringe driver should have been started or increased.
- We did not see reference to the guidance outlined in the 2015 core standards for pain management services within any of the trust documents that related to pain relief, however in the records we reviewed, where appropriate, we saw without exception, that patients at the end of life were prescribed anticipatory/ just in case medication in line with NICE guidelines.
- We saw from patients' records that pain levels were assessed regularly and patients we were able to speak with told us that their pain relief was managed effectively and that staff responded quickly when they requested painkillers.
- We observed an end of life care consultant discussing pain control with a patient and suggesting alternative pain relief methods including the use of heat packs, topical applications, unlicensed products that might have been appropriate and also acupuncture.
- In a trust survey of bereaved relatives, we saw that 100% of those surveyed said that they were satisfied or extremely satisfied with the comfort of their relative.

Nutrition and hydration

- An audit completed by the SPCT in 2015 highlighted a lack of documentation of discussions around nutrition and hydration at the end of life. It also highlighted the lack of documentation around regular mouth care, making it difficult to ascertain the level of care given at the end of life to individual patients. This also indicated that the end of life guidance was not always adhered.
- We saw nutrition and hydration assessments in all of the care records we looked at. If patients were assessed as high risk of malnutrition or dehydration food and fluid charts were implemented. ;
- We saw that some patients were prescribed nutritional supplements and that these had been administered as prescribed.
- During our inspection, we saw staff performing mouth care for patients who were nearing the end of their life.
- Patients we spoke with told us that the quality of the food was good and that water jugs were replenished regularly as well as hot drinks and snacks being provided throughout the day.

Patient outcomes

- We saw an audit that had been undertaken in 2015 by one of the SPCT nurses. This audit highlighted areas of good and poor practice. It showed that the end of life guidance developed and implemented by the trust was not always adhered to. The outcome of this audit was that the end of life care guidance would be reviewed following the publication of the National Care of the Dying Audit in 2014. The team felt that the national audit would provide further evidence of the care patients at the end of life and their relatives had received in the trust and would provide a benchmark of other trusts nationally.
- The End of Life Care Audit – Dying in Hospital 2015, showed the trust scored below the England average for three out of the five clinical key performance indicators however, they achieved five out of the eight organisational quality indicators.
- The audit identified that there was no lay member of the trust's board with responsibility for end of life care, the trust did not provide face-to-face access to specialist palliative care for at least the hours 9 am to 5 pm, Monday to Sunday and the trust did not have any end of life care facilitators.

End of life care

- Wards where care at the end of life was provided contributed to the National council for Palliative Care Minimum Data Set (MDS). The aims of the MDS are to provide good quality, comprehensive data about hospice and specialist palliative care services on a continuing basis. The data is used to inform service development, management, monitoring and audit. The information is also used for commissioning of services and development of national policy.
- The trust was not a CQC outlier in terms of any cancer related outcome measures.
- The mortuary team completed a full capacity audit each day.
- The trust did not participate in the gold standards framework.

Competent staff

- At the time of our inspection appraisal rates for the SPCT were 62.5%. In six of the previous 12 months, compliance with appraisals had been 100%. This had dropped due to sickness and newly recruited members of staff joining the team.
- Appraisal rates for the medical team were predominantly 100% between June 2015 and May 2016 however, this had dropped to 75% in September 2015 and May 2016.
- At the time of our inspection, the appraisal rates for the mortuary team were 87.5% and 100% for the bereavement team.
- Appraisals for the chaplaincy team were 83.3%.
- Information provided by the trust showed that the SPCT nurses had all achieved postgraduate qualifications in palliative care at English National Board, diploma, degree or masters levels.
- All of the medical team had trained as a Specialist Registrars in Palliative Medicine before joining the trust as consultants.
- A member of staff who had recently joined the SPCT told us that they thought that all of the specialist palliative care nurses had excellent communication skills and we witnessed this whilst observing the team providing care and support to patients and their families.
- We were told that most wards had a palliative care link nurse. Twice yearly seminars were held for these staff and the SPCT nurses told us that these sessions were well attended.
- All staff in the mortuary were competent at corneal retrieval for organ donation purposes. A report by the HTA in September 2015 deemed that the mortuary staff had worked at the establishment for a number of years and were motivated and experienced in their roles. They were well trained and had worked towards developing robust mortuary procedures.

Multidisciplinary (MDT) working

- The SPCT held an MDT each week on a Wednesday morning. This was held in the Queen's Centre at Castle Hill Hospital. SPCT medical and nursing staff attended in person and attendance was recorded by signing a register. A member of the chaplaincy team and a social worker also attended the meeting. The MDT co-ordinator collated attendance data.
- All new referrals to the service (both in-patient and outpatient) and ongoing complex patients were discussed at the MDT. The list was compiled by the MDT co-ordinator in conjunction with the team from the current caseload as documented on the electronic care record system. In April 2016, the team updated the MDT proforma to ensure that the recommendations of the NICE Guidelines on Care of dying adults in the last days of life, was included.
- In addition to the weekly MDT, the nursing staff from the SPCT also held a daily board round.
- The SPCT also had close working relationships across all wards and departments where care at the end of life was provided and also the local hospice.
- In addition to this, we also saw that staff attended the end of life discharge facilitation and patient pathway meeting. This was a multi-disciplinary meeting involving members of the trust team along with other local NHS trusts, the local hospice, local commissioners and the local authority.
- In their report in September 2015, the Human Tissue Authority reported that the mortuary staff had developed good working relationships with staff in other establishments including the coroner's office, visiting pathologists and local funeral directors.
- The chaplaincy service told us that they have multiple contacts within various faith communities including most religions and also secular, humanist and pagan associations

Seven-day services

- The National Institute for Health & Clinical Excellence (NICE) guidelines state that palliative care services should ensure provision to visit and assess people

approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.

- At the time of our inspection, the SPCT operated a five-day service from 08:00 – 18:00, Monday to Friday. New nursing staff had recently been recruited and a seven-day service was due to become operational in September 2016.
- Out of hours, staff could access specialist support from the local hospice, although staff on some wards were not aware this service was available.
- Hospice staff were also able to contact the regional on call consultant in palliative medicine, on behalf of trust staff, for further specialist advice if required.
- The trust chaplaincy team operated a seven-day service with an out of hours call out system in place.
- The mortuary operated a seven-day service including a 24 hour on call system. This included staff being available for relatives who wanted to see their relatives after they had died.
- The trust had seven day services for imaging, pharmacy and therapy services such as occupational and physiotherapists.

Access to information

- Staff on the wards we visited told us that they were able to access palliative and end of life care policies and guidelines on the trust intranet.
- The palliative care team had an intranet site, accessible to all staff electronically where current policies and information re palliative and end of life care could be accessed.
- We also saw palliative care resource folders on some of the wards however; on two wards we visited, some policies within these folders were out of date. This included the just in case prescribing (valid until 2014) and the syringe driver guidance (valid until December 2014). We raised this with either the link nurse or a senior nurse on the wards.
- The SPCT had access to an electronic patient records system that is also widely used by general practitioners and community nursing teams in the region. Staff were able to view and share end of life care patient details on the system. However, the SPCT also completed written documentation in the patients paper based care record that was resulting in duplication of work.
- Staff in the mortuary were able to book appointments electronically with the registrar's office for bereaved relatives. However, most systems within the mortuary were paper based. Staff believed that more electronic systems would be beneficial.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- Patient or next of kin consent to share information was documented in patients care records. We saw this in 100% of the records we reviewed. In addition to this, we witnessed staff seeking consent before providing any care or treatment.
- During our inspection we looked at 16 do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found all of these forms were kept in the front of the patients medical records, which was in line with trust policy.
- Six of the16 forms indicated that the patient lacked capacity. We could not find evidence of a mental capacity assessment in two of the patients' notes; however, in all of the records we saw that a best interest decision discussion or meeting had taken place involving the patients' family.
- In all records, we saw documented evidence that a discussion had taken place with the patient or their relatives.
- 100% of the forms were signed and dated, however a senior clinician had not signed one form.
- This meant that predominantly the completion of DNACPR forms was of a high standard and in line with local policy and national recommendations.
- Staff completed training in consent, MCA and DoLS. Information provided by the trust showed that 79% of staff from the SPCT had completed this training. 100% of mortuary, bereavement and chaplaincy staff were compliant with this training.

End of life care

- The trust had a mental capacity act, deprivation of liberty safeguards, consent and physical restraint policy and also a resuscitation policy (which incorporated DNACPR guidelines) to support staff.

Are end of life care services caring?

Good

In 2014 we rated caring as 'Good' and this rating was maintained in 2016 because:

- Feedback we received from patients was consistently positive about the way staff treated them.
- We observed a number of staff and patient or carer interactions during our inspection. We observed consistently caring and compassionate staff.
- Staff were highly motivated and inspired to offer care that is kind, promotes people's dignity, and involves them in planning their care.
- Patients said that the staff were 'marvellous' and that the SPCT 'had got it right'.
- Patients were supported emotionally. All staff were very responsive to the psychological needs, not only of patients but also those close to them.
- We saw an initiative that had been implemented by the bereavement team which we thought was outstanding.

Compassionate care

- We saw ward staff and the SPCT being compassionate and caring to patients and their families.
- We observed consultations between the SPCT and their patients, we saw that the team were sensitive, and used appropriate communication. Patients were given the opportunity to ask questions.
- We found that staff were sensitive to the needs of the patients and their families.
- We spoke to one patient who told us that the staff were 'really caring -marvellous' and that the ward had a lovely atmosphere.
- Another patient could not praise the SPCT highly enough. This patient told us 'they have got it right' and that other areas of the trust could learn from the team. We witnessed a consultation with a patient and a consultant. We noted that the consultant was caring and compassionate with the patient and her family member. Following the consultation the patient told us that this was usual for the team and 'no different because we were there'.
- In a 2015, externally collated, survey of bereaved relatives, we saw that 100% of people surveyed were satisfied with the way in which the palliative care team respected the patient's dignity. One patient told us that staff always maintain their dignity.
- The trusts own, 2015, bereavement survey showed that most (87%) bereaved relatives felt that their relative received a high standard of care. 9% of relatives disagreed with this. 4% did not respond to the question on the survey.
- The bereavement team had implemented an initiative to support bereaved relatives. They had displayed a notice, which said that they were aware that not everyone had the chance to say what they wanted to someone before they died. They provided a supply of cards and envelopes and invited people to write a message to their loved one, which the team then placed with the deceased patient. We felt that this was an area of outstanding practice.
- In addition to this a member of the bereavement team told us that 'often relatives do not realise this is the mortuary.' But that they always say to the loved ones 'this is where mum or dad is now and I will look after them whilst they are here.'

Understanding and involvement of patients and those close to them

- We saw staff involving patients and families in decisions about care and that conversations with relatives were documented in patients care records.
- One relative told us that they had been given open visiting and described the hospital as being like a hotel.
- A patient told us that a doctor had discussed the treatment options available and had given them 'time to think' about what they wanted in terms of treatment.
- One patient told us that the SPCT involved their family at all stages of their illness.
- The trust provided the results of a service evaluation of bereaved relatives by the association for palliative medicine of Great Britain and Ireland (APM), which had been undertaken in August and September 2015.

End of life care

- The results of this were predominantly positive including 80% of relatives being satisfied or extremely satisfied with the availability of the palliative care team and 87% being happy with the way the family was included in treatment and care decisions.
- The trusts own bereavement survey in 2015 showed that 94% of relatives felt that their relative had been treated with dignity and respect at all times and 96% of relatives said that they found the information provided in the trusts bereavement pack useful.
- One of the chaplains told us that 'listening is very important.'
- The bereavement office included a waiting area, with complimentary tea and coffee facilities. There was also a private room available for the bereavement staff to speak to relatives and carers in private.

Emotional support

- We saw staff providing emotional support to patients and their relatives during our inspection.
- In an externally collated bereaved relative's survey, conducted in 2015, we saw that 87% of relatives were satisfied or extremely satisfied with the emotional support provided by staff.
- A bereavement support group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- Following a death on a ward, staff completed a deceased transfer form, which was transferred with the patient to the mortuary. Ward staff advised relatives that they should contact the bereavement office. The bereavement office team then dealt with all aspects of care for the bereaved family. This included collecting the patients belonging from the ward, ensuring death certificates and cremation forms were completed appropriately and in a timely manner and that families received help and support to contact the registrar's office.

Are end of life care services responsive?

Good

In 2014 we rated responsive as 'Good'. In 2016 we rated the services as 'Good' because:

- Services were planned and delivered in a way that meets the needs of the local population.
- All teams involved in caring for patients at the end of life were highly responsive to the needs of the patients in their care and those close to them. This included the mortuary service who were available operated a 24 hour service.
- Care and treatment was coordinated with other services and other providers to ensure that specialist teams saw patients in a timely manner and each patient's choice in relation to their preferred place of care was achieved for high numbers of patients.
- The facilities and premises were appropriate for the services being delivered.
- We saw evidence that staff were responsive to meeting the needs of vulnerable patients including those living with dementia.
- There were no complaints about the teams providing specialist end of life care, however when complaints were received about end of life care on generalist wards, senior staff from the Health Group were made aware and contributed to providing a response.

Service planning and delivery to meet the needs of local people

- Care at the end of life care was provided on generalist wards at the hospital, staff were able to refer patients to the SPCT if they needed advice and support to care for any patients with complex needs including symptom management.
- The team also provided training and education to the staff on the generalist wards and the majority of wards had palliative link nurses.
- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed the patients at end of life patients and had discussions with them and their families.
- Care at the end of life was also provided in other departments at the hospital including the critical care units.
- The trust had a 'Preferred Priorities of Care' document that was completed for patients. We saw these in the majority of care records we reviewed. An audit provided by the trust showed that, between January and December 2015, 82% of 205 patients had their preferred place of care recorded in their care records.

Meeting people's individual needs

End of life care

- The results of a recent trust survey showed that 100% of relatives were satisfied with the information they had been given about how to manage the patient's symptoms. In addition, 100% of relatives indicated that they were satisfied or extremely satisfied with the palliative care team's response to changes in a patient's care needs and 87% indicated that they were happy with the speed at which symptoms were treated.
- However, within the same survey, only 50% of relatives who responded felt that their relative had enough choice about where they wanted to die however, 27% of relatives did not answer this question. 23% felt that their relatives did not have enough choice about preferred place of death.
- On all wards we visited staff told us that whenever possible end of life care patients would be cared for in a single room.
- The trust provided details of the interpretation/ translation services used. Staff we spoke with knew how to access the services as and when they were needed.
- The trust employed a learning disabilities (LD) liaison nurse who would be made aware of any patients with learning disabilities who were being cared for in the hospital. At the time of our inspection we spoke with the LD liaison nurse; however there were no patients with LD receiving end of life care.
- The trust used a dementia screening assessment and the butterfly scheme. Trust policies such as the dementia and delirium policies were available to support staff to care for these patients.
- Dementia training and education was not part of the trusts statutory or mandatory training. Three members of the SPCT had undertaken training in dementia.
- In all areas we visited, we were told that relatives and carers of patients at the end of life would be offered open visiting.
- Chaplains were also able to conduct funerals on behalf of the trust if requested.

Access and flow

- Staff working on the wards and departments, providing care at the end of life, were able to access specialist support from the SPCT via a referral form. Staff we spoke with told us that the team were very responsive and usually saw the patients within 24 hours or sooner if required.
- The SPCT had seen a year on year increase in referrals from 689 in 2010 to 1,386 in 2015.
- The team had also seen a yearly rise in the number of referrals for non-cancer patients from 215 (18.1%) in 2013 to 343 (24.7%).
- In November 2015 and April 2016, snapshot audits of referrals to the SPCT showed that 98% of patients were seen within one working day of referral and 2% within 2 working days.
- The SPCT also held consultant led clinics. Patients were able to ring and refer themselves for appointments or they could pre-arrange appointments. One consultant told us that in addition to this they would see patients outside of the clinic times dependant on need.
- The trust employed 5.35 wte chaplains (six people in total) which met the NHS Chaplaincy Guidelines 2015. Promoting Excellence in Pastoral, Spiritual & Religious Care. In addition to this, there were 26 chaplaincy volunteers. The role of this team was to provide religious, pastoral and spiritual care appropriate to the needs of individual patients. Referrals for spiritual care came from:
- Patients themselves using the chaplaincy team phone number and email.
- Staff recognising spiritual need in a patient and offering immediate support themselves or referring on to the chaplaincy team.
- Carers of patients may refer to the chaplaincy service for support.
- Community groups outside of the trust are able to refer their members for care to the chaplaincy team
- The chaplaincy team used an electronic patient flow management software system that enabled them to alert colleagues to spiritual care needs for patients by a flag on the system.
- The trust had developed a 'rapid discharge' pathway to support ward staff to be able to organise a rapid discharge home for patients at the end of life. This was a checklist and aide memoire for staff, giving prompts to ensure they are able to organise care and services in a timely manner. Collaboration was sought with social services and the discharge team to support this and the SPCT also supported and facilitated if required.
- Data provided by the trust showed that 47% of patients were discharged to their preferred place of care on the same day, 35% were discharged the following day and 18% of patients were discharged 48 hours or more later.
- We saw that mortuary capacity was listed as a risk for the mortuary service. Staff we spoke with in the service explained that when some of the elderly care wards had

been transferred from Castle Hill Hospital this had increased demand for the service at Hull Royal Infirmary. In order to minimise the risk, staff had developed close working relationships with undertakers and were able, if necessary, to liaise with funeral directors to collect deceased patients. Staff explained that it was possible to transfer deceased patients to the mortuary at Castle Hill but that this option would only be taken with the coroners and families consent.

Learning from complaints and concerns

- There had been no complaints relating to the SPCT, mortuary, bereavement service or chaplaincy teams in the 12 months prior to our inspection.
- Information provided by the trust indicated that there had been two complaints involving patients who had died in the previous 12 months however further data received indicated that, between April 2015 and March 2016, 45 complaints involved a patient death.
- The most common clinical area for complaints involving a death was in oncology with nine complaints (20%). The majority of these complaints related to dissatisfaction over the way the patient was treated prior to their death.
- During our inspection, we discussed complaints with the Clinical Support Health Group senior management team and were told that they would be involved in any complaint that involved a patient at the end of life. We were also told that complaints were analysed for themes within the Health Group and where necessary the senior management team would be involved in the response to the complaint.
- We saw Patient Advice and Liaison service information displayed on the wards we visited.
- Following the death of a patient, the bereavement team offered support to relatives. This included asking relatives if they had any concerns with the care provided on the ward where their relative had died. Patient Advice and Liaison service leaflets were available in the bereavement office reception area and bereavement staff signposted relatives to this service if necessary.
- Staff we spoke to told us that complaints were shared with the team including the learning and actions. We saw this in minutes of team meetings we looked at.

Are end of life care services well-led?

Good

In 2014 we rated well led as 'Good' and this was rating was also 'Good' in 2016 because:

- All teams were aware of the trust vision and values. We saw these displayed during our inspection. In addition to this, we saw team visions and mission statements for individual teams for example, the mortuary and bereavement team and the chaplains.
- Whilst there was no trust end of life strategy at the time of our inspection, the SPCT were working collaboratively with other providers and using the national End of Life Care strategy: New Ambitions document to benchmark and influence the care and treatment they provided to patients.
- Robust governance, risk management and quality measurement processes were embedded in the teams and the Health Group. The Health Group had a Quality Governance & Assurance Committee.
- The Health Group management structure was clear. Staff we spoke with told us that senior staff were visible and supportive. There was a lead consultant for end of life care and a director who provided representation at the trust board.
- We found that staff in all teams were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- We saw examples of Innovation, improvement and sustainability.

However we also found that:

- At the time of our inspection, the trust did not have a Non-Executive Director (NED) for end of life care representation at board level.

Vision and strategy for this service

- All staff we spoke with were aware of the trusts vision and values. We saw these displayed in clinical areas. We also saw individual visions and mission statements displayed.
- We saw the vision for the mortuary and bereavement service displayed in the reception area of the

bereavement office. This was to deliver 'Specialist, high quality mortuary facilities and bereavement care'. Staff we spoke with were aware of and based their care around the service vision.
- The chaplaincy's mission was to be available for those requiring spiritual care in the broadest sense of the word, to listen and be alongside those who may be experiencing loss, fear, distress or anxiety.
- We requested a copy of the trust strategy for end of life care but were told that the trust did not have a strategy. We were told that this was being developed and this was currently in draft stage. However, the SPCT were working collaboratively with other care providers and completing a gap analysis in relation to the national End of Life Care Strategy: New Ambitions document.
- In addition to this, the team had a specialist palliative care multidisciplinary team operational policy (2016). This document outlined the aims, objectives and responsibilities of the team.

Governance, risk management and quality measurement

- The SPCT were part of the clinical support Health Group. The Health Group had a quality Governance & Assurance Committee.
- The SPCT produced an annual report, which highlighted any service developments, achievements and risks in terms of quality assurance.
- Operational policy meetings to discuss operational issues and service development within team were also held quarterly. We saw an action plan that had been developed to monitor compliance with the operational policy and service development.
- We saw the risk register for end of life care. There was only one risk highlighted which was in relation to mortuary capacity. Staff we spoke to about this were aware of the risk and could explain why the risk had arisen and the actions taken to mitigate the risk.
- Following an inspection of the mortuary services at the hospital, in September 2015, the Human Tissue Authority (HTA) found that all applicable HTA standards were assessed as fully met.
- The HTA also reported that all aspects of the mortuaries work was supported by ratified documented policies and procedures as part of the overall governance process.

Leadership of service

- The Health Group management structure included a medical director, an operational director, a director of nursing and a clinical director.
- Clinically there was a lead consultant and a lead cancer nurse; however, there was not a lead nurse within the SPCT.
- The trust met the recommendation to have a designated board member with specific responsibility for care of the dying. This was the chief medical officer. There was also Medical Director for Clinical Support; however, there was not a Non-Executive Director (NED) lead for end of life care on the trust board, we discussed this with the senior management team and were told that the director of nursing was progressing this.
- There was a mortuary and bereavement services manager who was deemed by the Human Tissue Authority (HTA) to have a good understanding of the HTA Act and who worked to ensure improvements are implemented as required.
- There was a lead within chaplaincy service.
- All staff we spoke to told us that senior managers were approachable, supportive and visible.

Culture within the service

- We found that staff were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- The end of life care teams, including the SPCT, the mortuary and bereavement teams and the chaplains were described by the senior management team as having a unity of purpose, being passionate, pulling in the same direction, being proactive and providing fantastic care.
- We spoke with a newly appointed member of the SPCT who told us that they had been made to feel really welcome in the team.
- The medical and nursing staff from the SPCT told us that they had very good, close working relationships.
- The HTA reported that the mortuary staff have worked at the establishment for a number of years and were motivated and experienced in their roles. They are well trained and have worked towards developing robust mortuary procedures. The team was dedicated to ensuring that the dignity of the deceased was maintained and that relatives visiting the mortuary were treated sensitively.

End of life care

- We spoke with three members of the chaplaincy team and found them to be warm, friendly and welcoming. Other staff commented that the chaplaincy service were excellent.

Public engagement

- The trust collated bereaved relatives feedback, on an ongoing basis, through the bereavement team and they used this information to improve the service for bereaved relatives by providing feedback to any areas where care fell below expectations.
- A bereavement group had been set up collaboratively with the social work bereavement team at the local hospice. The bereavement counsellor at the trust ran this.
- One family we spoke with said that they would like to be issued with a pass so that they could access or leave the ward without disturbing the staff. The SPCT nurse we were observing told the family that she would let the ward staff know about this suggestion.

Staff engagement

- Staff we spoke with told us that they were supported to professionally develop.
- Staff told us that they felt that communication between the team members and the information received from the trust was good.
- Compliments from patients and other services were discussed at the SPCT meetings.
- New staff told us that they felt supported by the team and a member of staff who had been on long term sick told us that the trust had been supportive.
- The chaplains provided an introduction to their service at the trusts induction for new members of staff. In addition to this, they also held a biennial spirituality day for staff, the aim of this was to raise awareness about staff wellbeing and coping strategies. There also ran spirituality in healthcare, spirituality in loss and spirituality in privacy and dignity sessions twice a year.
- The chaplains had 2700 contacts per year, of these 20% (540) were contact with staff members.

Innovation, improvement and sustainability

- The SPCT operational policy outlined the responsible key clinicians for service improvement including research, audit, education, information and patient and carer issues.

The SPCT were working collaboratively with other teams and care providers on initiatives such as:

- Improving access to hospice care from the acute hospital through cultural transformation and
- Improving specialist palliative care services to patients with non-malignant diseases through cultural transformation.
- Three of the SPCT nurses had been nominated for the trusts golden heart awards.
- Macmillan Cancer Support recognised one of the SPCT nurses with a 2014 'Henry Garnett Award'.

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

Information about the service

Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the other hospital within the trust, Hull Royal Infirmary (HRI). The trust also has several off-site locations delivering outpatient and diagnostic imaging services.

Between January 2015 and December 2015 there were 641,018 outpatient attendances for first and follow up appointments at the trust overall, including the off-site locations. In addition to appointments at the HRI and CHH sites, the trust ran outpatient clinics at The East Riding Community Hospital (ERCH), Westbourne NHS Centre and Bransholme Health Centre. These locations had 5.3% of the trust's total appointments in 2015, with 4% (27,984) at ERCH, 0.6% at Westbourne NHS Centre (4592) and 0.3% at Bransholme Health Centre (2547). We visited Westbourne NHS centre as part of this visit, but not the other two off-site locations.

Between May 2015 and April 2016, there were 704,483 attendances at the HRI and CHH sites; 299,903 (43%) of these were at the CHH site. The highest numbers of attendances were seen in clinical oncology (previously radiotherapy) at CHH, with 69,000 attendances during this12 month period, followed by cardiology (30,000), ear, nose and throat (24,000) and plastic surgery (22,000).

Services at the trust were split into four Health Groups, medicine, surgery, family and women's health and clinical support. Outpatient services were provided in each of the four Health Groups.

During the inspection, we visited the following outpatient departments, clinics, and areas:

- Cardiology
- Respiratory medicine
- Ear, nose and throat Audiology
- Eye clinic
- General outpatients
- Bookings team
- Orthopaedic
- Cardiothoracic
- Plastics outpatients
- Westwood Suite (plastics day surgery unit)
- Breast care unit
- Radiology
- Pathology (haematology, biochemistry and blood transfusion)

From April 2015 to March 2016, the total number of investigations in all radiology modalities was 410,341. This was an increase of 13,172 compared to 2014/2015 and represented a 3.3% increase in demand.

Radiology at the CHH site had two CT scanners and two MRI scanners, in addition to four general x-ray rooms, two fluoroscopy rooms and four ultrasound rooms. Radiology provided staff to work in the four rooms in the cardiac catheter labs, but did not manage this service. Scanners in oncology were not managed by the radiology service. The nuclear medicine PET (positron emission tomography) CT scanner was in a separate building. An external company was contracted to manage this building and scanner.

We spoke with 47 members of staff in outpatients, radiology and pathology, including managers, nurses,

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radiographers, medical staff and administration staff. We also spoke with eight patients and two relatives. We reviewed paper and electronic patient records in outpatients and radiology and looked at other records such as audits, meeting minutes, policies and procedures. We also reviewed the systems for managing the departments and quality and performance information.

We carried out an announced comprehensive inspection between 28 June and 1 July 2016. When we inspected this service in May 2015, the service was rated as good overall.

Summary of findings

At the inspection in 2015 we rated outpatients and diagnostic imaging services as 'Good' overall. The effective domain was inspected but not rated. This was because we are currently not confident we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the service as 'Requires improvement' overall because:

- The trust was not achieving the national standards for referral to treatment and urgent cancer treatment. However, a plan was in place with trajectories, that had been agreed with commissioners and NHSI and at the time of the inspection this was being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual health groups were taking action.
- A cluster of eight serious incidents had been declared in outpatients, relating to patients that had not had their appointments when they should: all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients, including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- In radiology, there had been two never events involving wrong site/side surgery since the 2015 inspection and a previous never event in March 2015.
- One of the issues identified at the last inspection was the inconsistent use of safety checklists when carrying out day surgery in outpatients and interventional radiology procedures. We found there was still inconsistency in the use of safety checklists across different specialties, and this was not being audited.
- The numbers of suitably qualified and experienced staff were insufficient in some areas at the last inspection, notably histopathology consultants and echo cardiographers. At this inspection, we found staffing for these two groups had improved, although there were still vacancies. However, we found high levels of vacancies for nursing and support staff in

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some outpatient specialties, and in radiology there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.

- We found there were a high number (166) of complaints about outpatients; 26% of the complaints received by the trust in the previous financial year related to outpatients. Patient care was the main category of complaint received. Radiology had received eight complaints in the same period and pathology none.

However,

- Outpatients and radiology had increased their appointment capacity by running clinics out of hours and at the weekends, to cope with the increased demand and ensure patients had their appointments. However, there were on going concerns about the trust not meeting national standards for referral to treatment and urgent cancer treatment. However, a plan was in place and locally agreed trajectories, agreed with commissioners and NHSI were being met. All of the patients on the trust waiting lists were being clinically reviewed to ensure no patient came to harm. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action to review any issues.
- Staff providing care and treatment to people in outpatients and radiology were caring. Patients gave positive feedback about the care they received and we saw staff treated patients with dignity and respect.
- Service planning and delivery accommodated the individual needs of people with additional needs or disabilities in the majority of the areas we visited. For example, there was additional support for patients with learning needs, dementia, hearing difficulties or those who needed an interpreter.
- The facilities and premises used to deliver services were good. The environment in all of the areas visited was in good state of repair, clean and comfortable and sufficient well-maintained equipment was available.
- Outpatient services were split between the four Health Groups, meaning there were different levels of management and clinical support for each service. There was no outpatient risk register, however risks were identified on risk registers of Health Groups but this did not allow a cohesive oversight. There was also limited evidence of outpatient audits and quality monitoring.
- There was inconsistency in the governance and management oversight in outpatients due to it being split across the four Health Groups. The trust had recognised this and it was being addressed with a weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality and an 'outpatient transformation project' , but this was running behind schedule. This project's aims included improving clinic utilisation, bookings processes and performance against national standards. We were also told that an overarching management post was to be developed.
- Leadership, governance and continuous quality improvement in radiology and pathology was well established. There were robust processes for risk management and quality monitoring and both departments were accredited. Radiology was partway through a five-year equipment replacement programme in which all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- The trust had effectively managed a serious incident that had been reported by Radiology had reported a serious incident in December 2015 related to a failure to print 50,000 radiology reports. A further seven six serious incidents regarding specific patients had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Staff and managers in radiology had a clear vision and strategy for future developments within the department and were aware of the risks and challenges they faced.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

In 2015,we rated outpatients and diagnostic imaging services at CHH as 'Good' for safe. In 2016 we rated the safety of this service as 'Requires improvement' because:

- A cluster of eight serious incidents had been declared in outpatients across the trust, relating to patients that had not had their appointments when they should: all eight had been reported since the last inspection. This had led to delays in diagnosis and incidents of varying harm to patients including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.
- There had been two never events declared in radiology at the CHH site since the last inspection, both involving wrong site/side surgery. There had also been a never event, in March 2015.
- The use of safety checklists was still not being audited. Safety checklists and witnessed swab counts were not being completed in line with trust policy. There was variation in practice in the use of surgical safety checklists and counts, of items such as swabs and sharps, between outpatient specialties carrying out day surgery. The medical director for the Family and Women Heath Group acknowledged this was an issue.
- There had been some improvements in the number of histopathologist and echo cardiographer vacancies since the last inspection, but there were still a number of vacant positions to fill.
- Staff vacancies in and across outpatients specialties were variable; there were regular unfilled duties for nursing and unregistered staff in ophthalmology, maxillofacial, medical outpatients and general surgery.
- In radiology, there were five vacant consultant radiologist posts out of an establishment of 33 and the department had been unable to recruit neuro-radiologists due to national shortages. In general x-ray there was a high proportion of radiographer vacancies; 9.5 whole time equivalent (WTE) posts were vacant out of an establishment of 56 WTE (17%).
- The on call rotas for radiologists in radiology had a high level of commitment and low numbers of staff on each of the four rotas.
- A new radiology checklist had been introduced following the never events, however no audits had been carried out to confirm staff compliance with its completion. Senior staff said audits were due to start in August 2016. This meant there was limited assurance both about the effectiveness of the new checklist for patients undergoing similar procedures in the future and whether lessons had been learned and shared.

However;

- Medicines were managed safely and kept securely, most departments had enough equipment to provide the safe care and treatment patients required and infection control practices were good.
- The trust had responded effectively to a serious incident reported within Radiology in December 2015 related to a failure to print up to 50,000 radiology reports. A further seven patient related serious incidents had been reported, of which four related to this printing issue. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment. The department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out.
- Staff were well supported for training, and services were meeting the trust target of 85%. Mandatory training included safeguarding, infection control, information governance and major incidents.

Incidents

Outpatients

- The majority of staff we spoke with knew how to report incidents and about learning lessons from incidents. Incidents were reported and tracked on the trust's Datix incident management system.
- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been seven incidents reported in surgical outpatients and 11 in medical outpatients. No data was submitted for the other outpatient specialties.
- In April 2016, a cluster of eight serious incidents had been declared in outpatients, relating to patients that

had been lost to follow up and/or delays in diagnosis. This had led to delays in diagnosis and incidents of varying harm to patients including deaths. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

- No 'never events' had been recorded in outpatient services. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Following never events in other areas of the trust, the trust had produced a training video and was in the process of delivering it to staff. Senior staff had undertaken 'human factors' training.
- However, we found a lack of awareness when discussing with outpatients staff the lessons learnt from the never events. Some staff could not tell us about the never events that had occurred at the trust.
- We found the majority of patients and their relatives had been contacted following the serious incidents and the requirements for the duty of candour had been followed. However, some patients and families had not been contacted about their serious incident investigations. These included patients with Alzheimer's disease and a patient who was admitted urgently to the intensive care unit.
- Representatives of the outpatients management team told us outpatients had a duty of candour register. The medical director for the Family and Women Heath Group told us patients who had suffered harm were always made aware of the event and asked whether they wanted to see investigation reports.
- When we reviewed the serious incident reports, we saw the panels discussed the duty of candour requirements and nominated a person who would be responsible for patient liaison.

Diagnostic Imaging

- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 166 incidents reported in radiology at the CHH site.
- A serious incident (SI) relating to the failure to print radiology reports had been reported in December 2015. The incident was detected when a consultant neurologist questioned why some radiology reports were taking so long to be sent to them.
- A root cause analysis investigation identified that the problem had been an issue for some time, with up to 50,000 radiology reports not being printed in the 12 months prior to the issue being identified. In addition to delayed printing, there was a high proportion of reports that had not been printed at all. For example, in the three months from June 2015, 20% of reports did not print. A sample from 2012 showed 4% of reports did not print at that time.
- Overall, seven SIs had been reported, four of which related to the radiology printing issue and this had been tracked with the commissioners at the monthly SI panel meeting to identify any more as they arose.
- Further investigation of the radiology SIs showed three were categorised as major, three as moderate and one as high. Three of the seven incidents were not related to the printing problem; one was caused by a misinterpretation and the other was due to the reporting backlog. All seven patients involved in the serious incidents experienced significant delays in diagnosis and/or treatment, which caused them distress. As a result of the incident the system had been changed so that all radiology reports were sent electronically both within the trust and to primary care and there was a mechanism in place which automatically monitored the opening of the reports and if action had been taken. Any exceptions were routinely reported and escalated to the medical director if required.
- Two never events had been declared in radiology since the last inspection, both involved wrong site / side surgery and both occurred at the CHH site. The first occurred in October 2015 and the second in March 2016.
- The two radiology clinical directors had made presentations to the trusts' Quality Committee about the SIs and never events on 23 June 2016, entitled ,"Learning from recent radiology SIs" and "Never Events in Radiology 2014/15 and 2015/16".
- A new radiology checklist had been developed by the radiologists after the second never event occurred. This was because the form developed after the first never event was found to be too complicated; with 33 boxes

and 55 questions for staff to complete. However, from reviewing this new radiology checklist we were not assured that it addressed the issue of a wrong site procedure being carried out.

- Staff we spoke with in radiology were all aware of how to report incidents and about the radiology serious incidents and never events. They also knew about the requirements the duty of candour. Staff told us there had been "a big push" in the past year to ensure staff knew about the duty of candour.
- Radiology managers told us the radiology safety checklist was currently kept in the patient notes and not scanned into the radiology information system (RIS). They said when the RIS was replaced, which was due in November 2016, the forms would be scanned in. They explained this was the reason it was currently difficult to audit the completion of these checklists.
- Radiology managers told us they monitored trends of incidents. They said the main incident type reported was extravasation incidents; however, these were lower than national averages. Extravasation is when fluid leaks into the tissue, usually surrounding an injection, site and the degree of injury experienced is variable.
- The number of radiation incidents requiring notification to external regulators was low. We reviewed the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) notifications from January 2015 to June 2016 and saw there had been seven incidents notified in this period.

Pathology

- The pathology laboratory manager told us incidents in pathology were recorded on 'Q-pulse' the department's electronic quality management system (QMS). They said a CAPA (corrective action preventive action) process was followed and if an incident had affected a patient, then it would also be reported on Datix. They said trends of incidents involving pathology were analysed in order to identify any recurrent issues.

Cleanliness, infection control and hygiene

Outpatients

- The environment in all of the outpatients' areas we visited was visibly clean, tidy and uncluttered. Surfaces and flooring were intact which aided effective cleaning.
- Cleaning staff followed cleaning schedules. We saw comprehensive cleaning checklists in all the clinical treatment rooms. These were all completed as required and up to date.
- We saw waste was correctly segregated and sharps bins appropriately labelled.
- Alcohol hand rub was easily accessible within the departments and we observed staff and patients use it appropriately. We saw staff and patients had good access to hand washing facilities.
- We saw infection-control awareness notices on display in patient waiting areas and toilets.
- Personal protective equipment was available in all clinical rooms visited. We saw equipment with 'I am clean' stickers attached. The nurse in charge in general outpatients explained equipment in the department was cleaned every evening after the clinics had finished. They also told us staff deep cleaned each trolley in the department weekly. Records we reviewed confirmed this.
- Mandatory training records submitted by the trust showed the majority of staff groups were up-to-date with infection-control training and were achieving the trust target of 85%.
- Staff in plastics outpatients told us the room in the Westwood Suite used for minor procedures was a cleanroom, but did not have air changes. We observed a minor procedure during the inspection. We saw staff in this area gowned up in surgical scrubs prior to carrying out the procedure.
- We also observed a patient undergoing a coronary angiograph in the cardiac catheter laboratory. A coronary angiograph is an invasive procedure involving insertion of instruments in to the patient's blood stream and the procedure is carried out under sterile conditions.
- The 'scrub' team consisted of the medical consultant and healthcare practitioner; both of whom wore a sterile single patient use surgical scrub gown and sterile gloves.
- However, the 'scrub' technique of the assisting healthcare practitioner was not in-line with expected standards. Prior to the small incision being made to the patient's neck, the assisting practitioner was sitting on a stool, arms crossed with hands under each armpit; on several occasions, the practitioner's hands went below waist height. At one point, the assistant's hands reached below their waist and under the gown to use it to cover

their gloves whilst they touched their face; at this point the senior practitioner in the room asked them to de-scrub and put on a fresh sterile gown and gloves. This showed infection control measures were not always being carried out effectively.

Diagnostic Imaging

- All of the areas visited with visibly clean and there were effective systems and processes in place to reduce the risk of spread of infection. People were cared for in a clean hygienic environment.
- We saw there were hand gel dispensers available and staff had access to appropriate personal protective equipment, such as gloves and aprons. Staff told us the escort nurses cleaned wheelchairs between uses.
- We saw appropriate hand washing notices in place, waste was segregated appropriately and flooring complied with current guidance for flooring in healthcare facilities.
- We saw cleaning records in the rooms, which staff completed each day. Records we reviewed showed these were all completed as required.
- Mandatory training records showed the majority of radiology staff were up-to-date with infection-control training, apart from admin and clerical staff whose percentage compliance was 45%. Medical staff compliance was 94%, against the trust target of 85%.

Environment and equipment

Outpatients

- The environment in all of the outpatient areas visited was in good state of repair, clean and comfortable. We saw water fountains in all of the clinic waiting areas visited. However, the junior sister in plastics outpatients told us their water fountain had only been recently installed, after two years of requesting one.
- In ophthalmology, we visited the eye clinic; we found equipment within the treatment rooms was appropriate. We found staff did not use any equipment that required sterilisation as everything was single use and disposable.
- We reviewed comprehensive equipment management and medical estates records for CHH equipment. We saw these documented the equipment number, location, manufacturer, model number, service and repair dates, and calibration dates.
- Staff in ear, nose and throat services told us medical physics at HRI kept equipment records for the department.
- The cardiology outpatients unit was around seven years old; the environment was in a good state of repair and of a suitable layout.
- The unit had recently purchased two new echocardiograph machines and the third existing machine was functioning well; service contracts were in place with the manufacturer.
- The unit had two cardiac analyser machines. Staff told us these did not have much service life left; a business case had been submitted for two new cardiac analyser machines.
- Staff told us there were four cardiac laboratories at Castle Hill Hospital, and two vascular laboratories at Hull Royal infirmary. A consultant interventional cardiologist told us the trust had purchased a digital reporting system six years ago; however, they said it did not work and had never been switched on.
- There was a capital replacement programme in cardiology, and staff told us they were currently buying a new treadmill. They said new 'echo beds' had been ordered in February, but these had not arrived yet. Senior staff had been getting quotes for changing room layouts.
- Staff in the cardiothoracic office told us the Lorenzo computer system for booking and changing appointments was very slow and sometimes, "went down." They said there was no option to toggle between different screens if someone phoned to change an appointment and that changing an appointment, "took forever."
- Staff in cardiothoracic and cardiology services had been piloting a new voice recognition (VR) system for about a month. Office staff in cardiothoracic and cardiology services told us colorectal and upper GI were going live the same system. We reviewed a letter produced by a consultant using VR. Staff explained when the consultant had signed the amended letter they copied it into Lorenzo. They felt the new VR system would be more accurate and would save on staff time and resources.

Diagnostic Imaging

Outpatients and diagnostic imaging

- Radiology was partway through a five-year equipment replacement programme, all of the computerised radiology (CR) equipment was being replaced with digital radiology (DR) equipment.
- Appropriate personal protective equipment was available for staff to use in radiology. We observed radiology staff wearing specialised personal protective aprons; these were available for use within all radiation areas. Staff were also seen wearing personal radiation dose monitors, these were monitored in accordance with the relevant legislation.
- Staff told us consumables were barcoded; this avoided any overstocking. The radiology department shared its stockroom with endoscopy.

Pathology

- The pathology laboratory manager told us pathology staff were delivering training across the whole trust for staff to use the new 'Bloodhound' system. They explained this tracked the removal of blood for transfusion from the blood storage units. They explained this would ensure there was a robust audit trail.
- Alarms on all of the blood storage units / blood fridges went through to the hospital switchboard.
- Haematology had plans to introduce digital morphology for reading blood films.

Medicines

- People were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines.
- Medicines storage and management was checked in all the outpatients and radiology departments visited. We found all medicines checked were in date and stored securely. Staff recorded fridge temperatures regularly as required. Review of historic checks showed these were all complete and within recommended ranges. Staff were aware of what actions to take if there was an issue.
- Room temperatures where medicines were stored were not monitored but we found air conditioning units were in use and the rooms felt cool.
- None of the areas where we looked at medicines storage at the CHH site used controlled drugs.
- Prescription pads and record books were stored securely. We reviewed prescription records in outpatient clinics and found they were all correct.

Records

Outpatients

- People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate patient records were available
- Patient records were stored securely: in general outpatients we observed that notes trolleys were kept locked and secured by a digital lock. In the ear, nose and throat (ENT) service, the paper notes were kept on notes trolleys in the consulting rooms. We did not see any notes left unattended during our visit.

Diagnostic Imaging

- The radiology manager told us the information system (RIS) was due to be replaced in November 2016. This would enable staff to scan checklists and forms into patients' records.
- Radiology stored and viewed images on the departmental PACS (picture archiving and communication system).
- The radiology department had recently implemented an electronic reporting system, eResults. The radiology manager told us the majority of users, including GPs, now received their results electronically. They said this would reduce the risk of the printing errors recurring in the future.

Safeguarding

Outpatients

- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology and medical outpatients were all up to date with training for vulnerable adults and safeguarding children. The trust data submitted showed that level 1 and level 2 children's safeguarding training was above the trust target of 85% in all four Health Groups apart from medicine (82% in level 1 and 84.6% in level 2) and surgery (84.6% in level 2).
- Most staff groups within these specialties had achieved 100% compliance against the trust target of 85% and dermatology was 100% compliant in all staff groups. Compliance rates medical and dental staff were lower in some areas but were still meeting the trust targets. For example, in ophthalmology, medical staff achieved 90.3% compliance in vulnerable adults training.
- The trust did not submit disaggregated mandatory training data for other outpatient areas.

- No safeguarding issues were identified during the inspection. Staff were aware of their responsibilities and were able to describe what actions they would take they had concerns.

Diagnostic Imaging

- The radiology manager told us staff received mandatory training in safeguarding adults and safeguarding children and this training was all up to date. We did not see evidence of this during the inspection, but radiology mandatory training records submitted after the inspection confirmed what the manager had told us.

Mandatory training

- Staff received training and development appropriate to their roles and responsibilities.
- Ten mandatory training courses were available for all staff these included infection control, information governance, major incidents and safeguarding.

Outpatients

- Staff we spoke with all told us their mandatory training was up to date.
- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology, ENT, surgical outpatients and medical outpatients were all up to date and meeting the trust target of 85%. The trust did not submit disaggregated mandatory training data for other outpatient areas.

Diagnostic Imaging

- The radiology manager told us they monitored mandatory training of staff on a monthly basis and that mandatory training for non-medical staff was up to date. Records submitted by the trust confirmed this.
- Mandatory training records were kept electronically and the radiology manager told us these records were reliable and kept up to date and meeting the trust target of 85%. The clinical leads in each modality area were responsible for managing training.
- We observed information about mandatory training was on display in the department.

Assessing and responding to patient risk

- We checked resuscitation trolleys in all areas visited, including the Westbourne NHS centre. We found appropriate equipment was available and in date. The trolleys were all clean and tidy. We reviewed; daily and monthly checks in all departments visited, and these were all completed.

Outpatients

- There were systems and processes in place for assessing and responding to patient risk to keep patients safe. For example, in general outpatients the nurse in charge showed us their emergency treatment room and explained this was for any patients who deteriorated or felt unwell while they were in the department. We observed there was a resuscitation trolley outside the door and the room contained a soft stretcher, IV equipment, blood tray, and vomit bowls. In ear, nose and throat outpatients, we saw cardiac emergency buttons in all ENT consulting rooms.
- Staff in ENT outpatients told us they kept records of which scope had been used for which ENT patient to provide traceability; staff told us these records were kept for 12 months.
- In general outpatients and ENT, we observed reclining chairs were available in clinic rooms where blood tests were carried out. This meant patients that felt unwell or fainted following the procedure could be laid back until they recovered.
- In the eye clinic, we followed a patient's eye injection treatment. We observed the completion of a paper pre-injection safety checklist. We saw the nurse completing the form and the doctor carrying out the injection both signed the form.
- However, we found a variation in practice between outpatients' specialties carrying out day surgery. For example, in the plastics outpatients Westwood suite, where day surgery was performed, we observed a patient undergoing a minor procedure. We observed one of the nurses completed the final surgical check on the checklist without speaking to the rest of the people in the room.
- We reviewed the minor procedures register and the theatre and day surgery specimen register in the Westwood Suite and saw these had been completed as required. Two nurses double-checked the labelling on the sample pot during the procedure we observed.
- We observed the same nurse (scrub nurse) complete steps four and five on the form. However, the verification step, step six, was left blank. When we asked the

registrar performing the procedure about the signing step six, they said the scrub nurse would complete that section. However, this meant the checklist was not being completed contemporaneously as required.

- We reviewed nine sets of notes from patients that had undergone day surgery in plastics outpatients. We found the safety checklists had three sections, which should be signed by different staff; i.e. ODP/anaesthetist, circulating nurse and scrub nurse. In all nine sets of notes checked, the same staff member had signed all three sections for signatures. This meant the checklist was not being completed as instructed on the form.
- In the cardiac catheter lab, we observed a patient undergoing coronary angiography. The unit used the WHO checklist. We observed the patient being checked by staff before entering in to the procedure room; this included checking the procedure, site, allergies and consent. Other appropriate checks were conducted with the patient and the staff team within the procedure room.
- During our observations of the coronary angiography, we noted that surgical swabs, sutures, hypodermic needles and a surgical blade were used during the procedure. We noted that these items were not 'counted out' between two members of staff before, during and after the procedure. We also noted that a 'sticky' surgical pad was not used during the procedure to prevent sharps from accidently being moved and/or lost during procedures.
- At the end of the procedure, some swabs remained on the surgical trolley which were placed in to a bin and some swabs remained on the sterile sheet on top of the patient; these were collected up along with the sterile sheet and but in the bin together.
- The sharps were individually placed in to sharps boxes, which is not as safe as using designated sharps holders and disposing of all contained sharps in one go.
- The processes we observed provided no guarantee that swabs and sharps were all accounted for at the end of the procedure.
- When we asked the medical director for the Family and Women Heath Group about staff conducting swab counts during surgical procedures, they acknowledged there was variation in practice between outpatients' specialties carrying out day surgery. They confirmed ophthalmology carried out swab counts during procedures but some outpatients specialties did not. A process of counting swabs and sharps between two members of staff provides assurance that they are all accounted for at the end of each surgical procedure.
- Staff in plastics outpatients confirmed there were no counts of blades done in the Westwood suite (day surgery). They said this was because there was only one blade in use at a time.
- We checked resuscitation trolleys in all areas visited, including the Westbourne NHS centre. We found appropriate equipment was available and in date. The trolleys were all clean and tidy, we reviewed; daily and monthly checks, in all departments visited, and these were all completed.

Diagnostic Imaging

- The radiology department had three radiation protection advisers (RPAs) and each modality area had named radiation protection supervisors (RPSs). These gave advice on radiation protection when needed, to ensure patient safety and minimise radiation risk. We reviewed the risk assessments for radiation protection and found these met with current requirements.
- The RPAs and RPSs had received appropriate training in line with IR(ME)R guidance. Staff told us the support given by the RPAs and RPSs was excellent.
- Staff told us the RPSs met every three months these meetings included sharing of learning about incidents.
- All of the staff in radiology had undertaken IR(ME)R training. Training was carried out by radiation physics staff, who also held the training records. Records of IR(ME)R training viewed during the visit and submitted after the visit confirmed these were all complete as required.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited.
- Radiology equipment had routine quality assurance tests to check diagnostic reference levels for radiation exposures. Staff reported any trends or increases in exposure to radiation to the RPS for investigation.
- The consultant breast radiologist in the breast care unit told us the recent introduction of digital tomosynthesis would help reduce the number of exposures patients underwent. It would also reduce the number of patients needing MRI scans.

Staffing

Outpatients

Outpatients and diagnostic imaging

- Staff vacancies in and across outpatients specialties were variable; there were regular unfilled duties for nursing and unregistered staff in ophthalmology, maxillofacial, plastic surgery medical outpatients and general surgery. For example, planned hours compared with actual hours in ophthalmology showed 17.9% of nursing and 26.9% of unregistered staff hours were unfilled. In maxillofacial the figures were 28.6% for nurses and 52.1% for unregistered and in plastics outpatients 16.8% for nurses and 19.3% for unregistered.
- Staff in outpatients told us they had daily safety huddles where staff discussed staffing levels, the work allocation for the day, which clinics were running and any issues.
- In cardiology, staffing had improved since its last inspection; however, senior staff told us they were still short staffed. They told us echo cardiographers were band six and were difficult to recruit. The service lead described how the numbers of newly qualified echo cardiographers coming through from university was limited; which made recruiting new staff challenging.
- The acting head of cardiac physiology told us it was also a struggle to recruit physiologists in cardiology. They said newly qualified physiologists at the trust were employed at band five, when some trusts offered band six posts for these positions.
- They said two band five staff were due to start and two band six positions had been filled and a third was out to advert. They said there was a business case for more band six staff in the department and one band seven post had been frozen. They said several people in the department were retiring and senior staff were looking at workforce planning.
- The department had not used any agency staff in the previous 12 months. Staff told us there was good flexibility among the staff in the department; most of the staff were part-time.
- Senior staff in cardiology told us the reporting sonographers were band six. They explained it was difficult to retain staff because nationally reporting sonographers were usually employed at band seven.
- Nursing staff in general outpatients told us there were currently no vacancies. Bank and agency staff had been used in respiratory clinics and to cover initiative clinics. However, staff from other areas working overtime or part-time staff working extra hours usually covered gaps in the rota.
- In the ear, nose and throat service (ENT), the charge nurse told us there was one band two vacancy and one member of staff on long-term sick leave. They said the department did not use agency or bank staff, in-house staff usually covered gaps in the rota.
- The senior management assistant for patient administration in general outpatients told us 15 WTE agency staff had been employed on 18-month fixed term contracts for clerical positions in the bookings team. They said funding was available for a further five WTE posts within this admin team.
- The staff nurse in charge of general outpatients told us their staff also covered shifts at East Riding Community Hospital as and when required.
- Staff at Westbourne NHS Centre told us staff from the Hull and East Yorkshire hospitals staffed their outpatient clinics.
- In plastics outpatients the junior sister told us there were vacancies for a 30-hour staff nurse and 1.5 WTE healthcare assistants. A business case had been written for another part-time staff nurse. They said the department was currently using bank staff and nurses from plastics trauma to cover gaps in the rota.
- They said the shortage of staff in the department affected communication within the clinic, as the healthcare assistant may be working in the day surgery theatre. They said some consultants clinics ran behind because they were waiting for staff to be available to act as chaperones.
- The reception staff in plastics outpatients were not part of the plastics team. This meant there was sometimes no one on reception after 3pm, depending on the working hours of these staff.
- Staff in cardiothoracic services (CTS) told us there were CTS outpatient clinics in cardiology at York, Scunthorpe, Scarborough, Grimsby, and CHH. They said the other sites had got rid of the secretarial staff associated with these clinics. This meant a large increase in workload for the CTS administrative staff at CHH, which had resulted in a backlog of letters to be sent out. However, they said all the clinic letters were currently up-to-date.

Diagnostic Imaging

- In radiology, general x-ray there was a high proportion of radiographer vacancies; 9.5 whole time equivalent (WTE) posts were vacant out of an establishment of 56 WTE (17%).

Outpatients and diagnostic imaging

- Staff told us there were currently seven radiographer vacancies at CHH; they said they were going into schools to talk to 16-year-olds about careers in radiology.
- Staff in CT told us five new staff were due to start in September and there were four locums currently working in the department. They said the department did not use any agency staff.
- Radiology supervisors and managers stayed in their own areas, band five radiographers rotated between sites. Some staff in CT and MRI rotated between the HRI and CHH sites. There were two advanced practitioners at the CHH site.
- The radiology managers told us there was low staff turnover and good staff retention in the department.
- The cardiac catheter labs were not managed by the radiology service but radiographers who worked in this area were managed by radiology.

Medical staffing

Outpatients

- Cardiology staff told us there was one locum in the medical consultant team. One of the consultant interventional cardiologists told us there was a national shortage of medical staff with experience and skills in cardiology. They told us the department had 14 consultants, seven interventionists and one academic. They said that in 2004 the department had eight consultants overall.
- At the time of the inspection, there were two consultant vacancies in cardiology; the establishment should have been 16 consultants.
- The consultant radiologist in the breast care unit told us there were, "no staffing issues at the moment." They said there were plans to replace a locum breast radiologist with a permanent position and one of the registrars was interested in becoming a breast radiologist.

Diagnostic Imaging

- There were two vacancies for vascular radiologists and two new consultants in the vascular team. The department was advertising for a musculoskeletal radiologist. There were 4.9 WTE radiologist vacancies out of an establishment of 33 consultant positions. The clinical directors told us there was a national shortage of neuro-radiologists. At the time of the inspection, there were two full-time radiology consultants working in neuroradiology.
- The consultant radiologists had four separate specialist on-call rotas; neuroradiology was one in five, interventional radiology (non-vascular) was one in four, CT was one in seven and vascular was one in six. This was a high out of hours' commitment for the radiologists. When we asked the clinical directors whether they felt this was sustainable in the long term, they thought it was.
- Two radiologists worked remotely for the radiology service, mainly reporting results.

Major incident awareness and training

- Major incident training was one of the mandatory training courses for all staff at the trust. Data submitted by the trust showed 94.3% staff in the trust had completed this training.
- The radiology department had a major incident policy which staff were aware of.

Pathology

- The pathology laboratory manager told us there were business continuity standard operating procedures to follow if an alarm on a blood storage unit (blood fridge) went off.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain is inspected but not rated. We last inspected the domain in May 2015. At the 2016 inspection we found:

- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas, nurse led clinics and expanding use of extended roles. There was high use of advanced practitioners, specialist nurses and reporting radiographers.
- Services were moving towards seven-day working, many clinics were working extended days and weekends.

- Patients visiting cardiology now had 40-minute appointment slots, in accordance with national guidelines. This was an issue at the last inspection, when appointment times were 20-minutes long.

However;

- We found issues with document and version control in radiology. We found uncontrolled paper copies in circulation. This meant there was a risk staff were not following the current procedure.
- There were issues with the completion of consent documentation in the cardiac catheter labs.
- The systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the National Institute for Health and Care Excellence (NICE) quality standards relating to frequency and reviews.

Evidence-based care and treatment

Outpatients

- The head of department in cardiology told us patients visiting the department now had 40-minute appointment slots, in accordance with national guidelines. This was identified as an issue at the last inspection, when appointment times were 20-minutes long.
- In cardiology, we asked about national bodies that provided best guidance for cardiology practice and whether benchmarking audits had been conducted against national standards. The service manager mentioned three national bodies but said audit information was limited. The three bodies were the British Heart Rhythm Society, British Cardiovascular Society and The Registration Council for Clinical Physiologists.
- Staff told us the cardiology department was following the RCCP (Registration Council for Clinical Physiologists) guidelines for stress tests.
- The audit lead in cardiology told us all implant (pacemaker) data was submitted to the British Heart Rhythm Society as required by national guidelines.
- A consultant cardiologist told us they were currently applying to the British Society of Echocardiography for accreditation of the four cardiac imaging subspecialties.
- They said the department contributed to national audits for dataset registry, angioplasties, mortality rates, and pacemakers. However, local audits within the department were yet to be established. They explained that a new IT system would be needed before this could happen, as data was currently held within different systems.
- However, the systemic problems with the outpatient appointments and clinics meant not all services were meeting all of the NICE quality standards relating to frequency and reviews.

Diagnostic Imaging

- The external July 2015 MPE inspection report for compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 in interventional radiology theatres showed good compliance with the regulations and no major areas of concern.
- Internal audits of compliance with radiation regulations showed good compliance.
- Radiology had an approved plan for clinical audit; this was discussed at the monthly radiology management team governance and strategy meeting.
- However, we found document and version control in radiology required improvement. For example, we found there were no dates on flowcharts and there were no lists of printed copies of documents in circulation in clinical areas, no electronic document control system and no way of knowing whether the document in use was the most up to date version.
- When we looked at the '2016 Radiology Checklist,' which was available in radiology clinical areas, we found there was no date of issue and no review date. The radiology manager told us all departments were using this document.
- We found there was no audit of the completion of the safety checklists at the end of each session / day. An audit of checklist completion had been approved by the trust; however, this was not due to start until August / September 2016.
- The radiology management team told us the results of audits were presented at radiology team meetings. They said reporting radiographers sent out teaching emails to staff telling them about the results of departmental audits.
- The consultant radiologist in the breast care unit told us they were using tomosynthesis. They explained this method used three-dimensional digital exposures, had higher sensitivity and was more accurate. As a result, the sensitivity of detection of breast cancers was improved by 40%.

Outpatients and diagnostic imaging

Patient outcomes

Outpatients

- Between December 2015 and March 2016 between 82.3% and 91.4% of cancelled outpatients clinics were cancelled within six weeks of the appointment date. The main reasons for cancellation of clinics were not provided by the trust.
- The follow up to new rate was similar to the England average from September 2014 to May 2015, ranging between 2.22 and 2.37 follow-ups per one new appointment.
- The ratio then dropped below the England average, falling to a low of 1.33 in August 2015. This was mainly due to a drop in Castle Hill Hospital's follow up rate.
- The trust had a low (better) follow up to new rate (2.0) between September 2014 and August 2015, compared with other trusts.
- The trust did not provide information relating to the percentage of patients waiting over 30 minutes to see a clinician.
- When we asked the audit lead in cardiology whether they audited patient outcomes, they said patient outcomes were only recorded in the patient case notes.
- A consultant cardiologist told us the department was currently performing an audit of patient outcomes following day case procedures compared with patients staying in overnight. They said this would be significant service change if patients did not have to stay in overnight after their procedures.

Diagnostic Imaging

- The radiation protection adviser's annual report for 2014 showed patient radiation dose audits had good compliance with the local and national diagnostic reference levels, and had continually improved.
- The radiology manager told us the reporting radiographers carried out the radiation dose audits.

Pathology

- The pathology laboratory manager told us all of the blood sciences pathology departments were accredited with clinical pathology accreditation (CPA). Their last inspection had been in February 2015 and the departments were due to be inspected by the United Kingdom Accreditation Service (UKAS) in February 2017.

Competent staff

Outpatients

- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas. There were a number of nurse led clinics and there was expanding use of extended roles.
- The head of department in cardiology told us the department was a training establishment for students, and students often requested to come back to the department when they qualified.
- Staff in cardiology told us there were two band three staff who had been trained to do tape analysis; this freed up time for the more senior grades within the department.
- Cardiology staff told us each technician should attend one British Heart Rhythm Society (BHRS) accredited course each year. The training lead told us two staff had attended the British Heart Rhythm Society conference in Birmingham in September 2015.
- Staff we spoke with all told us their appraisals were up-to-date. One auxiliary nurse who had been in post for eight months told us they had appraisals after three and six months.
- Staff in plastics outpatients told us dressing clinics were nurse led and the department had nurse prescribers. The junior sister told us they planned to do more nurse led clinics in the future.
- Staff in the eye clinic told us there were no nurse practitioners at Castle Hill Hospital and medical staff carried out eye injections.
- We asked a technician who had been working in the eye clinic for four months about their training. They told us they had learnt "on the job" by following another technician. A senior technician signed them off as competent, in their learning workbook after six to eight weeks.
- Appraisal data submitted by the trust showed the majority of staff groups in the four Health Groups were compliant with the 85% target. However, in medicine all staff groups had compliance rates below 85%. The data did not show figures for staff working in outpatients separately. Staff told us appraisals were done via the trust's HEY247 electronic system. Staff we spoke with all told us their appraisals were up-to-date.
- Nursing staff told us the trust was offering training for revalidation; they said there was a NMC (Nursing and Midwifery Council) link person in the trust. They felt comfortable about the process.

Outpatients and diagnostic imaging

Diagnostic Imaging

- Records were kept of consultants' registration / qualifications and robust systems were in place to record ongoing continuing professional development (CPD) with the Royal College of Radiologists (RCR). This was relevant to each consultants practice, as part of the appraisal and revalidation process.
- Consultants were required to participate in appraisal annually and submit evidence of CPD to the Trusts database system, where copies of the evidence were stored. These were confidential to the consultant and the responsible officer (and their deputies). There was an automated system of alerts, including reminder letters from the Chief Medical Officer. There was a separate database of satisfactory completion of the RCR CPD.
- Radiology staff received equipment specific training and managers kept separate records for new equipment used by the radiologists.
- Staff we spoke with told us they were trained and competency assessed on all the equipment they needed to use. Staff told us there were good opportunities for continuing professional development within the department, they told us there had recently been an MRI study day.
- We saw there was a good induction programme for agency staff working in radiology, which covered all departments. Staff told us their induction was supportive and included a six-month probationary period. We saw that staff induction documentation was kept in individuals' folders. Staff told us the forms had been changed recently to include trust induction.
- Radiology ran a preceptorship programme with existing staff mentoring staff on the programme. Staff explained staff on the preceptorship programme had a six-month probationary period. Newly qualified staff were employed at band four until they achieved Health and Care Professions Council (HCPC) registration.
- Radiology had a number of extended roles for radiographers. The radiology management team told us the president of the Royal Society of Radiographers had visited the department recently and was impressed with the number of extended roles for staff.
- Appraisals were up-to-date in all of the radiology departments.
- The radiology manager told us there was a training budget within the department and staff had not been refused any request for training, as long was as it was required for their role. There was a separate training budget for the radiologists and external companies financially supported the department for training.

Multidisciplinary working

Outpatients

- The nurse in charge in general outpatients told us there were bariatric MDT's once a week. Attendees included dieticians, psychiatric nurse practitioners and consultants. They discussed patients' options, lifestyle, nonsurgical weight loss and follow-up.
- In cardiology outpatients, staff told us they worked together well with the cardiology ward staff.
- In the ear, nose and throat service (ENT), the charge nurse told us multidisciplinary team meetings were held on Wednesdays for ENT and maxillofacial patients.
- The junior sister in plastics outpatients told us they ran joint clinics with physiotherapy and occupational therapy. They said they also worked closely with the tissue viability nurses on the wards.

Diagnostic Imaging

- We found good examples of internal and external MDT working in radiology.
- The radiology management team told us their service was critical to many of the other departments in the hospital. They said they maintained good working relationships with staff in other areas.
- The consultant breast radiologist in the breast care unit told us the breast surgeon's office was near to theirs. They said this was convenient for MDT working and there was, "fantastic communication" between the two services which helped keep patients safe.

Seven-day services

Outpatients

- Staff in the majority of outpatients' clinics we visited told us they held evening and weekend clinics to keep up with the backlog. When we met with the outpatients' management team, they confirmed this.
- For example, staff in the ear, nose and throat service (ENT) told us they ran initiative clinics every Thursday evening from 5pm to 8pm. The normal opening hours in ENT were 8am to 5:30pm Monday to Friday; the Department did not open on Saturdays.

- Staff at Westbourne NHS centre told us there were no outpatient clinics on Fridays, as City Health Care used the premises for paediatrics on Fridays. Clinics at the centre were open from 8am to 5.30pm Monday to Thursday.

Diagnostic Imaging

- The radiology manager told us the service was unable to further extend the working day or increase capacity across seven days due to the finite number of radiologists and radiology support staff.
- Staff in radiology told us CT scanners were open from 8pm to 6pm. Contrast appointments were between 9am and 5pm and non-contrast between 8am - 9am and 5pm - 6pm. Staff told us there was always consultant cover. They said the Saturday rota had just been extended to 8am – 6pm.
- Staff in CT told us the opening hours might be extended to 8am – 8pm.This was due to the outpatient backlog.
- Radiology staff in plain imaging at CHH did on call from home. The departments were open until 10pm and on call was from 10pm to 9am. There was an on-call room staff could stay in. CT staff at CHH also did on-call.
- There was on call cover for urgent and emergency work at the CHH site in all modalities. On call started when the day shift finished Monday to Friday and at weekends.
- In fluoroscopy, the weekday finish time was 5.30pm. In MRI, on call cover from Monday to Friday was from 8pm to 8am. In CT, weekday on call cover started at 6pm on weekdays and in ultrasound and the cardiac catheter labs weekday on call started at 5pm.

Pathology

- The on-site pathology laboratory services closed at 5pm; after 5pm, urgent samples were sent to the HRI site. There were haematology, biochemistry, blood transfusion and virology laboratories at the CHH site. We did not visit the virology laboratories.

Access to information

Outpatients

- Trust data submitted prior to the inspection showed that 1% of patients were seen in outpatients without their full medical record being available. Missing clinical information can result in delays or disruptions to patient care and a potential risk of harm.
- Nursing staff in the cardiology clinic told us preparation of patient notes was very well organised. They said notes were tracked and traced in advance and were available the day before they were needed.
- The senior management assistant for patient administration in general outpatients told us the majority of missing notes were located in time for the patients' appointments. They showed us evidence, in the form of a list, of missing notes that could not be found. We saw there was an average of two sets of notes missing per day.
- The manager explained temporary notes would be made until the originals could be located. The list of missing patient records was reviewed every month by the team that prepared notes and searched for missing records. The senior management assistant for patient administration said that 26,000 patient notes were used every month and key performance indicator (KPI) data showed 99.3% of these were available in May 2016 and 99.5% were available in April 2016. This meant the KPI target was being met.
- Staff in the eye clinic told us patient records were 'paper free' and were available on the Med iSOFT and Lorenzo computer system. This meant there were no missing patient notes in the eye clinic.
- Staff at Westbourne NHS centre told us patient notes were requested centrally. They said each clinic had between five and 15 patients and was a mixture of first appointments and follow-ups. They said temporary sets of notes were put together for patients without notes; they estimated temporary notes were used about five times a month.
- The manager in general outpatients told us the medical records team would be "going electronic" within 18 months.

Diagnostic Imaging

- Staff in radiology told us the intranet site was easy to use.
- The radiology management team told us that the radiology information system (RIS) was due to be replaced in November 2016. They said the new system would feed into the electronic patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff with spoke with in outpatients and radiology understood the relevant consent and decision-making

requirements of legislation and guidance. Staff received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information submitted by the trust showed overall compliance rates of 87.6% for MCA training and 86.8% for DoLS training.

- In audiology and ENT, we saw DoLS leaflets were available. The band seven charge nurse told us DoLS was included in mandatory training for staff.
- We reviewed nine sets of notes from patients undergoing day surgery in plastics outpatients. We saw consent forms had been correctly completed in all of the records.
- Staff in the eye clinic showed us a patient's consent form; this was completed as required.
- In the eye clinic, we observed a patient assessment, which included the patient giving verbal and written consent. The nurse asked the patient to check their signature on the consent form. The nurse also checked the patient could see it clearly. The patient agreed it was their signature and that they could see clearly. We also observed the doctor checking the consent form with the patient prior to their procedure.
- Nursing staff in general outpatients told us they did not perform any procedures which required consent. They said if consent was required it would be completed by the consultant during the consultation.
- In the cardiac catheter lab, we reviewed two sets of patients' notes, in one case, the patient copy of the consent form remained in the notes. In both cases, consent for the procedure did not follow the trust policy on two-stage consent. On one patient's consent form, the patient had signed for the procedure on the day; there was no signature prior to the day of surgery. On the second patient's consent form, the patient had signed at the pre-assessment clinic but not on the day of the procedure. Patients should sign the consent form at pre-assessment and on the day of the procedure.

Are outpatient and diagnostic imaging services caring?

Good

At the 2015 inspection, we rated the outpatients & diagnostic imaging services as 'Good' for caring. At the 2016 inspection the rating remained 'Good' for caring because:

- Staff treated people with respect, and respected their privacy and dignity.
- Feedback from patients and relatives about the care received was generally good.
- People understood the care and treatment choices available to them and staff gave them appropriate information and support about their care treatment.
- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.
- Staff told us how they supported patients emotionally. For example, in the breast care unit a new procedure had been introduced which meant the number of procedures breast cancer patients required was reduced. Staff in the unit did all they could to minimise stress and anxiety for patients.

Compassionate care

- We observed positive, friendly interactions between staff and patients in all of the areas visited.
- We heard nursing staff introducing themselves to the patients. We observed staff had a caring approach towards patients, especially those with mobility issues and/or poor vision.
- We spoke with eight patients and two relatives during the inspection. They were all happy with the service. One patient in audiology outpatients commented, "I have been treated with kindness and the staff are courteous and respectful" and a patient in the cardiology outpatients waiting area commented that staff had been "accommodating and friendly."
- Patients and relatives waiting in the eye clinic told us the staff were always helpful, pleasant and respectful. They said they were happy with the care
- Friends and family test results for outpatients at the trust were good, with 94% of those surveyed saying they would recommend the service. However, response rates over the six months from December 2015 to May 2016 were low, ranging from 2.9% in December 2015 to 5.3 % in April 2016.
- We saw friends and family cards and boxes (for completed cards) in outpatient reception areas and friends and family display boards showing results and feedback. In the plastics outpatients waiting area we saw their friends and family test results were displayed on a tree.

Outpatients and diagnostic imaging

- We saw friends and family test results and information were on display in the outpatient waiting areas. Staff told us they gave patients friends and family test cards to complete after they had had blood tests taken
- Staff in cardiology felt their patients got a good service. One auxiliary nurse said, "The patients are happy."
- Nursing staff in general outpatients told us they had their own clinics, which was good for patient continuity.
- All of the outpatient areas visited had water fountains, some also had refreshment machines and televisions for patients to use.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with were all happy about the information provided relating to their care and treatment. We observed and staff told us, that staff introduced themselves.
- In general outpatients waiting area we saw there were clear instructions for patients using the self-check in kiosks.
- We saw the TV screen in the general outpatients waiting area was displaying health information. Information boards on the walls also displayed health information. There were a wide range of information leaflets, covering a large variety of health conditions, available for patients.
- Patients we spoke with, told us staff had explained everything clearly to them. One patient in the eye clinic told us they were always kept informed about their care and treatment.
- When we visited the respiratory medicine outpatients' clinic, we saw information for patients about lung cancer awareness on display.
- We observed a patient assessment in the eye clinic. The nurse carrying out this assessment fully informed the patient about the procedure. The auxiliary nurse carrying out the vision test also explained to the patient clearly about their vision test.
- We observed the eye surgeon giving their patients information about their eye injection procedures; these were regular injections (every 10 weeks).
- In the Jack Brignall PET-CT scanning centre, patients were given written information about the centre and its aim, which was to provide patients facilities and treatment of the highest quality.

Emotional support

- Patients and their relatives received good emotional support from staff to help them cope with their care and treatment. Feedback from patients about emotional support was positive.
- Patients attending bariatric clinics all sat together during talks from dietitians or other health professionals. These patients could also choose to attend peer support meetings.
- In general outpatients, there was a counselling room. The nurse in charge told us this could also be used for patients with behavioural problems, learning difficulties or dementia. They said this room was also used for prisoners attending the department, to ensure they moved quickly through the department.
- In the plastics outpatients Westwood Suite for day surgery we saw posters and leaflets about 'Changing Faces' which provided a skin camouflage service.
- Staff in plastics outpatients told us two people had been on a camouflage make-up course. This was used to teach patients how to use camouflage make-up following facial reconstruction. The department could also access breast tattooing for patients following mastectomies.
- A photographer came to plastics outpatients' clinics once a week to take before and after photographs of patients undergoing treatment.
- Plastics outpatients told us if patients came from care homes without a carer they would ensure they were given something to eat and drink if they were in the department over lunchtime.
- There was a clinical specialist nurse based in oncology who provided emotional support for patients attending melanoma clinics in plastics outpatients.
- In the ear, nose and throat service (ENT), we saw one of the consulting rooms was used as a quiet room for breaking bad news to patients.
- One patient in audiology told us they had a phone number so they could ring the clinic directly if they had any problems.
- The breast care unit carried out vacuum assisted biopsies. This one stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient.
- The consultant breast radiologist told us, "We do all we can to decrease patients' anxiety and stress." We looked in the comments book in the breast care unit and saw that patient feedback about the service was universally positive.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

In May 2015, we rated the responsive domain as 'Requires improvement'. At the 2016 inspection the rating remained as 'Requires improvement' because:

- Outpatients were not meeting the national referral to treatment (RTT) standards for incomplete pathways. This meant patients were not always able to access outpatient services when they needed to. There were appointment backlogs and waiting lists in the majority of outpatient specialties, which totalled over 30,000 patient episodes at the time of the inspection.
- The percentage of people waiting more than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between Q1 2014/2015 and Q4 2015/2016.
- The appointment booking process was variable across services, specialties and sites. Several patients told us their choices of appointment time and location were not taken into account.
- There were capacity and demand problems in the majority of outpatients clinics visited. Staff in clinical areas were unsure of the details of their waiting lists and backlogs.

However;

- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since Q3 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in Q1 and Q2 of 2015/2016.
- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway. Standard operating procedures and clinical validation had been agreed in early June 2016 and was ongoing at the time of the inspection.
- The bookings centre had dedicated staff dealing with cancer referrals and extra 'initiative clinics' were being used to help reduce the backlog. For example, one of the orthopaedic consultants had recently offered five Sunday dates for clinics.
- We found many examples of nurse led clinics, which meant the capacity for appointments was increased.

Service planning and delivery to meet the needs of local people

Outpatients

- The trust was working with local commissioners on capacity and demand planning and had agreed local trajectories in order to move towards achieving the national target of 92% for the 18-week incomplete pathway.
- The clerical officers in the booking centre told us there was a text message service to remind patients about their appointments.
- The facilities and premises used to deliver services were good. Signage was clear in all areas visited.
- Patients told us there was no problem getting through to the appointment centre by telephone. Staff told us the appointment centre was open from 8am to 8pm on Monday to Friday and 8am to 12 noon on Saturdays.
- The bookings process appeared to give patients a choice about their preferred hospital site or location. However, most of the patients we spoke with told us their preferences about location or time of appointment had not been taken into account.
- The clerical officers in the booking centre told us they could enter a patient's appointment preferences into the system. For example, a.m., p.m., evenings, certain days of the week or dates when they were on holiday. However, we observed that these preferences had not been used/entered in the majority of patient records reviewed.
- When we asked the patient administration manager about this, they told us that giving patients a choice of appointments was difficult to manage.
- Some patients told us there were parking problems at the CHH site; they said parking could be difficult and was expensive. Staff at Westbourne Health Centre told us the main complaint from their patients was the lack of a car park.

Diagnostic Imaging

Outpatients and diagnostic imaging

- We saw there were appropriate waiting areas for patients, including areas for hospital beds, which had piped oxygen available. However, there were no facilities for baby changing. When we asked staff about this, they said they would let parents use a private room.
- There was a central helpdesk in the radiology department for requesting porters.
- Patients attending radiology for plain film imaging were mostly walk-ins and unplanned.

Access and flow

Outpatients

- Between April 2015 and March 2016, the trust's referral to treatment (RTT) performance was consistently worse than the England average and the national standard for incomplete pathways. The operational standard is that 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. The trust was performing clinical validation for patients that had breached the 18-week RTT standard in order to prioritise appointments for those most at risk.
- The trust had an agreed trajectory with the local Clinical Commissioning Groups (CCGs) and NHS Improvement (NHSI) to meet the standard by March 2017. The trust had met the individualised local trajectory between April and June 2016.
- The trust position relating to the RTT and cancer national standards was improving. The improving cancer position meant the majority of cancer targets were being delivered. The RTT trajectory had improved overall for 2015/16 when compared with 2014/15. There were specific challenges in some areas, and a recovery plan had been agreed for 2016/17.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was consistently below (worse than) the 85% cancer wait standard and England average between Q1 2014/2015 and Q4 2015/2016.
- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was consistently above (better than) the 96% cancer wait standard since Q3 2014/2015.
- The trust generally met the 93% cancer wait standard for the percentage of people seen by a specialist within two weeks after an urgent GP referral, but fell below the standard in Q1 and Q2 in 2015/2016.
- The 'did not attend' (DNA) rate was mostly higher than the England average between September 2014 and August 2015. The DNA rate ranged between 7.1% and 10.2% at trust level, compared with the England average of between 6.6% and 7.7%.
- On 22 June 2016, there was an outpatient follow-up backlog of 29,968 patients. This was the number of patients on an access plan who were overdue a follow-up. The largest individual specialties follow-up backlogs on this date were: - ophthalmology 8,117, ear, nose and throat (ENT) 1,032 and plastic surgery 1,369.
- A further backlog report dated 27 June 2016 showed there were 30,431 patients overdue for their appointments on that date, 6,702 of these were over six months overdue and 2.898 were 12 months overdue.
- An 'outpatient waiting list backlog report' was run every day. The patient administration manager said these reports helped bookings centre staff know where to focus their work.
- Members of the outpatients' improvement team told us cardiology had a large backlog. Data provided following the inspection showed cardiology had the largest backlog in the Medicine Health Group; 2,092 on 22 June 2016. They said they were looking at ways to reduce the DNAs, cancellations and new to follow-up ratios by increasing activity and slot utilisation. They were also looking at clinic productivity.
- The medical director for the Family and Women Heath Group told us there were long waits for appointments in some specialties, due to a shortfall in capacity. They told us there were problems with the additional slot issues (ASI) list; they told us patients were not meant to be on the ASI list for more than four days but this was not always achieved.
- There was follow up slippage in outpatients for patients with chronic diseases and long-term conditions. In some specialties, there was evidence this had led to patient harm. For example, ophthalmology patients with wet macular degeneration needed regular injections every four weeks. The capacity and demand problems meant these patients were often not seen until between six and eight weeks. There was evidence that some patients vision had deteriorated because of this.
- We asked the patient administration manager about booking rules, they told us staff in the appointments

and referral centre did not work from booking rules. However, members of the outpatients' improvement team told us different specialties had their own booking rules.

- Staff told us, and we observed long waits in some outpatient clinics. For example, in plastics outpatients we spoke to a patient whose appointment was already running 20 minutes late. They told us they would like to know how long their wait was going to be. About 20 minutes later a nurse came out and told all the waiting patients how long the clinic waits were; these were not on display. The wait time for the patient we spoke with was almost an hour.
- This patient also told us they had waited more than three months for their follow-up appointment, and then had to ring twice to make their own appointment. They had been told to ring if no follow-up appointment was sent. This patient was waiting for results to show whether they had cancer after a biopsy. This meant the service appeared to be putting the responsibility onto the patients to follow up and book their own appointments if the hospital missed sending them an appointment.
- The patient administration manager told us they held regular RTT meetings with the business managers in each specialty. They said some business managers were responsible for more than one specialty. They discussed additional slot issues (ASIs), targets and holding lists. They explained that holding lists were lists of patients that there was no appointment slot for.
- They explained some specialties were worse than others; for example, upper gastrointestinal, neurology and paediatrics were worst. In trauma and orthopaedics, some areas were better than others. We asked about the serious incidents, which had been declared in outpatients, they confirmed these had occurred because patients had not had their planned appointments.
- When we asked the patient administration manager why some individual specialties, such as cardiology, booked their own appointments they told us cardio thoracic services and cardiology had always booked their own appointments. However, cardiology staff told us that when the central bookings team had booked their appointments, clinics slots were left unfilled.
- The patient administration manager told us they were looking at centralising appointment bookings for all specialties. They felt this would improve quality and consistency. They said East Riding Community Hospital appointment bookings were done centrally and that worked well.
- In the central bookings centre, we found there were dedicated staff assigned to booking clinics for patients on the cancer two-week wait pathway. They told us they followed the patient through from initial referral to checking the patient had attended their appointment.
- If patients did not attend for their cancer appointment, staff followed a process to contact them and rebook. If the patient did not want to rebook or was not contactable after two phone calls, then staff contacted the initial referrer and informed them.
- Staff in the booking centre told us there were regularly extra clinics, called initiative clinics. They told us one of the orthopaedic consultants had recently offered five Sunday dates for clinics.
- The senior management assistant for patient administration in general outpatients told us initiative clinics at Castle Hill Hospital were held across all specialties. These included Saturday morning clinics and evening clinics during the week. For example, urology held extra clinics on Wednesday and Thursday evenings from 5pm to 7pm and neurology held Saturday morning initiative clinics at both hospital sites.

Cardiology

- The head of department in cardiology told us appointments started at 8.05am in the morning. They said the waiting time for routine appointment was currently six weeks and urgent patient referrals were given an appointment within a week.
- Staff in cardiology told us that the change in appointment time from 20 minutes to 40 minutes had been,'fantastic' for both patients and staff.
- In cardiology, appointments for patients requiring an ECG and an echocardiogram were arranged the same day. Urgent requests from clinics for echocardiograms were done on the same day and urgent ultrasound scans were fitted in on a regular basis.
- Senior staff told us the department was meeting the six-week target for routine scans, however they said it would be better to see these patients within four weeks.
- Cardiology patients had open access and were not discharged until staff were happy with their progress. Cardiology staff told us a protocol had just been

approved for patients to be discharged after six hours. They explained this would save patients staying in hospital overnight after their procedure, which would also have financial benefits.
- Cardiology ran a regional service and was a referral service for neighbouring trusts in North Yorkshire. Staff told us demand has increased by around 3% per year. They said the department currently received approximately 7,000 referrals annually, this was predicted to increase to 9,000 referrals a year.
- One of the medical staff in cardiology told us the department needed to increase their throughput to cope with the increasing demand.

General outpatients

- The manager in general outpatients told us the appointment and referral centre at HRI made all new appointments and the centralised booking team in the Queen's Centre at CHH booked follow-up appointments.
- We visited the Queen's Centre and found the centralised bookings team was two band 2 clerical officers. The staff told us they were responsible for filling vacant clinic slots and booking follow-up appointments for CHH and the East Riding Community Hospital. They explained that clinic receptionists booked patient appointments at the desk after a patient's first appointment, if the appointment was within six weeks.
- The clerical officers told us patients always had at least three weeks' notice of their appointments. They said if an appointment was less than a week away, they had to phone the patient to inform them. We saw that coloured flags on the system indicated where the patient was in the 18-week referral to treatment pathway.
- They said each consultant had their own waiting list and some consultants had a different waiting list for each site if they worked at multiple sites.
- The clerical officers told us that if a patient cancelled their appointment they came back onto the waiting list.
- In general outpatients we observed patients using the self-check-in kiosks and booking in at reception. There were two staff on the desk. In audiology we saw patients had to use an automatic check-in as there was no receptionist.
- The senior management assistant for patient administration in general outpatients told us the computer system generated daily 'clinic utilisation reports.' These were reviewed on a regular basis. For example, on the day of our visit there was a meeting between the senior management assistant for patient administration and business manager for urology, plastics and ear, nose and throat (ENT).
- The senior management assistant for patient administration showed us the agenda for a scheduling meeting on 8 June 2016. We saw the agenda included; tracking of slots, capacity, initiative clinics, and meeting targets.
- In general outpatients, we observed, and patients told us, that appointments were running on time. However, in ENT, we heard a new patient being told there was a one-hour wait for appointments. We saw the whiteboard in the ENT patient waiting area gave wait times for each of the six doctors on duty. On the day we visited, one clinic was running 45 minutes late and another one hour and 20 minutes late.

Patient feedback

- We spoke with eight patients and two relatives during the inspection.
- One patient and their spouse in the eye clinic told us they were, "not impressed with the booking system." They couldn't understand why they couldn't make an appointment when they were leaving the department or why they got appointments at different hospital locations.
- Another patient and their spouse in the eye clinic told us they preferred appointments at HRI, as transport was easier for them. They were not aware they had an option to choose a preferred site.
- We spoke with two patients in the cardiology outpatients waiting area. Patient one had been discharged from hospital two weeks previously and was happy with the service including outpatients. They had received their outpatient appointment on time. Patient two told us they went in to their booked appointment slightly ahead of time.

Westbourne NHS Centre

- Staff at Westbourne NHS centre told us patients often received duplicate appointments. They said most of their DNA appointments were in neurology. The bookings team at HRI booked these appointments centrally.

Plastics outpatients

Outpatients and diagnostic imaging

- Staff in plastics outpatients told us there were large backlogs in appointments for Botox and in the hand clinic. Data submitted by the trust showed the number of patients on an access plan who were overdue for a follow up in plastic surgery on 29 June 2016 was 1,325.
- The junior sister in plastics outpatients told us they did not keep records of patient waiting times in clinics. They said clinics frequently ran over time by 30 minutes to one hour.
- Plastics outpatients had a system for fast tracking patients, using a smiley face on their notes.

Cardiothoracic

- Office staff in cardiothoracic told us ward clerks emailed them when patients required a follow-up appointment. They said usually these appointments were required after six weeks, however capacity issues meant appointments were not currently available to be booked for 10 weeks.
- They said 'patient admin' i.e. the central bookings team at HRI, were meant to do the cardiac follow-up appointments from the outpatient clinics but they did not have the resources to do this. They said extra outpatient clinics had been put on in the past in order to clear backlogs.

Diagnostic Imaging

- Radiology staff told us there were four escort nurses available to transfer inpatients to the department. These were either called by telephone or a message sent on the computer.
- Staff in CT told us appointment slots were 20 minutes long between 9am and 5pm.
- The Operational Plan for 2016/2017 showed there had been a 5% annual increase in demand across all of radiology.
- The percentage of patients waiting over six weeks for a diagnostic test was consistently below the England average between April 2014 and March 2016. We saw the majority of breaches for six-week imaging appointments occurred in MRI; these were due to issues relating to sedation and general anaesthetic and 'cardiac capacity'.
- Staff in radiology told us their 'did not attend' (DNA) rate in ultrasound was currently 5% and in MRI and CT varied but was around 3%. When we visited the MRI department at 10am, staff told us there had been two DNA patients already that day. When we asked staff whether any actions were being taken to reduce the DNA rates they said no actions were being taken currently, as this was not a priority.
- If plain films were not reported within six days, these were outsourced. This ensured patients got their results in good time.
- Managers told us demand for the services was increasing; for example, plain film x-rays had increased by 1%.
- The department used two radiologists who reported flexibly and remotely one in Scotland and one in Portugal.
- The radiology clinical directors told us consultant radiologists could have PACS (picture archiving and communication system) installed at home. This enabled them to do their reporting remotely and was a way of coping with the shortfall in radiologists.
- The clinical directors told us plain imaging reporting had changed from paper to electronic on 22 May 2016. They explained that all reports were now sent back to the referrer electronically. This reduced the paper used, staff time spent sorting reports and postage costs. Two emails were sent for each report, one to the consultant and one to the group, to ensure they didn't get missed.
- They said all reports were audited daily to check they had gone out on the day of authorisation. There was previously a delay of six to seven days between the authorisation of the report and it being sent out to the referring clinician. They said 11 out of 150 trusts in the country had electronic reporting in place in radiology and Hull was number 12. They told us this improved patient safety.
- Any urgent reports were faxed to GPs; this was also audited.
- We asked the radiology clinical directors about reporting backlogs. They told us there had been a backlog of 64,000 plain films a year ago; this had reduced to 8,000 at the beginning of April 2016 and 2,500 on 30 June 2016. The demand for plain film had increased 1% 200,000 annually.

Pathology

- The pathology laboratory manager told us urgent sample results were available within one hour. Air tubes transported samples from the wards to pathology specimen reception.

- There were three external blood storage units (BSUs) at the Castle Hill site; one of these was in the oncology day unit and one in the cardiac building. This ensured blood for transfusion was readily available for procedures, such as those in cardiac theatres.

Meeting people's individual needs

- Staff in cardiology ECG told us they would fast-track patients with complex needs. They said their patient population was mostly older (over 70) and they saw a significant proportion of patients with dementia. However, staff were not trained in dementia awareness. Staff confirmed the trust did run dementia awareness training.
- In general outpatients, we saw dementia friendly signage on the disabled toilet.
- Interpreters were available; if these were required, they were arranged prior to the clinic appointment. Secretaries informed the department if a new patient had any additional needs.
- We spoke to one patient accompanied by an interpreter. They told us (via the interpreter) that everything was fine and they had no problems with the service.
- In general outpatients we heard that a bell rang when a patient's name came up on the electronic board and staff called the patient into the clinic room. This meant people with hearing difficulties knew when they were called for their appointment.
- In ear, nose and throat and audiology, we saw that mixed patient toilets were clearly signposted. We saw these were large toilets with a handrail; however, there would be no room to turn a wheelchair. Waiting areas we visited were all accessible for patients in wheelchairs.
- In the eye clinic, we observed staff guiding patients with poor vision between different waiting areas, treatment and testing rooms.
- In general outpatients, we saw there were bariatric scales and large blood pressure cuffs for use with bariatric patients. There were also specific bariatric chairs available in the waiting areas. The nurse in charge explained there was a pilot bariatric clinic running which was funded by North Lincolnshire Clinical Commissioning Group. They said bariatric clinics were held at least once a week during the pilot.
- We saw there was a small children's play area in general outpatients. When we asked staff about this, they said there were no children's clinics but this play area was to support parents who came for appointments accompanied by their children.
- The nurse in charge in general outpatients told us about their 'patient clarity system.' This was used to identify any patients with special needs so that staff were aware. For example, patients who were very anxious or who had hearing or vision difficulties.
- The junior sister in plastics outpatients told us they were developing a card, which would be used to bookmark patient notes, to alert staff to patients living with dementia, those with pressure care problems or those needing transport.
- Staff in the bookings centre told us that, in addition to booking clinics, they booked 'advocacy.' This included additional support for patients with learning needs, hearing deficiencies or needing an interpreter. If face-to-face interpreters were not available, they would check with the clinic to see whether they could use the language line at the patient's appointment.
- In radiology, there were disabled toilets available in patient waiting areas and we saw low reception desk areas so that people in wheelchairs could access this reception area.

Learning from complaints and concerns

Outpatients

- Data submitted by the trust showed there were 166 complaints about outpatients in the 12-month period from April 2015 to March 2016; this represented 26% of the 646 complaints received by the trust. Seventy-one (43%) of these related to patient care.
- The highest number of complaints were received by the outpatients fracture clinic (15), followed by elective orthopaedics (10) and ophthalmology (10). Cardiology outpatients had eight complaints and plastics outpatients six complaints.
- The junior sister in plastics outpatients told us complaints were usually about waiting times in clinic. They said they recorded verbal complaints in a book and would advise patients about the Patient Advice and Liaison Service (PALS).

- The patient administration manager told us they did not get as many complaints as they would expect. They told us they did not record verbal complaints from patients or relatives.
- Office staff in cardiothoracic told us patients frequently complained about changes to appointment dates. They said they had no way to record verbal complaints and would redirect patients that complained to PALS.

Diagnostic Imaging

- Radiology had received eight complaints in the same period, two of which related to patient care.
- The consultant breast radiologist in the breast care unit told us complaints were discussed at their governance meetings; however, they did not remember ever having a complaint about the service.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

When we inspected this service in May 2015, we rated the 'well led domain as 'Good'. At this inspection, we rated the well-led domain as 'Requires improvement' because:

- The effectiveness of the leadership, governance, culture and support for outpatient services varied between the four Health Groups .The visibility of the leadership was variable. There had been no overall governance structure or cohesive management oversight of the outpatient departments, but this had recently been addressed and was development.
- The trust, for some time, had not been achieving the national standards for referral to treatment and urgent cancer treatment and current outpatient capacity did not meet the demands on the service. There were significant concerns relating to appointment backlogs and waiting lists in outpatients which had not been addressed since the last inspection. The trust had agreed revised local trajectories with the local commissioners (CCG and NHSI) and was meeting these.
- The ongoing backlog position was being monitored and addressed at senior management level; however, staff we spoke with in outpatients clinics were unaware of what was being done to improve the situation and were unaware of their own waiting list positions and backlogs.
- The systemic problems with the outpatient appointments and clinics meant the service was not meeting all of the NICE quality standards relating to frequency and reviews.
- There were high numbers of complaints about outpatients. The overarching system for capturing and managing issues and risks within outpatients was under development. This meant that at the time of the inspection there was limited management oversight of incidents, risks, audits, quality and patient safety about outpatients.
- Since the last inspection, outpatients had declared eight serious incidents and radiology had declared seven. There had also been two never events in radiology. In both services, there was a lack of assurance that the lessons learnt from the serious incidents in both services and never events in radiology had been embedded to ensure no further incidents occurred.
- In cardiology, there was lack of clarity about clinical audit, audit plans and audits that had been conducted including the results of such audits and their impact on the service. This was an area requiring improvement from the previous inspection.

However;

- The trust had a vision and strategy and staff were aware of this.
- Management, leadership and governance were good overall in radiology and pathology. Radiology and pathology had risk registers in place.
- The Clinical Support Services Health Group had operational plans and an outpatient improvement team was working on a two-year plan for the outpatient specialties. There were plans to appoint an outpatients matron or manager.
- The trust was aware of the problems in outpatient services and had plans in place, agreed with commissioners and NHS Improvement, to make improvements. The lack of an overarching governance structure or management oversight in outpatients had recently started to be addressed by the weekly Performance and Access (PandA) group, which reviewed all waiting lists by speciality. An 'outpatient

transformation project' was also in progress, which was running behind schedule. This project aimed to improve clinic utilisation, bookings processes and performance against standards.
- Staff reported positive culture changes at the trust, especially relating to the historical bullying issues. A more positive ethos had led to change in staff morale; staff told us they were well-supported by their local line managers and there were positive comments about the new trust board
- There were good examples of innovation in radiology.

Vision and strategy for this service

- The trust had developed its five-year strategy following wide consultation; this was approved at the Trust Board in April 2016.

Outpatients

- We saw the 'HEY Improvement Portfolio' included an outpatient transformation project. The project overview document showed this work had started in August 2015. This was to review the overall outpatients management structure, operational policies and processes.
- When we reviewed the directors report from 25th of April 2016, we saw the project was categorised as 'at risk 'and was currently running four weeks behind schedule. Goals included clearing the outpatient follow-up backlog and improving customer service. Work streams in oncology, cardiology, cardio thoracic and orthopaedics had commenced. The project had an agreed project overview document, rollout schedule and key performance indicators. Weekly performance against the KPI's was being monitored.
- Representatives of the outpatients' management team told us they felt there was a positive culture change happening within outpatients. For example, services were moving to seven-day working and extended days. Staff were going through consultation at the time of the inspection. Any new staff employed had seven-day working as part of their contract. Many procedures were being done as day cases and non-theatre nurses were carrying out procedures.

Diagnostic Imaging

- The CT and MRI operational plan for 2016/2017 showed services were working towards seven-day working, expanding radiography reporting and expansion of the CT colonography (CTC) service.
- The radiology manager told us radiology was part way through a three to four-year programme of retrofits of all rooms in the main building. Radiology had a clear strategy for equipment replacement; the plan was to have digital radiology (DR) equipment installed across all areas.
- Radiology staff we spoke with knew about the trust vision and values and the radiology equipment replacement programme.

Governance, risk management and quality measurement

Outpatients

- Each of the four Health groups had a number of outpatient services within it. The Family and Women's Health group included dermatology ophthalmology, plastic surgery and ENT. The Medicine Health Group included general medicine, cardiology and neurology. The Surgery Health Group included neurosurgery, head and neck, urology and general surgery. The Clinical Support Health Group included audiology, oncology and clinics for allied health professionals.
- There had been limited overarching governance and management oversight of the outpatient departments, however recent changes were starting to address this including the Performance and Access (P and A) meetings and the work of a transformation board. There had been variation in the management of and support for outpatient specialities across the Health Groups.
- There were significant concerns relating to appointment backlogs and waiting lists in outpatients, especially in ophthalmology, which had not been addressed since the last visit. Senior managers were regularly monitoring the ongoing position.
- At the time of the inspection there was oversight of governance at trust level and a project overview document and outpatients' action plan was in place. Their aims were:
  - to quantify, as a priority, by specialty, the number of patients that had passed their outpatient follow up date;
  - a standard approach to validating these patients;
  - to develop trajectories for reduction and elimination of follow up backlogs and;
  - a clinical review of these patients to quantify if any had experienced harm.
- Some action plan target dates were overdue.

Outpatients and diagnostic imaging

- There were trust-wide performance and access (P and A) meetings every week to review and monitor waiting lists. These meetings were led by the chief operating officer and had started a few weeks before the inspection. We were told these meetings provided assurance and oversight and that attendance lists and action notes were taken.
- There was an outpatient project steering group, which met every month. We reviewed the notes from February 2016 meeting. We saw agenda items included consultant annual leave, clinic slot utilisation, hospital cancellations and project updates.
- There was no specific outpatients risk register. However, we found some risks were identified within the Health Group risk registers, which reflected the main areas of concern. These specifically included ophthalmology, dermatology and a composite risk relating to specialties within the Medicine Health Group regarding the number of overdue appointments outstanding in respiratory medicine, endocrinology, diabetes, cardiology, neurology and rheumatology.
- There were no overarching outpatient governance or quality meeting minutes submitted and there was no discussion recorded of risks, risk management, governance or quality monitoring at the outpatient project steering group meeting.
- Outpatient managers told us there were regular weekly operational meetings between patient administration, business managers and divisional general managers.
- The trust had introduced a new patient IT system to improve the tracking and monitoring of patients including those who were on waiting lists. Outpatient managers told us there had been many issues with the new IT system and the transition from the previous computer system and this meant there had been some double counting and cleansing of the data had been required. They said this meant that data collated following the changeover to the new computer system had not always been reliable.
- In cardiology, there was a weekly meeting to present interesting cases. Staff told us these were beneficial.
- Cardiac physiology staff had carried out capacity and demand audits, which resulted in a reduction to the numbers of available clinic slots. Repeat audits had been carried out six months later, and the numbers of clinics reduced again. Staff told us this meant a better match between clinics and demand.
- We spoke with the service lead in cardiology about clinical audit, as this was an area requiring improvement from the previous inspection. We found there was lack of clarity about audit plans and audits that had already been conducted, including the results of such audits and impact on the service.

Diagnostic Imaging

- Data provided prior to the inspection showed radiology was aware of the departmental risks and kept up-to-date with compliance against regulations. Their most recent medical physics expert (MPE) and RPA reports were very good, and clearly identified any issues that needed action.
- We saw some evidence of identifying and learning from serious incidents and never events. The two radiology clinical directors had made presentations to the trusts' Quality Committee about the SIs and never events on 23 June 2016, entitled: 'Learning from recent radiology SI's' and 'Never Events in Radiology 2014/15 and 2015/16'. We saw evidence of actions taken and changes made to practice.
- Radiology had undertaken a look-back exercise with the commissioners to check for harm from serious incident relating to the non-printing of reports incident. A new monitoring system alerted staff if radiology reports had not been viewed and/or actioned; this could be escalated to the medical director for action.
- We reviewed the radiology risk register and saw a number of risks related to ageing equipment. The department was well aware of this issue, and had a rolling equipment replacement programme to replace all the computerised radiology equipment and digitise all of the rooms. There were also issues with the RIS and PACS information systems and plans were in place to replace these.
- The radiology management team told us the department was collaborating with neighbouring trusts in the area to undertake regional insourcing. This is where critical work within the region is assigned using local resources within a collaborative network, rather than outsourcing it. This should be more cost effective and helps maintain local control.
- Eight trusts were undertaking a joint procurement of a new PACS system. They said they would be able to manage capacity and demand better when the new radiology information system (RIS) was installed.

Outpatients and diagnostic imaging

- Two of the consultant radiologists shared the clinical director role in radiology; one for governance and one for information technology. This was because the role was felt to be too much for one person. They worked four long days a week each, with one crossover day. The radiology manager and section leads in each modality area supported them.
- The radiology management team told us there was 'excellent in-house governance' in radiology. For example, in 2015, 2,050 ultrasounds were peer-reviewed and this work had been nationally recognised. They said they were proud of their work and maintaining the safety of patients.
- We reviewed minutes of the radiology management team meetings and radiology governance and strategy meetings for February, March, and April 2016. We saw these discussed serious incident investigations, business cases, workforce planning and departmental risks.
- The two reporting radiologists who worked remotely for the department visited the department regularly and understood the local discrepancy and governance policies.
- The radiology management team told us the departmental spend on outsourcing reporting was significant. They said they had to balance the finances against the turnaround times for results. They said the trust executive team were supportive and recognised their challenges.

Leadership of service

Outpatients

- There was limited trust-wide operational management of outpatient services at the trust and each of the Health Groups offered different levels of management and clinical support. Staff talked of plans to get all outpatients services into one structure, and the appointment of an outpatients matron. However, we did not see any documentary evidence to confirm this.
- The leadership in the four Health Groups had changed recently. Each of the Health Groups had a medical director, director of nursing, and operations director. These were supported by matrons, apart from the Surgery Health Group, which had a divisional nurse manager.
- There was an outpatients' transformation project board and representatives of each of the Health Groups attended this. This reported to a trust transformation board; weekly performance against key performance indicators was monitored.
- The junior sister in plastics outpatients told us they had started in the department at the end of March 2016. They said their band seven manager was based at HRI and they saw them about once a week or once a fortnight. They said the previous band six sister had retired two years ago and the post had been vacant since. The junior sister in plastics outpatients was responsible for the plastics outpatients' clinics and the Westwood Day surgery suite.
- Staff in plastics outpatients told us they had had no support for two years, since the previous sister left.

Diagnostic Imaging

- We found competent staff managing the radiology areas we visited and staff we spoke with told us the leadership and support in the departments was good.
- Interventional radiology was part of radiology and radiologists carried out interventional radiology procedures.
- The two radiology clinical directors told us the medical director in the Health Group was supportive and they could take any problems to them.

Culture within the service

- Staff we spoke with were aware of the requirements of the duty of candour. They knew about being open and honest with patients and families when things went wrong and some were able to give us examples of when they had done this.

Outpatients

- Staff had heard of and/or attended the PaCT (bullying awareness) training. Staff acknowledged the history of bullying in the trust and reported that things had improved recently. They said the PaCT training was good.
- Staff in cardiology told us the atmosphere was good in the department and the managers were very approachable. They said it was a good team to work with.
- An auxiliary nurse in general outpatients told us the department was supportive about training and development and the whole team was very supportive.

Outpatients and diagnostic imaging

- Staff in general outpatients told us they were aware of the historic culture of bullying; however, this was not currently a problem. They said emotional support was provided if there were problems with aggressive patients.
- The outpatients' management team told us they felt the bullying culture had changed, there was additional support to staff, and PaCT training was available. They said outpatients had good working relationships between staff and departments.
- Representatives of the outpatient management team told us that serious incident investigations were more supportive to staff than they had been in the past. They said the new chief executive 'set the tone.'

Diagnostic Imaging

- Radiology staff we spoke with were generally positive about culture within the department and told us the team was very supportive. Staff told us they got good backup from the radiologists and good feedback from students. One radiographer told us there was, "A nice atmosphere."
- The radiology management team told us they felt the culture in the department was good. They said they had involved the trust's 'anti-bullying Tsar' when there had been issues with bullying. They said the staff survey results for the department had shown an improvement.

Public engagement

Outpatients

- Outpatients' friends and family test results were consistently good but the response rate was low.
- Cardiology staff told us the department did not carry out a separate friends and family test.
- The nurse in charge in general outpatients told us they were currently carrying out an audit of bariatric patient opinions. They said when this was completed they would collate the information and add it to the patient information board. It would also be shared with North Lincolnshire CCG as they were funding the pilot of bariatric clinics at the CHH site.

Diagnostic Imaging

- The Friends and Family test (FFT) results for the radiology day unit (RDU) were good; recent scores for people who would recommend the service were reported as 4.89 / 4.9 out of 5.
- We were not provided with any national friends and family test data for other radiology services.
- We were shown a flyer given out by staff PET-CT scanning centre which asked patients to give feedback about their experience in the department.

Staff engagement

Outpatients

- On 1 June 2016, plastics moved to the 'Family and Women's Health Group. They told us the senior management team felt this was a better set up in order to manage the service effectively. Surgical outpatients was in the Surgery Health Group.
- The junior sister in plastics outpatients told us the department was now having staff meetings every six weeks and the minutes were circulated to staff. We observed staff meeting minutes were on display on the staff noticeboard.
- Staff felt they were "well-looked after" from a lone working point of view, with security staff being available to escort staff around the grounds of the hospital after dark. They said the lone working policy was helpful to them with the site being very spread out.
- In cardiology, staff told us there was a telephone communication book for messages. They said it was very difficult to hold staff meetings due to the limited staff resources in the department.
- Staff told us managers sent regular updates by email, for example training updates and changes to standard operating procedures. They were required to respond to confirm they had read them. This provided an audit trail.
- Staff in general outpatients told us they had staff meetings every four weeks, when managers shared information and talked about incidents. However, staff in ear, nose and throat service (ENT) told us their team meetings were "occasional." The charge nurse told us an ENT newsletter was being developed.
- Reception staff in the general outpatients' department told us there was a good support network and good teamwork.
- We saw staff noticeboards in staff areas / staff rooms in general outpatients and ENT.

Diagnostic Imaging

- There was a radiology newsletter, this was available to staff on the trust's intranet.

Outpatients and diagnostic imaging

- Radiology staff reported seeing their manager frequently.
- Staff told us there was staff meeting every six weeks.

Pathology

- The pathology laboratory manager told us there was a daily huddle first thing in the morning. They said staff talked about what had happened the day before and whether any improvements could be made.

Innovation, improvement and sustainability

- The chief executive of the Society of Radiographers attended a meeting between nursing staff and a support worker in radiology to discuss creating radiology link nurses on all wards. As a result, they wrote an article for the Society of Radiographers magazine, to be published in the summer of 2016.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit were doing vacuum assisted biopsies. The consultant breast radiologist told us this was a one-stage procedure which avoided patients needing two or three biopsies. This significantly reduced the stress and anxiety for the patient and saved resources in terms of time and finances.

Outstanding practice and areas for improvement

Outstanding practice

We found areas of outstanding practice including;

- The responsiveness of the Specialist Palliative Care Team (SPCT) in relation to acting on referrals. For example, we saw that the SPCT was prepared to see patients without having received a referral and 98% of patients referred to the team were seen within one working day.
- The bereavement initiative of providing cards for relatives to write messages to their loved ones.
- The breast care unit were using digital tomosynthesis. This method of imaging the breast in three-dimensions improves the sensitivity of detection of breast cancers by 40% and is more accurate.
- The breast care unit carried out vacuum assisted biopsies. This one-stage procedure avoided patients needing two or three biopsies, significantly reducing the stress and anxiety for the patient and saving on resources.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that planning and delivering care meets the national standards for the referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to longest waits.
- The trust must ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls.
- The trust must ensure learning from never events is further disseminated and lessons learnt are embedded.
- The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's national early warning score (NEWS) and escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- The trust must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.
- The trust must ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- The trust must ensure the effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts.
- The trust must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The trust must review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board.
- The trust must ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.

Outstanding practice and areas for improvement

- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- The trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitability skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

Action the hospital SHOULD take to improve

- The trust should ensure nursing staff have the correct skills to work specialist areas, specifically within medicine.
- The trust should ensure ward sisters/charge nurses have dedicated time to carry out their management duties.
- The trust should review the provision of rehabilitation after critical illness in line with national recommendations (Guidelines for the Provision of Intensive Care Services 2015 and NICE CG83 Rehabilitation After Critical Illness).
- The trust should strengthen formal mechanisms to obtain patient and relative feedback within critical care and other services.
- The trust should ensure that all policies, guidelines and pathways on the trust intranet are up to date.
- The trust should ensure that staff become fully compliant in completing syringe driver checking forms.
- The trust should ensure that all members of the Specialist Palliative Care Team are fully compliant with all mandatory training.
- The trust should consider appointing a non-executive board member with responsibility for end of life care and an end of life care facilitator.
- The trust should consider developing a trust end of life care strategy.
- The trust should ensure the facilities and environment used by audiology are appropriate for patients' needs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for patients. The trust must: 1. ensure that planning and delivering care meets the national standards for referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to the longest waits. Regulation 12(1) 2. ensure that staff complete risk assessments and take action to mitigate any such risks for patients; in particular, risk assessments for falls. Regulation 12(2)(a) & (b) 3. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b) 4. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National Early Warning Score (NEWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b) 5. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy. Regulation 12(2)(g) 6. ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient. Regulation 12(2)(g)

Requirement notices

7. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: Some patients' food diaries and fluid balance chart were not fully completed therefore it is not possible to monitor whether their needs were being met. The trust must: 1. ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not always operated effectively to ensure improvement and good governance of services. The trust must: 1. ensure that elective orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a) 2. ensure the effective use and auditing of best practice guidance such as the 'Five steps to safer surgery' checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)

This section is primarily information for the provider

Requirement notices

3. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).

4. must ensure outpatients services have timely and effective governance processes in place to ensure they identify and actively manage risks and audit processes to monitor and improve the quality of the service provided.

5. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient services. Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients. The trust must: 1. ensure that there are at all times sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national guidance taking into account patients' dependency levels on surgical and medical wards. And specifically ensure critical care services have sufficient numbers of staff to sustain the requirements of national requirements (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012). Regulation 18(1)