

# Hull and East Yorkshire Hospitals NHS Trust

## Hull Royal Infirmary

### Quality Report

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11 July 2016  
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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



Urgent and emergency services

Good



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Requires improvement



Services for children and young people

Good



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. HRI is the main centre for emergency services including the emergency department (ED). The trust provides services for a population of approximately 602,700 people. This is made up of approximately 260,500 people in the city of Kingston Upon Hull, and 342,200 in the East Riding of Yorkshire.

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

We rated HRI overall as 'requires improvement'; safe, responsive and well led were rated as 'requires improvement' with effective and caring rated as 'good'. Improvements had been made since our last inspection but these were not significant enough to change the rating for HRI as whole. Some areas had made considerable improvements, especially the emergency department (ED) which was now rated as 'good'. Medical Care, Surgery and Children's Services had improved. End of Life Care remained 'good' across all domains. However, there was deterioration in the ratings overall for Critical Care, Maternity and Outpatients & Diagnostics from 'good' to 'requires improvement'.

Our key findings were as follows:

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

# Summary of findings

- 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. The maternity service did not collect the relevant data and therefore could not provide assurance that women received one to one care in labour.
- There were also some gaps within the medical staffing, especially within critical care.
- 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 although there were some instances on the acute medical unit at HRI where not all call bells were within reach of patients.
- Patients told us they were offered a choice of food and regularly offered drinks. Patients were offered alternatives on the food menu and were provided with snacks, if required, during the day.
- The areas we visited were clean and ward cleanliness scores were displayed in public areas. We observed good infection prevention and control practice on all wards we visited. There had been a significant improvement in the operating theatre environment at HRI.

We saw several areas of outstanding practice including:

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

# Summary of findings

- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.

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

- Planning and delivering care meets the national standards for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- A review of the process for categorising incidents is carried out, including safeguarding incidents relating to children, to ensure effective investigation and lessons learnt.
- Staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- Learning from never events is further disseminated and lessons learnt are embedded.
- Staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.
- Staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- It continues to work actively with other professionals, internally and externally, to make sure that care and treatment remains safe for children with mental health needs using the services.
- Staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- Staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- Staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.
- Records of the management of controlled drugs are accurately maintained and audited within A&E.
- Patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- Staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- Antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol).
- There is effective use and auditing of best practice guidance such as the "Five steps for safer surgery" checklist within theatres and standardising of procedures across specialties relating to swab counts.
- Elective orthopaedic patients are regularly assessed and monitored by senior medical staff.
- The critical care risk register is reviewed so 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.
- Outpatient 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 and maternity services.
- At all times there are sufficient numbers of suitability skilled, qualified and experienced staff (including junior doctors) in line with best practice and national 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).
- It continues to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour.

# Summary of findings

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

#### Urgent and emergency services

### Rating

Good



### Why have we given this rating?

At our previous inspection in May 2015, the service was rated as 'Requires improvement' overall. In June 2016 we rated this core service as 'Good' because:

- The service was meeting a locally agreed trajectory to see and treat patients within four hours of arrival, and had done so for three consecutive months.
- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nursing staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Patients care and treatment followed evidence based guidance and recognised best practice standards that were monitored for consistency. Care was delivered with compassion and staff treated patients with dignity and respect.
- Risks to the delivery of care and treatment for patients were appropriately managed. The governance of the department had become more embedded
- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this. The executive team and senior staff in the emergency department were recognised and respected.

#### However:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival.
- We found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.
- No formal arrangements or protocols were in place for liaison with other specialties.

# Summary of findings

## Medical care (including older people's care)

### Requires improvement



In May 2015 Hull Royal Infirmary Medical Care services were inspected we rated them as 'Requires Improvement' overall. In 2016 the rating remained as 'Requires improvement' because:

- Staff were not always assessing and responding appropriately to patient risk. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care; however, some staff were unclear about what to do if a patient's score increased.
- Falls risk assessments were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment. We found poor compliance with the completion of food charts and fluid balance charts.
- Fridge temperature checks were not always performed and we found that when recorded as out of range, no corrective action had been taken. Controlled drugs were appropriately stored with access restricted to authorised staff however, on most wards; we found daily and weekly checks were not consistent with trust standard operating procedures.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients.
- The trust was not meeting the 18 week referral to treatment standard for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed. There were still issues with bed capacity and medical outliers were affecting other services.

However;

# Summary of findings

- Leadership had improved. There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork. There was a drive for continual change and improvement within the Medicine Health Group. Further work was needed to embed the changes and to continue to improve standards.
- Staff were caring. Feedback from patients and relatives was positive. We saw good interactions between staff and patients and staff maintained patients' privacy and dignity when providing care. Patients and relatives felt well informed and involved in decision making about their care. We found that patients' access to call bells had improved and the trust was auditing this regularly.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years where compliance had been 68.7% and 74.9%. There were mixed results in national audits; however, action plans were in place to improve areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.

## Surgery

### Requires improvement



In 2015 we rated surgical services at HRI as 'Inadequate'. At the 2016 inspection the services had improved and were rated '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 for medical review, but this had not always occurred.
- 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.



# Summary of findings

- 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 at both sites.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. 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 doctors' rota, especially overnight; this was highlighted on the risk register.
- Nursing staff did not always complete accurately the falls and dementia risk assessments.
- National audit performance was variable; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 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.
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.
- Due to the environment in the day surgical unit it was difficult to maintain privacy and dignity.
- 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 Surgical Health Group, this team recognised that they needed more time to develop and become fully effective in their roles.

## However,

- We noted major improvements from the 2015 inspection to the theatre environment.
- 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.

# Summary of findings

- 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 mainly positive or neutral and interactions with patients were positive.
- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust's values and strategy.

## Critical care

### Requires improvement



We had not inspected critical care services at HRI since February 2014 when they were rated as 'Good'. During this inspection 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% national standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified that controls for some of the risks on the risk register were limited and unsustainable. 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 of some of the risks on the risk register.
- There was no documented evidence that some patients were seen by a consultant within 12 hours of admission or that twice daily ward rounds took place. The medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015)
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care

# Summary of findings

services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.

- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts. Some patients were not seen by a consultant within 12 hours of admission; twice daily ward rounds did not take place and medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015).
- Planned nurse staffing levels were not consistently achieved and this impacted on the number of beds available in the critical care units. Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. This member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.
- We saw evidence during our inspection of patients who were referred to critical care requiring level three care that had not been escalated in line with trust policy.
- 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 mechanisms of collecting patient or relative feedback.

## However, we also found:

- 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.

# Summary of findings

- There was clear nursing and medical leadership on the units and in the critical care outreach team and staff had confidence in the units' leadership.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- We observed patient centred multidisciplinary team working.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

## Maternity and gynaecology

### Requires improvement



At the comprehensive inspection in 2014 we rated Maternity and gynaecology services as 'Good'. In 2016 the services were rated as 'Requires improvement' overall because:

- We found process for recognising deteriorating patients were not always reliable. It was not clear from observation charts how frequently observations should be repeated if a patient was unwell.
- The service did not meet the national benchmarking for midwifery staffing. Data was not collected on the number of women who received 1:1 care in labour to provide assurance about midwifery staffing levels.
- We found that some governance arrangements did not always allow for identification of risk.
- Lessons learnt following a recent never event were not embedded.
- We found that in some areas the approach to service delivery was reactive especially in relation to how the service had implemented the Growth Assessment Protocol (GAP).

#### However:

- Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
- Patient outcomes were in line with national averages when compared to similar services.
- Women spoke positively about their experience and said they felt well supported and cared for.
- The trust had engaged with the public and sought their views over the development of the midwifery lead birthing unit.

# Summary of findings

- We saw strong leadership at a local level. Staff felt supported and felt their concerns would be listened to.

## Services for children and young people

Good



At the 2015 inspection, we rated the services for children and young people as 'Requires improvement'.

At the 2016 inspection we saw improvements had been made and rated the services overall as 'Good' because:

- Nurse staffing was appropriate and was planned using an acuity tool. Multidisciplinary working took place and staff worked well as a cohesive team. Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Requirements around the duty of candour were being met.
- The service performed positively in infection prevention and control audits.
- Policies were based on national and local guidelines. Consent to care and treatment was obtained in line with legislation and guidance.
- Staff treated children, young people and their relatives/carers with kindness, compassion, dignity and respect. Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- We saw children and young people being assessed and treated in a timely way. A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- Playrooms and a schoolroom were available to meet the learning needs of patients.
- Following our inspection, the trust informed us they had decided to commission an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's needs.

# Summary of findings

- Staff spoke positively about their managers and the culture of the trust and were able to articulate the trust's vision and values.

However,

- Not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patients and how those needs would be met.
- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.
- Records concerning the administration of medications were not appropriately completed.

## End of life care

Good



At the comprehensive inspection of end of life care services in February 2014 we found the service to be 'Good' overall. In 2016 the rating remained '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. 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 multi-disciplinary working across all teams. The trust had recently

# Summary of findings

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 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.

# Summary of findings

## Outpatients and diagnostic imaging

### Requires improvement



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 that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the services overall as 'Requires improvement' because.

- The trust was 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.
- A cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients, 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 in some outpatient specialties, and in radiology, there were five vacant radiologist posts and a significant proportion of radiographer vacancies in general x-ray.



# Summary of findings

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- The facilities and premises used to deliver services were of variable quality. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair.
- We found there was 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.
- There was inconsistency in the governance and management oversight in outpatients due to the clinics 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', which was running behind schedule. This project was to improve clinic utilisation, booking processes and performance against national standards. We were also told that an overarching management post was to be developed.

## However,

- 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. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action.
- At the last inspection, patients undergoing hysteroscopy within gynaecology outpatients were not completing consent forms. We found these patients were now completing consent forms as required.

# Summary of findings

- Outpatients and radiology had increased their capacity by running clinics out of hours and at the weekends, to cope with the increased demand and to make sure patients had their appointments in a timely manner.
- Staff providing care and treatment to people in outpatients and radiology were very caring. Patients gave positive feedback about the care they received, and 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 deficiencies or those who needed an interpreter.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching risk register for outpatients which meant there was a lack of cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- 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, 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 declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. 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.

# Summary of findings

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- 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. The trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. 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.
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# Hull Royal Infirmary

## Detailed findings

### Services we looked at

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

# Detailed findings

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## Background to Hull Royal Infirmary

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

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

The trust provides services for a population of approximately 602,700 people mainly across two local authority areas. Life expectancy for those in East Riding of Yorkshire is better than average, but worse than average for those in Hull. 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 of pregnant women at the time of delivery, recorded diabetes and deaths and serious injuries on roads. In the 2015 Indices of Multiple Deprivation, Hull was ranked the third most deprived of all local authorities in England. 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. We also carried out unannounced inspections on 9 June and 11 July 2016. The trust had 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 April 2014. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services inspected. The overall rating for the Trust was 'Requires improvement'. The Trust was found in breach of the

# Detailed findings

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).

The Trust had developed a Quality Improvement Programme in response with three objectives, which were;

- Aid in achievement of the Trust's overall ambition to meet its vision; Great Staff, Great Care, Great Future
- Deliver Trust wide quality improvement based on the priorities identified through the programme such as the Quality Accounts, Sign Up to Safety and CQC inspections
- Address MUST and SHOULD do actions identified by the CQC.

## Our inspection team

Our inspection team was led by:

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

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

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

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

## How we carried out this inspection

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

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

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

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology

# Detailed findings

- 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 sessions using stalls prior to the inspection to hear people's views about care and treatment received at the trust; one at HRI and the

other at CHH. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended these events.

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

## Facts and data about Hull Royal Infirmary

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

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

As of 1 April 2016 there were 6,979 whole time equivalent (WTE) staff in post against an establishment of 7,620 WTE. Of these, 956 were medical (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

Hull Royal Infirmary had over 700 beds and was the main centre for emergency work. The beds were primarily for acute medical and surgical services. The main accident and emergency (A&E) services were on this site. The A&E services were seeing year-on-year increases in attendance, and treated over 132,195 attendances in 2014-15. The Women and Children's Hospital was located at HRI and housed the maternity and children's services, including neonatology with a 26-cot neonatal intensive care unit. The obstetrics department provided maternity services to women of Hull and East Yorkshire. The trust was accredited as an Endometriosis Centre in the North East of England.

In addition, the hospital provided critical care services, with 24 beds available for intensive care and high dependency, close to the main theatre complex. There was also an ophthalmology (eye) hospital on site.

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.

# Detailed findings

## Our ratings for this hospital

Our ratings for this hospital are:







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

### Notes

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



# Urgent and emergency services

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

## Information about the service

Hull Royal Infirmary emergency department received 132,195 attendances in 2014-15, which excluded patients attending the Beverley Minor Injuries Unit (MIU) and represented more than 360 patients attending the department each day. Of the total number of patients attending, 29.2% of these resulted in an admission to hospital, which was above the England average of 22.2%.

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

The adults' emergency department included a major's area, eight initial assessment bays and 24 cubicles. The children's emergency department had eight cubicles, two assessment rooms, one paediatric resuscitation area, one neonate's resuscitation cubicle and a waiting area. The minor's area consisted of a rapid self-check-in for patients, supported by a staffed reception area. Ten cubicles were available in the minor's area. A waiting area behind the nurse's station was used for vulnerable patients.

The further phase of building work had been completed since 2015. A relatives' area consisted of three family rooms and a relatives and viewing room. A trolley bay for trolley and equipment cleaning and separate storage had also been completed since our visit in 2015.

The Beverley MIU, operated as part of the emergency department, was located within the East Riding Community Hospital which opened in July 2013. The MIU consisted of an adult waiting area, four treatment rooms and a separate children's waiting area. Patients had the use of an adjacent radiology department.

At our previous inspection in May 2015, the service was rated as Requires Improvement overall. The responsive domain was rated Inadequate and the safe and well-led domains were rated Requires Improvement. This was because:

- Performance against the four-hour target to see and treat patients had deteriorated over a considerable period.
- Shortages of consultants and other medical and nursing staff had an impact on assessment of patients, access and flow and major trauma preparedness.
- Governance structures had recently changed and the revised arrangements were still to become embedded.

During one announced and two unannounced visits in June and July 2016 we spoke with 40 patients and their relatives, and 50 members of staff of different disciplines which included visiting healthcare professionals, for example ambulance staff. We observed the care and treatment of patients and reviewed electronic records and other documents provided by the trust prior to our inspection.

# Urgent and emergency services

## Summary of findings

At our previous inspection in May 2015, the service was rated as 'Requires improvement' overall. In June 2016 we rated this core service as 'Good' because:

- The service was meeting a locally agreed trajectory to see and treat patients within four hours of arrival, and had done so for three consecutive months.
- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nurse staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Patient's care and treatment followed evidence based guidance and recognised best practice standards that were monitored for consistency. Care was delivered with compassion and staff treated patients with dignity and respect.
- Risks to the delivery of care and treatment for patients were appropriately managed. The governance of the department had become more embedded
- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this. The executive team and senior staff in the emergency department were recognised and respected.

However:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival.
- We found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.
- No formal arrangements or protocols were in place for liaison with other specialties.

## Are urgent and emergency services safe?

Good



At our previous inspection in May 2015, safe was rated as 'Requires improvement'. In June 2016 we rated safe as 'Good' because:

- The trust had invested substantially in the environment of the emergency department and in new equipment including its major trauma facilities.
- Staff were encouraged to report incidents and lessons were learned from the investigation of incidents.
- Nursing staffing was close to meeting planned establishment levels and medical staffing had significantly improved.
- Risks to all patients in the department were reviewed every two hours by medical and nursing staff working together. Arrangements were in place to respond to major emergencies.
- Safeguarding procedures were in place and records in the emergency department were fully maintained and audited.

However:

- Although medicines were stored and administered appropriately, we found gaps in the recording of medicines administration and in the monitoring of checks of controlled drugs.

### Incidents

- 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. Fourteen serious incidents were reported between May 2015 and April 2016. None of these were never events. There were no overdue incident investigations pending, which represented a significantly improved position from 2015.
- No falls with harm or urinary tract infections in patients with a catheter were reported to the patient safety thermometer between March 2015 and March 2016. Over the same period, three new pressure ulcers were reported. Action was taken to reduce falls risk, for

# Urgent and emergency services

example, yellow socks and yellow wristbands were worn by patients identified as at a higher risk of falls. A weekly safer care audit which included a check for compliance of falls risk assessments was undertaken.

- The service had taken action to identify learning from the investigation of incidents. Investigation reports included documented actions and shared learning. We found evidence that practice in the emergency department changed because of the investigation of incidents. Quality and safety bulletins and lessons learned newsletters used examples from the investigation of incidents and were published regularly.
- Actions taken after our 2015 inspection included the lessons learned newsletters (available through the staff intranet), the use of safety bulletins and the sharing of serious incident investigation findings to clinical and leadership teams. Actions taken to support lessons learned in 2016 has included briefing and discussion events for staff and strengthened audit arrangements following a serious incident.
- The service had also prepared a learning video for staff based on an actual incident in the hospital and human factors training was available to staff. Human Factors principles are applied to health care training to enhance safety through changes in clinical practice.
- The divisional nurse manager held a weekly meeting to review reported incidents and to focus on themes and lessons learned. Face to face feedback following a reported incident was available to staff from a specialist teaching practitioner dedicated to working with staff within the emergency department. Medical staff were supported with learning from incidents through the emergency department governance lead.
- Posters displayed in the department were changed regularly to share current learning from incidents. Staff we spoke with confirmed that they received feedback from the investigation of incidents, but said that this could be slow and said they did not always see changes because of the investigation of incidents.
- 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 to provide reasonable support to that person. The trust had in place a policy relating to the duty of candour requirements.
- Incident information reported under the duty of candour requirements was included in the electronic

incident reporting system. Senior managers confirmed that the recording and follow up of incidents related to duty of candour had improved significantly since our visit in 2015. Training in duty of candour had increased staff awareness, which was supported by the weekly meeting to discuss reported incidents. Our own review of incidents confirmed that duty of candour was applied effectively.

## Cleanliness, infection control and hygiene

- The emergency department was visibly clean and we found infection control and hygiene standards were maintained to a consistently high level. A weekly cleaning schedule was followed by the housekeeping team, supported by a hygienist. Cleaning rotas were dated and signed.
- Following use, the majors and resuscitation rooms were closed for cleaning and restocking before the arrival of the next patient. A colour co-ordinated lighting system was used for each resuscitation room, which showed green if the room was ready to use, and red if it required cleaning. Equipment, including trolleys that were ready to use were labelled with an “Hey I’m clean” sticker.
- The central area of majors used by staff was clean and clutter free. Disposable curtains were used throughout the department. Two sluices were located in the initial assessment and majors areas. Dirty commodes and bed pans were washed in the dirty sluice then labelled and moved to the clean sluice. “Hey I’m clean” labels were used on commodes and bed pans. Entry to the clean utility area was restricted by swipe access. The clean utility area was clutter free.
- A cleaning area for trolleys had opened since our visit in 2015, with separate designated dirty and clean trolley areas for porters to use. Porters cleaned trolleys after each patient use, and also weekly, in the dirty trolley area. Trolleys were labelled as ready for use and stored in the clean area.
- We observed that staff followed the bare below the elbow policy in clinical areas, and personal protective equipment was used. We observed that medical and nursing staff undertook effective hand washing between patients. Hand gel was not readily available in some areas of the department, although staff carried a small gel dispenser on their person. Following the inspection the trust informed us that action had been taken to

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provide additional hand gel dispensers. Sharps boxes were provided in each cubicle, although we observed these were opened and stored at waist level, meaning they were accessible to members of the public.

- Cleanliness and hygiene was maintained and a checklist was used in each cubicle that indicated areas that needed cleaning. Cubicles were taken out of action until they were cleaned and restocked. Two rooms in the major's area were fitted with ventilation to isolate patients. Alerts in the computer display indicated patients with MRSA.
- The environment and equipment in each area of the department was cleaned following a regular schedule and this was recorded. Environmental and infection control standards were reviewed for each area of the emergency department each month and an overall score awarded for compliance. We saw evidence that action was taken where cleaning failures were identified from audit.
- The audit confirmed, for example, that mandatory safety training in infection control was compliant. Over 85% of staff were up to date with infection control training. We found evidence of compliance with infection control policies, for example, hand audits achieved 95% compliance and patient-led assessments of the care environment (PLACE) audit achieved 98%.
- The emergency department cleaning standard used in the children's emergency department was supported by nursing staff. The play specialist undertook cleaning of toys and we saw that this was recorded. The department was reviewing its cleaning policies with input from infection control.
- When we visited the Beverley Minor Injuries Unit (MIU) we observed that public areas and rooms were clean and tidy. Evidence that cleaning was done was signed and checked daily. Staff used personal protective equipment. We observed that staff washed their hands after giving treatments to patients. Toys were cleaned daily and this was recorded. Trolley cleaning and checking was undertaken by domestic staff. The sluice area was clean although we found five bed pans that were not labelled "Hey I'm clean." No hand gel was available in the unit.

## Environment and equipment

- The hospital's extended and refurbished emergency department opened in April 2015. The major's area consisted of 24 enclosed cubicles. Visibility was

maintained through the use of extensive glazed panels with curtains for privacy. Each cubicle included suction facilities and 11 cubicles were fitted with telemetry equipment for cardiac monitoring. Two of the cubicles were lead-lined for X-ray use. Two of the major's cubicles had en-suite facilities and were fitted with moveable partitions, which were used for scenario training. The monitoring and observation area in majors was located centrally in the line of sight for staff, with 12 cubicles on each side. The reception for the major's area was opened since our visit in 2015.

- The initial assessment area consisted of eight cubicles. A separate, supervised room was used for mental health patients.
- The resuscitation area comprised of 10 cubicles as we reported in 2015. The resuscitation cubicles were fitted with trolleys and equipment to support resuscitation intervention.
- The separate, linked children's emergency department had also been recently refurbished. The children's area consisted of eight main cubicles, two triage or initial assessment rooms, one paediatric resuscitation cubicle, one neonate's resuscitation cubicle and a waiting area for children.
- The further phase of building work that was still to be completed when we visited in 2015 was now finished. Since 2015 the minor's area (now known as the "emergency department") had been completed. The emergency department patient self-check-in was supported by a staffed reception area. Ten cubicles (six of these were opened in 2015) were used to see and treat patients. One cubicle with two exits was alarmed and was available to support patients experiencing mental health issues. Other cubicles were designated as a plaster room, an eye room and a physiotherapy room.
- The relatives' area consisted of three family rooms and a relatives' viewing room. A trolley bay for trolley and equipment cleaning and separate storage had also been completed since our visit in 2015. A computed tomography (CT scan) area was located next to the main emergency department.
- The clinical decision unit (CDU), which operated within the emergency division, opened in December 2015. The CDU provided for an extended short stay for up to six male and six female patients who had attended the

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emergency department and required further observation or treatment. These patients may not be ambulant and may need a period of observation of up to eight hours.

- The adult major trauma ward facility located in Ward 40 within the Hull Royal Infirmary tower block was opened in December 2015. The major trauma ward consisted of 10 beds. There was no dedicated provision for paediatric intensive care although some facilities were available in neurosurgery.
- The Beverley MIU, operated as part of the emergency department, was located within the East Riding Community Hospital which opened in July 2013. The MIU consisted of an adult waiting area with magazines provided, four treatment rooms and a separate children's waiting area with toys and TV. Patients had the use of an adjacent radiology department.
- The medical physics department undertook the maintenance of medical devices and equipment checks were reported through an on-line system. We reviewed the planned and actual maintenance for the period from 1 April 2015 to 31 March 2016 and for the period from 1 April 2016 to the date of our inspection, which provided assurance that maintenance was up to date.
- We found there was a shortage of observation equipment available in the children's department. Staff told us that equipment shortages particularly happened in the morning as equipment could be moved to the adult department overnight.
- Equipment checklists were used throughout the department and equipment labels we checked were in date. Resuscitation trolleys were checked and signed daily, although we identified three days in June 2016, which were not signed as checked. Bins were provided in the emergency department mental health room and we queried this with staff as it presented a potential hazard.
- At the Beverley MIU the resuscitation trolley was checked daily, although on six days in March 2016 the defibrillator had not been signed and checked.

## Medicines

- Medicines and intravenous fluids were stored safely and securely, and access was restricted to authorised staff. Controlled drugs were appropriately stored and accurate records were maintained, however we found daily balance checks were not always performed as per

the trust policy. For example, in the resuscitation area checks had not been carried out on six days within the last three months. In the paediatric area checks had not been performed on 10 days within the last four months.

- Emergency medicines and equipment were readily available throughout the emergency department; however checks of resuscitation trolleys had not always been performed regularly in accordance with the trust policy. For example, daily checks had not been performed on 15 occasions within the last four months in the major's area and on eight occasions within the last three months in the minor's area.
- We checked medicines requiring cold storage and found they were not always managed in accordance with the trust policy and national guidance. Records of fridge temperatures had not been completed on 11 occasions within the last four months in majors and on eight occasions in minors. In addition, records showed the fridge temperatures in majors had been outside of the recommended range on six occasions and no action had been recorded in response to this. We raised this with the ward sister who was unaware the fridge had been out of range. We also found temperature records in the paediatrics area showed the fridge had been outside of the recommended range on nine occasions and again no mitigating action had been recorded. The staff nurse we spoke with was unaware of the correct procedure to follow when the fridge temperature was not within the correct range.
- Patient Group Directions (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately. PGDs are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked a PGD used by the nursing team in minors and saw this was being used effectively to support patient access to medicines in a timely way.
- Hospital prescription pads were appropriately managed and were stored securely throughout the department.
- At our unannounced inspection in July 2016 we again found some gaps in the checks undertaken in the major's area (six omissions). The minors area (three omissions) and in paediatric resuscitation (five omissions). In the paediatric area the process for checking was not clear and was dependent on staff remembering the checks needed to be done and remembering to escalate to the sisters if the staff had



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been too busy to do the checks. The sister we spoke with said they checked the logs weekly and emailed or spoke with staff that had missed the checks and not escalated and this would be dealt with in line with any performance issues. Fridge temperatures were not checked on two days in July 2016. In the major's area, an incident report had been completed for a controlled drugs error in July 2016.

- Following our inspection the trust informed us it was introducing weekly returns for each department to confirm compliance with the monitoring of daily checks of controlled drugs, resuscitation trolleys and fridge temperatures. The medicines management elements of these checks were to be augmented by a monthly medicines management audit and action plan undertaken jointly by nursing and pharmacy staff.
- At the Beverley MIU we found evidence of daily fridge temperature checks. Medicines were stored in locked cupboards in the clean utility. Spare drugs for the resuscitation trolley and emergency drugs for patients who may experience a fit were available.

## Records

- The emergency department used an electronic patient record system widely used in the NHS. Nursing and medical documentation was electronic within the trust. The department and the trust had implemented revised nursing documentation since our 2015 visit.
- We reviewed the recording of patient information for a selection of the records of 10 patients who had arrived in the emergency department. We found that overall the patient information was very well documented. We also reviewed a selection of records at our unannounced inspection, which confirmed that records were generally well maintained.
- We reviewed the documentation checks that the department undertook as part of its safety audit for the week of our inspection and a compliance level of 82.2% was achieved against a minimum expected standard of 70%.
- Following our inspection the trust informed us that senior nurses had been requested to undertake spot checks of record keeping standards.
- The Beverley MIU had also implemented the new system of electronic recording. We found that patient records for the MIU were well maintained.

## Safeguarding

- Information provided to CQC by the local authority confirmed there were clear communication channels in place with the hospital's safeguarding specialist practitioner. All safeguarding adult concerns raised by hospital staff were checked by the trust safeguarding practitioners for accuracy before being referred to the local authority safeguarding team.
- Medical and nursing staff we spoke with were aware of their responsibilities relating to safeguarding adults and children and were aware of procedures to follow. For the emergency department, 91% of medical and 90% of nursing staff had completed vulnerable adults' training. In addition, we found that 89% of medical and 95% of nursing staff had completed safeguarding children level 3 training. Staff we spoke with in the emergency department confirmed they were up to date with safeguarding training.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situations where abuse or neglect of children is suspected'. However, four other specific guidelines we reviewed on the trust's intranet were out of date including 'Safeguarding children: children and domestic violence' which expired in September 2015. 'Safeguarding children in whom illness is fabricated or induced', expired in June 2015 and 'Safeguarding children: managing allegations or concerns against staff', expired in June 2014 and 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.
- Following a safeguarding incident in 2016, the department had reviewed its chaperone guidance and we saw that notices about the availability of chaperones were displayed in the emergency department, which included each cubicle. Medical staff we spoke with confirmed they were aware, and complied with, the chaperone guidance. We found the chaperone guidelines were discussed with all temporary staff. The patient's choice of whether to use a chaperone or not was documented.
- The child safeguarding team was available to provide support for the children's emergency department. For children or young people presenting with emotional, behavioural or substance use issues, the department liaised with the Child and Adolescent Mental Health Service (CAMHS).

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- Following the inspection, the trust confirmed that each emergency department referral was screened each morning (Monday to Friday) for each child under the age of 18 years. Following a weekend or bank holiday, patient information was screened on the next working day by the safeguarding children's team.
- At the Beverley MIU we observed that notices were displayed about the chaperone policy, which stated that chaperones were available for all medical examinations. Staff confirmed they had received safeguarding training.
- Staff we spoke with had completed their mandatory training, some of which was completed on line. Staff were able to view the status of their training on the trust intranet. We confirmed from the intranet that staff were fully compliant with their mandatory training.
- At the Beverley MIU staff confirmed they had completed their mandatory training and that allocated time was available for this.

## Assessing and responding to patient risk

### Mandatory training

- For the emergency department overall, 84% of medical staff and 83% of nursing staff had completed their mandatory and statutory training in the last 12 months, against the trust's target compliance level of 85%.
- The trust was assured that the numbers of nursing staff trained in the care of children enabled the emergency department to provide sufficient numbers of competent staff to manage paediatric emergency admissions out of hours. The department had an ongoing training plan in place to support nursing staff to manage paediatric admissions.
- We found three of the five nursing coordinators (band 7) in the majors department were RSCN (Registered Sick Children's Nurse) trained. In addition, 11 adult nursing staff had completed EPLS (European Paediatric Life Support) training and a further four staff were due to attend this training. Paediatric immediate life support training had been completed by 24 adult nursing staff. A further 22 adult nursing staff had completed Embrace (Emergency Department Staff Recognition of Critical Illness, Spotting the Sick Child) training. Also, one senior nurse had completed a university course in care of the child in A&E.
- We reviewed separate evidence of advanced trauma life support training and resuscitation training completed by medical and nursing staff. For non-qualified staff, basic life support training was mandatory.
- Protected time was allocated to members of staff who required training. The specialist teaching practitioner followed up members of staff by email when their training was due.
- Between April 2015 and March 2016 the department experienced 1,081 black breaches. In February 2016 there were 156 breaches and 144 occurred in March 2016. There were black breaches on 42% of days over the year (152 days) and on 39 days there were 10 or more black breaches. Black breaches are defined as the time between an ambulance arriving at the hospital to the patient being formally handed over to the emergency department, which is longer than 60 minutes.
- During the week of our 2016 inspection, ambulance handovers occurred in an average time of 36 minutes. For patients arriving by ambulance, nursing staff completed a handover with ambulance staff and then undertook an initial clinical assessment. Since our visit in 2015 the emergency department had reviewed the patient pathway through the department and revised escalation procedures had been agreed with the ambulance service. Senior managers told us the trust was reviewing the approach of other trusts to ambulance handover in order to compare practice in reducing ambulance handover times.
- The rapid assessment and treatment (RAT) system which had been discontinued in 2015 because of staff shortages we found was now resumed. We observed consultant and middle grade staff as they undertook RAT. Staff told us they felt initial assessment ran more smoothly when RAT was operated.
- The self-registration system for the emergency department (minor's area) was supported by nursing reception staff who helped patients who were unsure as to how to use the system. The check in system prioritised how quickly a patient was seen, based on the information they submitted. The department had taken steps to identify patients who entered exaggerated data to be seen more quickly. The patient was red flagged on the system if they needed pain relief or were

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experiencing acute illness. If a patient was triaged as “Red” they were seen by a triage nurse within 15 minutes of arrival (escalation policy states within 30 minutes).

- Following an audit of self-registration six weeks prior to our visit, the system was changed to include a question to the patient as to whether they had a referral letter. The trust confirmed it was auditing the use of the self-registration system at the time of our visit.
- In the resuscitation area we observed the progress of a major trauma incident. We spoke with external staff involved with the response to the incident who confirmed that patients involved in major trauma within a radius of 35 miles could arrive at the hospital within one hour. We were informed that pathways at the hospital were recognised as better for major trauma.
- Every two hours, as indicated by a digital clock at the staff base, the progress and developing risks for each patient in the department were reviewed. A designated member of senior medical staff acting as emergency physician in charge (EPIC) facilitated a ward round with medical and nursing staff supported by screen displays for each area of the department. Each patient was reviewed according to their room number and time critical cases were identified. The patient care plan was discussed and concerns were welcomed. Decisions from the previous board round were followed up and new actions were documented. The ward round typically took 15 minutes to complete. The ward rounds at 8am, 4pm and midnight were handovers.
- We visited the department in the evening and found the ward round had not taken place for five hours 25 minutes. The EPIC role had been transferred to a locum consultant. When we discussed this with senior managers we were informed there had been an exception because of pressure on workload, but the frequency of ward rounds may be varied at night. After discussion, managers acknowledged that maintaining the ward round was essential to support the safety of patients particularly when the department was very busy. Managers stated that if necessary a focused ward round could take place within a 10 minute turnaround and need only involve the senior doctor and senior nurse. Managers confirmed that currently 80% of daily ward rounds were audited. Bringing the whole staff group together was recognised as important to share learning and maintain safety in rapidly changing situations.
- In the children’s emergency department, ward rounds took place three-hourly, at 9am, 12noon, 3pm and 6pm. Escalation arrangements were in place for a medically sick child. Paediatric consultants or specialist registrars could be called on to provide support and advice. A dedicated internal telephone number (2222) was used for a paediatric “crash” call.
- Escalation criteria were used for deteriorating patients. The National Early Warning Score (NEWS) observation chart was completed, supplemented by a local assessment. The trust provided evidence to CQC of the completion and auditing of the NEWS score in the emergency department for the last 12 months. A standard operating procedure (SOP) was used with escalation triggers for staff to follow. We discussed with senior staff the operation of the escalation mechanism. Staff acknowledged the importance of maintaining the review of patients through regular (two hourly) board rounds including at night and when the department was particularly busy.
- Medical staff in a focus group confirmed that rising NEWS scores were documented, but stated that they were not always referred, which resulted in patients being missed. They expressed concerns there was no system to identify the deteriorating patient.
- We saw the arrival of adult patients by ambulance and through self-check in. We also observed the arrival and initial assessment of patients in the children’s department. A fast track system for arriving children to move to the nurse-led paediatric assessment unit was introduced in 2015 following our previous visit. We observed that triage and streaming of patients took place appropriately.
- Following our inspection the trust informed us it was introducing weekly returns for each department to confirm compliance with the monitoring of daily checks of early warning scores and risk assessments.
- At the Beverley MIU patients were booked in by a receptionist and allocated to a waiting room. There were separate waiting rooms for adults and children. Nursing staff relied on the receptionist to report any change in a patient’s condition. We found nurse practitioners prioritised patients by their illness symptoms rather than according to the time they had waited. However, we found there was no standard operating procedure for escalation in place for when the MIU was busy and faced likely breaches. Nursing staff



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were not able to explain clearly the escalation procedure they would follow, although they told us support was available from the main emergency department.

## Nursing staffing

- We found the trust had made significant progress in its emergency department nursing staffing compared with our 2015 visit.
- The trust confirmed that the emergency department nursing establishment was in line with published guidance and the staffing rota was devised to meet demand. The safer nursing care tool was also used and staffing concerns were escalated to and discussed at the twice daily safety brief. The nursing establishment for the emergency department was 79.4 WTE and the department was carrying four vacancies for qualified nurses at the time of our visit, which were due to be filled during 2016. Seven student nurses working in the department were due to be qualified in September 2016 when they were to be offered permanent posts. This represented a substantially improved staffing complement compared with 2015, and also included the recruitment of advanced nurse practitioners (ANP), as anticipated at our 2015 visit.
- We found the nursing staffing rota was planned to provide for staggered start times which reflected the demands of the department over the 24 hour period. We observed in the emergency department that the EPIC, working with the nurse in charge, allocated staff from the current rota to the various areas of the department, dependent of the assessed need. The allocation of resources was reviewed during the progress of the shift.
- The paediatric emergency department was staffed with RSCN trained nurses between 8.30am and midnight. When the children's emergency department was closed, out of hours staffing was provided by adult nurses, with the paediatric ward coordinator attending for resuscitation calls. We were informed that emergency department staff had access to paediatric trained staff 24 hours per day should this be needed. We observed that during busy periods, nursing staff were moved between the adult and children's areas. Adult trained nurses were rotated to the paediatric area on a six-weekly basis. Staff we spoke with and staff side representatives expressed some concerns as to the availability of suitably competent staff deployed to each area of the department.

- The department used temporary or agency staff only rarely. All staff received an induction before working in the department. The specialist teacher practitioner was not rostered into the staff rota, but was available to work in the department if there were staff shortages.
- At the Beverley MIU, nurse practitioners were used to provide a nurse led service, supported by qualified and unqualified nursing staff. Staff numbers were planned using an acuity tool.

## Medical staffing

- Our 2014 inspection report referred to the Royal College of Emergency medicine (CEM) 2011 operational handbook which stated that every emergency department that had over 100,000 attendances per year should have a minimum of 16 consultants. At this visit the trust confirmed the consultant establishment in the emergency department was 17.00 WTE. Of these, 11.35 WTE were substantive in post. Of the 5.65 WTE vacancies, 1.45 WTE was provided by internal long term locum cover and 2.36 WTE by regular agency cover. The emergency consultant shortfall was therefore 1.84 WTE.
- As in 2015, the trust was actively recruiting to the consultant posts and we were informed that the trust expected four further substantive emergency department consultants to be in post during 2016. This meant the trust was significantly ahead of its trajectory of three-year consultant recruitment which we reported in 2015.
- Following our inspection the trust confirmed that trainee vacancies and establishment for emergency medicine were 86% filled effective July 2016. The proportion of junior doctors was higher than the national average and the proportion of consultants was higher than average.
- The EPIC on duty explained to us how medical staffing numbers were deployed in the majors, resuscitation and paediatric areas of the department, according to patient need and flow. There was a recognised shortage of medical staff at night. We discussed with senior managers the deployment of medical staff resources for the two hourly ward rounds in the emergency department. Although the medical resource was recognised as significant, the advantages of ensuring patient safety and of potentially more effective use of other staff resources were felt to outweigh any resourcing implications.

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- We also expressed concern as to the long hours worked by some consultant staff to provide night cover. One consultant had worked from midnight to 8am the previous evening and returned to work at 4pm to work until midnight. During the evening medical staff were attending to a high acuity patient in the department in addition to six patients in the resuscitation area. We found there was no guidance related to shift turnaround for medical staff and we discussed our concerns with senior managers as to the safety aspects of this arrangement.
- The trust informed us there were three consultants in the emergency department who were paediatric trained. Consultants provided cover for the children's department Monday to Friday 8am to midnight and 8am to 5pm on Saturday and Sunday. Locum consultant cover was provided from 5pm to midnight on Saturday and Sunday. Overnight cover was provided by consultants on Wednesday and Thursday. Registrars (ST4 and above) provided overnight cover on Monday, Tuesday, Friday, Saturday and Sunday. Providing adequate consultant cover was recognised as challenging.
- The hospital was designated as a major trauma centre. Regulators had identified there was not a consultant trauma team leader always available within five minutes, 24 hours per day which was the national requirement for co-ordinating care to trauma patients. In addition, there was no evidence to demonstrate that times when the department was not covered by a consultant trauma leader there were minimal number of trauma calls received. The trust had reviewed six months' data which indicated that each patient triggering a trauma call was seen by a consultant within five minutes and a policy was in place to support this. The department was to explore the feasibility of a tiered trauma alert system. An external peer review visit was planned for October 2016.
- At the Beverley Minor Injuries Unit MIU, the emergency nurse practitioners accessed consultants on duty in the main emergency department if they needed medical advice.

## Major incident awareness and training

- The trust had a major incident plan accessed through the staff intranet. The document identified the role of the hospital major incident plan in the escalation pathway in the event of a major incident. The previous

alert took place during 2016. We reviewed the major incident plan and discussed with staff their awareness of the plan and the actions they would take in the event of a major incident. Alert forms and supporting documentation were available in the staff base area. Staff undertook CBR (Chemical, Biological, and Radiological) training weekly and were familiar with procedures to follow in the event of a major incident alert.

- Staff at the Beverley MIU had not received major incident awareness training.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



At our previous inspection in May 2015, we rated effective as 'Good'. In June 2016 we rated effective as 'Good' because:

- Patient care and treatment followed evidence based guidance and recognised best practice standards.
- The service supported the learning and development of both medical and nursing staff. All staff new to the department received an induction and all staff received an annual appraisal.
- Medical and nursing staff worked closely with other disciplines in the hospital to coordinate care pathways for patients. Patients being discharged or referred to another service were supported with information which followed their pathway of care.
- Patients' pain was assessed and controlled and they were provided with appropriate nutrition and hydration. Outcomes for patients were audited.
- Patients' consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act were followed where this was appropriate.
- The department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme, measured its performance against other trusts, and performed well in some of these audits, for example, initial management of the fitting child.

However:

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- The trust's performance against some standards measured through audit, for example, cognitive impairment in older people, was poor. Action plans were in place for these audits.

## Evidence-based care and treatment

- The emergency department used National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) with supporting clinical guidelines and patient group directions to ensure the effectiveness of treatment provided for patients.
- As examples we reviewed the clinical guidance cards for emergency department head injury which included the NICE head injury guidelines and the Canadian C-spine rules; we also reviewed the clinical guidance cards for minor side ankle foot which included the Ottawa ankle rules and the Ottawa knee rules. The guidance was part of mainstream practice followed by all staff in the department. Guidance was accessed through the staff intranet.
- Use of the sepsis care bundle was a College of Emergency Medicine recommendation. We found it was used in the emergency department. The trust presented evidence which showed the percentage of patients who met the criteria for the local protocol who were screened for sepsis correctly in the emergency department had risen from 25% to 92% in the period from August 2015 to May 2016.
- The emergency department participated in the Royal College of Emergency Medicine's national programme of clinical audit. For 2014-15, the department performed well in the initial management of the fitting child audit, meeting all five standards. In the assessing for cognitive impairment in older people audit, the department failed to meet the fundamental standard for all patients to have their early warning score documented. Although one of the two developmental standards was technically met, only one case was audited against this standard. Performance against the remaining standards was poor. In the audit of mental health in the emergency department, the department was in the lower England quartile for four indicators, but it was in the upper England quartile for two developmental standards, one of which was met. The trust provided evidence it was taking action in response to these audit results.
- In support of the development of the major trauma centre, we found systems were in place for recording and collecting trauma audit and research network

(TARN) data. This enabled comparative information relating to trauma care in the department to be shared externally and provided evidence based measures of meeting NICE guidance.

- The local audit programme in the emergency department in the last 12 months included an audit of asthma, a record keeping audit and an audit of minimising missed antibiotic doses. We did not review the results of these audits.
- At the Beverley Minor Injuries Unit (MIU), nurse practitioners confirmed they followed NICE guidelines as for the main emergency department.

## Pain relief

- In their initial assessment the patient was asked about whether they were experiencing pain and whether they required pain relief. The record of the assessment showed that checks were undertaken and medication administered to provide pain relief for the patient.
- We spoke with 14 patients in the initial assessment, minor injuries, majors and paediatric areas of the department about whether they were offered pain control medicine if they were in pain. With two exceptions, which were for clinical reasons, patients were asked about their pain. Three patients had declined pain relief. Although we observed patients were asked to score their pain, we did not see that this was always recorded.
- Patients using the self-registration screen were asked to complete a pain score, to answer whether they required pain relief, and to identify the area the pain was located.
- We observed that staff were prompt in following up patients' pain symptoms and administering pain relief. Patients we spoke with who had required pain relief spoke positively about the way staff had handled their request. Patients who declined pain relief said they were satisfied with the care they received.
- At the Beverley MIU, patients we spoke with confirmed they were offered pain relief.

## Nutrition and hydration

- Food and drink was offered to patients in the department if clinically appropriate. In addition to meals being offered three times a day, sandwiches and drinks and cultural and special diets were available on request throughout the day and monitored using the fluid balance chart.

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- We saw there were water fountains and juice provided in the initial assessment and major's areas of the department. When we visited the department unannounced, we observed as a nurse gave priority to getting a drink for a patient.
- Checks included in the initial assessment included the patient's needs for food and drink, their need for assistance if required, and the need for intravenous fluids.
- We reviewed the clinical observation and hydration checks that the department undertook as part of its safety audit for the week of our inspection and a compliance level of 95.4% was achieved against a minimum expected standard of 70%.
- Patients we spoke with had mainly been offered a drink and could order food during their time in the department. A patient who had been in the department more than three hours had taken drinks but declined food. They told us they were satisfied with their care.
- When we visited the major's area in the evening, we spoke with one patient who had not been offered any food or given an explanation why. They said it was an hour since they had a glass of water.
- We discussed with senior managers our concerns about a patient who had no food or drink for more than two hours and staff had not informed the patient they were nil by mouth for clinical reasons.
- At the Beverley MIU, we observed that a water dispenser was available in the main area of the department. No facilities were available for snacks.
- For 2014-15, the department performed well in the RCEM initial management of the fitting child audit, meeting all five standards, including the fundamental standard. However only one case was audited against the fundamental standard (blood glucose is recorded in all children actively fitting on arrival) and the standard that children actively fitting on arrival are managed according to the APLS or EPLS algorithm. Furthermore only two cases were audited against the standard that patients' parents or carers should be provided with written safety information.
- In the RCEM audit of assessment of cognitive impairment in older people 2014/15, the department failed to meet the fundamental standard for all patients to have their early warning score documented. Although one of the two developmental standards was technically met, only one case was audited against this standard. Performance against the remaining standards was poor.
- The department failed to meet either of the two fundamental standards in the RCEM audit of mental health in the ED 2014/15. The department was in the lower England quartile for four indicators (including three developmental standards). On the other hand it was in the upper England quartile for two developmental standards, one of which was met.

## Competent staff

### Patient outcomes

- The percentage of patients leaving the emergency department before being seen was higher than the England average between June 2015 and January 2016.
- Unplanned re-attendances to the emergency department within seven days of discharge were consistently worse than the 5% standard for England between February 2015 and January 2016.
- The emergency department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme and measured its performance against other trusts through taking part in these audits. Action plans to take forward the results of national audits were completed and ongoing actions were monitored through the trust's quality improvement programme action plan and progress report (QIP).
- The proportion of nursing staff in the emergency department who had received an appraisal as at May 2016 was 78.4%. The proportion of administrative and clerical staff in the emergency department who had received an appraisal, as at May 2016 was 90%, and for ancillary staff, 100%. For other clinical services staff it was 75%. The proportion of medical staff in the emergency department, who had received an appraisal as at April 2016, was 80%. This represented a significant improvement from our 2015 visit.
- A specialist practitioner (band 7) provided a teaching role for the emergency department. Staff new to the department attended an eight-day induction programme and worked for a supernumerary period, usually one month. Student nurses were oriented to the department. Staff new to the department worked in the major's area for six to twelve months, before working in the resuscitation area. Staff needed to complete competencies before moving to other areas of the department, for example initial assessment. All staff rotated to the children's department for six weeks to

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support their competency development. Newly qualified staff were supported by preceptorships. Qualified staff we spoke with said they felt well supported with their development.

- Nursing staff from the children's department may work in the adult area during their shift. Staff working in the children's department and staff side representatives, expressed concern as to the deployment of adult trained nurses in the children's area, and of children's nurses in the adult area, who may not have relevant skills and competence for the role.
- Following our inspection we asked the trust to provide assurance as to the competencies of staff to care for children 24 hours a day. The trust provided evidence that specialist support from children's trained nurses and paediatricians was available 24 hours a day. Also, the department rotated nursing staff into paediatrics for six weeks so that adult staff could be assessed for competency in the care of children and 15 adult nursing staff had undertaken this assessment.
- The trust confirmed that advanced trauma nursing course (ATNC) trained nurses were available on all emergency department shifts, which was verified during our inspection. A major trauma coordinator (band 7) was in post from December 2015 and we reviewed evidence of the coordinator's training plan for the centre. Trauma intermediate life support (TILS) training and other specialist training was planned to support staff working in the major trauma ward.
- The General Medical Council (GMC) reported in 2016 that doctors in training received a good level of supervision but work intensity remained an area of focus. The GMC reported that it continued to support the trust with enhanced monitoring to ensure changes were sustainable. The GMC provided evidence of the revalidation decisions and deferral rates for medical staff in the trust.
- Doctors in training that we spoke with confirmed they received protected time for their regular and mandatory training activities. Medical grades CT1 to CT3 attended morning teaching sessions. Consultant staff we spoke with confirmed the trust provided developmental support through coaching and mentoring.
- At the Beverley MIU, emergency nurse practitioners we spoke with had received an appraisal and developmental training. Clinical supervision included

informal support from consultant medical staff. Clinical support staff confirmed they had received an appraisal; they told us they were well supported through mentoring and were encouraged to develop their skills.

## Multidisciplinary working

- We observed effective multidisciplinary working within the department between medical and nursing staff of all levels of seniority, and with other clinical services and administrative staff. Effective cross-team working was observed particularly in the two-hourly ward round. Information was shared by the whole team, which supported learning.
- During or following the ward round, emergency department staff engaged with other disciplines, for example physiotherapists and mental health nurses, to coordinate patient care. Managers we spoke with identified the need to develop more effective links with the medical wards as the area which most needed development.
- The children's emergency department worked jointly with the paediatric ward. The paediatric ward provided medical and nursing support for the emergency department.
- The emergency mental health liaison team based at the hospital supported patients who arrived with symptoms of mental illness. The children's emergency department worked with the child and adolescent mental health services team to support patients.
- Multidisciplinary meetings identified major trauma patients across the hospital and coordinated the care and movements of patients within the trauma network. We observed a trauma patient in the CT suite and the effective working of the multidisciplinary team. The ambulance service attended monthly meetings.
- In the Beverley MIU, X-ray facilities were on site and staff liaised effectively with radiographers on duty.

## Seven-day services

- The emergency department, including the major's reception area, was open 24 hours a day, seven days a week. Patients with symptoms of mental illness were supported 24 hours a day.
- The children's emergency department was open from 8.30am to midnight. We were informed the children's emergency department could be kept open after midnight in emergency situations. The children's waiting area remained open and patients who arrived



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after midnight were cared for in the major's emergency department. From September 2016, the children's emergency department was to stay open until 2am for a trial period.

- Diagnostic tests for patients including X-rays, blood tests and CT scans were available 24 hours a day. A second CT scanner was located on the second floor of the Hull Royal infirmary building which was open from 9am to 5pm.
- The Beverley MIU was open Monday to Friday, from 9am to 5.15pm. At weekends and bank holidays it was open from 9am to 6pm. Another NHS organisation operated a GP out of hour's service from the MIU location from 6pm until 8am.

## Access to information

- The computer information system used in the department was widely used in the NHS and had been implemented since our last visit in 2015.
- In the central staff area of the majors department large information screens displayed real time information about patients in each area of the department, in each cubicle. For example, information displayed included arrival time in the department, medications, and any abnormalities with blood results, highlighted with an exclamation. Three hours from arrival patients were marked in purple, and after four hours, in red. Information screens were sited to support patient confidentiality.
- Clinical Information and guidance was available through the staff intranet. Information also included operational policies and procedures for the department. The front page of the staff intranet showed the latest operational performance information for the emergency department. The emergency department operational performance was also displayed on a whiteboard, titled, "How are we doing?"
- The executive team used a recently devised management information report with key operational management information also displayed in graphical format which was produced daily. Some senior staff used a mobile app which showed current average waiting times and the number of patients in attendance in the department.
- A whiteboard was used to record tasks for portering staff. We observed that portering staff used the computer displays to track the whereabouts of patients.

- A picture archiving and communication system (PACS) was used to access radiology images on line.
- Each member of staff had access to their own email account.
- Posters located on notice boards were also used in the common area and in cubicles to display useful information for patients and staff. Each major's cubicle displayed named nurse information outside of the room, with "Things to do" documented and marked when done. In the emergency department (minors) coordinating area we observed a whiteboard was used to show the status of patients in each of the 10 cubicles. A handwritten whiteboard was used to display patient information in the resuscitation area.
- We found after discussion that there was currently no system of checking that patients' blood results had been checked before they were discharged.
- In the Beverley MIU, a display board in the waiting area informed patients of staff on duty and waiting times. The computer displays in the emergency department also showed the situation at the Beverley MIU.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were requested for their consent to treatment and we found evidence this was discussed with them so that consent was obtained appropriately. For most patients who arrived in the department, interventions required informal or verbal consent.
- The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were included in mandatory training. Nursing and medical staff we spoke with had completed their training.
- Staff we spoke with, including junior medical staff, demonstrated a clear understanding of the MCA, of their responsibilities and of DoLS procedures. The emergency department's specialist practitioner supported staff who may not have had previous experience of using the procedures.

## Are urgent and emergency services caring?

Good



At our previous inspection in May 2015, we rated caring as 'Good'. In June 2016 we rated caring as 'Good' because:

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- Care was delivered with compassion and staff treated patients with dignity and respect.
- Staff responded promptly and empathically when patients needed help and support to meet their basic personal needs and staff anticipated these needs in a caring way.
- Information from patients about their experience of using the service reflected a relatively high level of patient satisfaction. The cultural needs of patients were understood and their individual needs were taken into account in the way patients received care.
- Patients received emotional support as part of their care.
- Patients were consulted and involved in decisions about their care and treatment.

However:

- When the department was very busy we found patients were not always kept consistently informed about progress with their care and treatment.

## Compassionate care

- The performance in the friends and family test between March 2015 and February 2016 was positive, although the emergency department's performance was mostly worse than the England average. Despite this, the percentage of patients likely to recommend the emergency department had doubled, to 78.1%, over the six months to January 2016. During the week of our visit the friends and family response rate was 89%.
- In 2015 we reported on the emergency department survey 2014, in which the trust performed worse than other trusts for 11 of the questions relevant to the caring domain, and "About the same" for the remaining 13 questions. No formal local patient survey information for the emergency department was available to inform this inspection.
- Ahead of this visit, we undertook an unannounced inspection of the emergency department on 9 June 2016, specifically to review the caring domain. We spoke with patients and their relatives to seek their opinions of care in the department, and observed care being delivered. We also reviewed a selection of the "I want great care" forms completed by patients in the emergency department, and a selection of letters written to the trust by patients about their care. In addition to the patients we spoke with at the CQC stall

in the hospital ahead of the inspection, we spoke with 20 patients in the emergency department and observed the care of a further five patients. We also spoke with five relatives.

- The overall theme of the 2016 evidence we reviewed was positive, which represented a continuing improvement from 2015. Patients we spoke with were generally very happy with the care they received and spoke positively as to their treatment in the department, as to staff respecting their dignity and as to their privacy and confidentiality being maintained. Patients said all grades of staff treated them with compassion.
- Relatives we spoke with said they were impressed with the speed with which their relatives were seen and how they were treated. We spoke with relatives of children being seen in the paediatric area who told us their children had good experiences of attending the department.
- We observed that staff interacted with patients empathetically and responses to their needs were usually prompt. In the majors area we observed that respect was shown to patients and their dignity was upheld. Staff assisted patients who were unsteady on their feet with their personal needs. A call button was also positioned near the patient so they could summon help, except in one instance we observed. At our unannounced visit we observed the transfer of one patient through the department where their dignity was not maintained. We also observed that although the doors of adjacent cubicles were closed during the ward round, this was only partially effective in maintaining confidentiality.
- In the children's department we observed that doctors and nurses spoke in an appropriate way to children and asked relevant questions in a way that the child understood. We observed that curtains were drawn to preserve privacy and dignity in the paediatric area. We observed one patient who went to the X-ray department by hopping or being carried by their parents, although there was a wheelchair nearby.
- The letters written to the trust by patients about their care included examples of compassionate care being given.
- Staff in a focus group told us that no member of staff would be concerned about a family member being treated in the emergency department.
- At the Beverley Minor Injuries Unit (MIU), we spoke with two patients and their relatives and observed as staff

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interacted with a number of other patients. Patients spoke positively about the convenience of the service and the relevance of the diagnosis they received. Patients visited the MIU from preference. The “I want great care” forms completed by patients at the MIU commented on the efficiency, friendliness and helpfulness of the advice given. They commented positively about the professionalism of staff and the excellence of the care they received.

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

- In the majors area patients told us they felt generally well informed about their care and treatment by doctors and nursing staff. However, when we visited the major’s department in the evening we spoke with one patient who felt they had not particularly been kept informed, although they stated that the staff themselves were fine. When the department was very busy we found patients were not always kept consistently informed about progress with their care and treatment.
- In the emergency department (minors) we observed that nursing staff explained to patients about their care and treatment so that they knew what to expect. Patients told us that nurses had explained what was happening all the way through their visit.
- In the children’s department we observed that clear explanations were given at each stage of the patients’ pathway through the department, which included reporting to reception, initial assessment and consultation. For example, we observed as staff spoke with patients and their relatives about a patient who required admission and gave a clear explanation to the patient who required admission as to the reasons why and the likely length of stay. For another patient who had had an X-ray staff explained what was to happen next, what the follow up actions were going to be which involved a clinic visit, and about self-management of pain when at home.
- Relatives told us they had been kept informed of what was happening next to their child and of what follow up actions were going to be. Relatives said they were happy with the explanations they had been given.
- In the major trauma ward, we saw that staff shared an information leaflet with patients who transferred to the trauma unit as a reference and confirmation of information they were given verbally on arrival in the unit.

- At the Beverley MIU we observed that at discharge, advice leaflets were given to patients about their illness and treatment which supplemented information given verbally to the patient about their condition and pathway of care after discharge.

## Emotional support

- A bereavement service was available for the relatives of patients who died in the department. The chaplaincy service was available to support relatives who had lost loved ones.
- Patients and their relatives who had received emotional support during their time in the emergency department spoke to us appreciatively of the service they had received.
- In the children’s department a play specialist was on duty from 6pm to midnight. We observed that the play specialist provided emotional support to children and their families visiting the department.

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

Requires improvement



At our previous inspection in May 2015, responsive was rated as ‘Inadequate’. In June 2016 we rated responsive as ‘Requires improvement’ because:

- For an extended period, the trust has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival
- No formal arrangements or protocols were in place for liaison with other specialties. When the department was very busy we found senior medical and nursing staff time taken up unduly with arrangements for the transfer of patients, while their care and treatment could be delayed.

However,

- The trust was meeting a locally agreed trajectory which had been agreed in conjunction with regulators and had done so for three consecutive months. In June 2016, 85.9% of patients were seen within four hours, which was in line with the agreed trajectory of 85.1%.



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- The needs of the local population had influenced the planning and delivery of the extensively refurbished emergency department. A new frailty team was used to assess the individual needs of this group of patients. The major trauma centre facilities had been upgraded since 2015.
- Patients with a learning disability, patients with dementia, and bariatric patients could access emergency services appropriate for them and their needs were supported. Patients needing care and treatment for their mental health needs could access services in a joined up way from within the department.
- Patients with different cultural needs were taken account of in the planning and delivery of services and actions were taken to address inequalities.
- Patients knew how to complain and staff knew how to deal with complaints they received. Complaints were investigated and learning was shared with staff.

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

- We reported in 2015 that the refurbished emergency department which opened in April 2015 was planned and designed in consultation with patients and staff following feedback received from patients and their relatives about their experiences in the department. A separate children's emergency department had been refurbished within the previous two years, also following feedback received from patients and their relatives.
- Since our 2015 visit the refurbished relatives' rooms had reopened which provided a suitable environment for bereavement support and a viewing area. The four family rooms included one with a link to a viewing room which could be accessed independently to the other rooms, which meant families' emotional needs were respected.
- Since 2015 the service had taken significant steps in developing its major trauma centre facilities. The trust had responded to serious concerns identified by regulators in achieving compliance with its major trauma centre accreditation requirements. A further external peer review visit was planned for October 2016.
- The trust had completed a business case for the development of the major trauma centre which was submitted to the executive team in May 2016. A major trauma ward for adults was operational from December 2015. The service did not include a paediatric major

trauma centre. The longer term development of rehabilitation facilities was being progressed in conjunction with the trust's trauma network and health economy partners.

- We were informed of plans to introduce a frailty service during 2016 as a further phase of development of the urgent and emergency services for the trust.
- We also commented in our 2015 report on the trust's longer term development of its emergency medical service pathways. The development of emergency services within the sustainability and transformation plans was in development and consultation with commissioners and neighbouring providers of care.
- The Minor Injuries Unit (MIU) emergency service operated from the East Riding Community Hospital was subject to review by commissioners at the time of our visit.

## **Meeting people's individual needs**

- At our unannounced inspection we observed staff in the major's area as they provided care and interacted with a patient's relative who was elderly and was living with dementia. We saw staff were skilled at re-orientating the relative to his surroundings and keeping him safe. Staff provided both the partner and the patient with sandwiches and a cup of tea. Staff showed concern and compassion and involved social care services in a timely way. The elderly man had been referred to the emergency duty team in social services who visited while we were still in the department. Emergency respite care was to be arranged.
- The needs of patients with complex needs who attended the emergency department were under review at the time of our inspection. The identification of patients at initial assessment suitable to be supported by a frailty service was planned for introduction during 2016.
- Patients with mental health needs accessed the services of a specialist mental health trust that was located in the hospital. From July 2016 an integrated care arrangement was used and services were available from an in-house mental health team 24 hours a day. Medical and nursing staff understood the procedures for reviewing a patient's mental health needs. An advocacy service was available for patients needing this support.

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- Interpreter services were available, including an on-line service. Staff used the intranet to access services for patients with specific cultural needs. A chaplaincy service was available 24 hours a day.
  - Staff in the children's emergency department confirmed they used the translation service and had developed a phrase book to help with immediate translation needs.
  - The cultural needs of patients were included in the initial assessment and available in the patient record. Staff gave the example of conversations about patient needs that took place during Ramadan.
  - Patient passports for patients with a learning disability may be completed by care providers prior to admission. The learning disabilities nurse received details of patients with a learning disability and was available to support patients and carers when a patient required admission to hospital. The service was available Monday to Friday 9am to 5pm. Groups representing carers had requested additional support.
  - Patients with dementia were identified by a butterfly sticker on their ID bracelet and a butterfly on their notes, which highlighted to staff the need for additional support for the patient. Dementia awareness was included in mandatory training for staff, supported by dementia awareness sessions. Aids were available to support patients with dementia.
  - The emergency department was equipped with trolleys capable of carrying bariatric patients. Bariatric chairs were available for patients' use in the department. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity).
  - The emergency department presented an extensive area for staff and visitors. Direction signage on the flooring helped people to find their way between areas.
  - At Beverley MIU, we found there were no facilities designated for mental health patients, although on request a room could be set aside until the mental health crisis team took over the patient's care.
- Access and flow**
- At the 2015 inspection, the trust informed us that operational issues had affected the trust's ability to move patients through the emergency care pathway in a timely manner, leading to crowding in the emergency department. This affected the trust's ability to take a timely handover of patients from the ambulance service, leading to black breaches. Staff identified patients who were likely to exceed the four hour wait after three hours, but actions required to support the care and treatment of these patients frequently involved liaison with other departments, including the identification of a bed for the patient to be admitted, or tests to be completed prior to discharge. Arrangements were followed to escalate long waits to on-call managers and to include the bed manager.
  - At this inspection the care pathway had been changed to improve patient flow. The acute medical pathway was revised so that stable, ambulant patients were managed in the ambulatory care unit. The acute medical unit was used for patients with complex needs unable to be managed outside of hospital. A clinical decision unit (CDU) provided for the extended short stay of patients who required a period of observation or treatment of between four and eight hours. Only the emergency department consultant or senior clinician had direct admitting rights to the CDU.
  - Ahead of this inspection we were informed that within the first two months of 2016 there had been an 11% increase in patients attending the emergency department. During June 2016 the actual daily attendance averaged 418 patients and on one day during our visit 470 patients presented to the department. This level of attendance substantially exceeded the average contracted number of patients, which were 372 in June 2016. We were informed flow had increased most at night between 8pm and 8am and we observed the department during this period which confirmed this.
  - To address this challenge the service further reviewed patient flow, the transfer of patients into and out of hospital and access to beds linked to discharging patients, and including secondary care. Escalation plans were revised to include provision for heightened escalation to maintain patient flow. The trust agreed an "Acute and emergency care plan" with commissioners, with a time line for delivery of March 2017.
  - We found the initial assessment area handled 100 to 120 patients daily, and handover from ambulance staff had been streamlined and rapid assessment and treatment (RAT) reintroduced. The RAT consultant worked with support from band 6 nursing staff. Patient flow support staff ("progress chasers") were used to facilitate the flow of identified streams of patients, for example, failed discharges or surgical referral. Frail elderly patients were admitted directly to the elderly admission unit between 8am and 6pm wherever possible.

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- Patients who could walk arrived through the emergency department (minors) area. We observed as patients used the self-registration screen. They were supported if they needed help and assisted if their responses indicated certain conditions, for example chest pain. Patients were assessed to determine if they needed to go to the major's area. On one day of our inspection 203 patients arrived in the emergency department through the minor's area. Progress chasers were used in minors for the first time during the week of our inspection.
- Paediatric patients were seen in a timely way. In the children's emergency department we observed as five patients arrived at the paediatric reception desk. They were each seen quickly and their initial assessment was prompt.
- Major's trauma coordinators oversaw admissions to the major trauma ward. We found the number of trauma calls had increased since 2015. The department handled 700 to 800 major trauma patients per year.
- The percentage of emergency admissions through A&E waiting four to 12 hours from the decision to admit until being admitted was consistently worse than the England average between February 2015 and February 2016. Between February 2015 and February 2016 8,976 patients waited four to 12 hours, and eight people waited over 12 hours, from the decision to admit to admission.
- The emergency department persistently breached the four hour A&E waiting time target between April 2015 and April 2016. Apart from April, performance was also consistently worse than the England average. In April 2016 there was a marked improvement, which was sustained in May and June. The department achieved 85.9% of patients seen within four hours in June 2016. This compared with only approximately 60% being achieved at the 2015 inspection. At 85% the performance was in line with the local trajectory and comparable with the England average.
- Patients who arrived in the department needed to be triaged within 15 minutes of arrival. The trust's median time to initial assessment was worse than the England median from October 2014 to January 2016.
- The standard for median time to treatment is 60 minutes. National comparative information showed that the emergency department breached the median time to treatment standard in all but three of the 22 months over the period October 2014 to January 2016. Performance from July 2015 to January 2016 showed a considerable improvement, although the standard was still breached in four of these seven months.
- The total time patients spent in the emergency department was longer than the England average in all but one of the 12 months from February 2015 to January 2016.
- The number of ambulance handovers delayed over 30 minutes at the emergency department during the winter of 2014/15 was the sixth highest of any department in England, with 3,535 delays. We commented on the trust's response to this in our 2015 report.
- The percentage of ambulance journeys with turnaround times over 30 minutes ranged between 65% and 72% between April 2015 and March 2016. The number of ambulance journeys with turnaround times over 60 minutes varied between 139 and 620. During the week of our 2016 inspection, ambulance handovers to the department occurred in an average time of 36 minutes.
- For the Beverley MIU, the percentage of patients admitted, transferred or discharged within four hours was consistently high between May 2015 and April 2016. Performance was higher than the England average in 10 out of these 12 months. In five months performance was 100%.
- We found there was no standard operating procedure in place for when the MIU was busy and had impending breaches; Practitioners redirected patients to other facilities nearby if capacity became unmanageable.

## Learning from complaints and concerns

- The patient experience team responded to complainants and progressed the investigation of complaints. Responses to complainants following an investigation were signed off by a director. Actions in response to complaints were progressed by emergency department senior staff.
- A system was in place to follow up actions from complaint investigations to check these were completed. A quarterly complaints report was prepared by the department's governance lead with a clinical summary and learning points. Learning was shared in team meetings and through the department's governance arrangements.
- The trust identified themes and trends from the investigation of complaints it received. A&E was the

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most complained about service; complaints related to lack of treatment, for example missed fractures. The department had not received any recent complaints which were the result of a serious incident.

- The emergency department had no formal registry of compliments it received, or analysis of themes and trends.
- For Beverley MIU, complaints were infrequent. We found no evidence of lessons learned as a result of complaints.

## Are urgent and emergency services well-led?

Good



At our previous inspection in May 2015, well-led was rated as 'Requires improvement'. In June 2016 we rated well-led as 'Good' because:

- A positive culture in the emergency department reflected the improved culture in the trust and staff commented to us favourably about this.
- The executive team, particularly the Chief Executive were visible to staff and were seen as approachable. The leadership roles of senior staff in the emergency department, including clinical leadership, were recognised and respected by most staff.
- Risks to the delivery of care and treatment for patients were identified, managed and action taken appropriately to mitigate them.
- Arrangements for the governance of the emergency department had become more embedded and were linked with governance arrangements in the wider Health Group and the trust.
- Patient experience in the emergency department was audited and results were cascaded to staff.

However:

- Performance and outcome measures from governance processes were not shared consistently, particularly with more junior staff.
- The vision and strategy for emergency services required development, linked to the vision and strategy for the trust.

### Vision and strategy for this service

- In 2016 the trust had adopted its vision – great staff, great care, great future and had adopted the linked values of care, honesty and accountability following consultation with staff. These informed the vision and goals and the trust strategy for 2016 to 2021. Staff in a focus group confirmed they were aware of the trust's vision.
- The vision and strategy for the emergency department was included in the operational plan for the Medicine Health Group. The delivery of emergency department targets was a recognised outcome for the trust. However, senior staff in the department told us the plan lacked a formal vision for the emergency department.
- A plan to implement change in the urgent and emergency care pathway which took account of system and hospital wide challenges to delivery was presented to the executive in March 2016. The urgent and emergency care plan for the department to March 2017 was agreed with regulators and commissioners. The trust agreed a local performance trajectory with regulators and commissioners to achieve the national four-hour waiting time standard by March 2017.
- Senior managers told us the development of the strategy linking the emergency department plan with hospital wide performance and specialities was involved in the next stage of the department's plans for five years to embed resilience and ensure consistency of delivery.

### Governance, risk management and quality measurement

- An independent external review of governance arrangements by regulators had taken place in December 2015 and the trust had adopted a revised governance framework with standard templates for reporting and streamlined escalation procedures. We attended a board committee quality meeting during the inspection where we observed that the performance and governance arrangements for the department were challenged effectively. An automated daily performance report for the executive and senior managers had been developed since our 2015 visit. The department's daily performance was reviewed by the trust's senior executive team.
- We spoke with senior managers and staff and the governance lead for the department about governance and quality. Governance arrangements for the department had become more embedded since our

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visit in 2015, with a pattern of regular meetings with actions recorded. An emergency department speciality governance meeting took place monthly. A clinical excellence meeting was held informally each month. A senior staff forum attended by senior medical and nursing staff was held weekly for sharing of clinical information. An emergency department consultants' meeting was held weekly to review the weekly performance dashboard and the consultants' rota. An emergency department senior nursing staff meeting was held monthly and actions were recorded. A clinical governance meeting took place monthly to which all staff were invited. The meeting was minuted.

- A quarterly governance committee for acute medicine and an integrated governance committee for the Medicine Health Group provided upward feedback to the Medicine Health Group board. An emergency division report and presentation for the board was prepared in March and April 2016 with performance, quality, safety and risk issues and set out what was being done to address these.
- The emergency department risk register identified the current risks for the department which included for example the recruitment of medical and nursing staff, the response to crowding in the department, and the delivery of waiting time targets. Each risk was identified with a named risk handler. The risk register was reviewed and risks were discussed at a monthly risk meeting for the emergency department which reflected both adult and paediatric risks. As well as consultants, registrars were invited to the risk meeting. Risk was also reviewed at clinical governance and Health Group governance meetings held monthly.
- Senior medical staff told us global themes and trends about the department's performance and outcomes needed to be shared more consistently with junior staff.
- Governance, risk and quality measurement for the Beverley Minor Injuries Unit (MIU) was managed through the divisional nurse manager and a monthly sister's meeting was held at the MIU.

## Leadership of service

- A clinical director for acute and emergency medicine provided oversight for the department. The clinical director was seen as getting things done. A divisional manager for emergency medicine had also recently been appointed. A divisional nurse manager (band 8b) provided oversight for the department's nursing staff.

The clinical lead for the department was held jointly by two members of the consultant staff. Another emergency department consultant was governance lead. Three lead sisters (band 7) were allocated to the emergency department (minors), the children's department, and majors. Staff told us the leadership within the emergency department was better and the management team had brought more confidence in the emergency medicine speciality.

- Staff we spoke with commented positively on the visibility and approachability of the Chief Executive and other members of the executive team. Staff in a focus group told us they received trust wide updates at monthly meetings and gave examples of the Chief Executive attending their local meetings. Staff told us the Chief Executive visited the emergency department and we observed this. Staff said they had seen quite a lot of the Chief Executive and he seemed very grounded and normal.
- The structure and composition of the Trust's executive management team had changed since 2015 and staff spoke positively of this development. Members of the executive team were approachable and would sort things out. Staff told us they appreciated that the trust was slowly turning round. Staff in a focus group told us they thought the new trust board was introducing positive change. They said they felt more supported now and there was a feeling of mutual trust. Staff were enthusiastic and conveyed positivity and optimism.
- The recently introduced role of the emergency physician in charge (EPIC) for the emergency department was seen as having helped other staff to be clear about their roles and for tasks to be allocated effectively. We observed that the EPIC role functioned effectively during the day and we saw the importance of the EPIC functioning effectively at night. Staff had mixed views about the effectiveness of the role of site team matrons overnight.
- A small minority of junior staff told us they did not feel well supported. Managers recognised the challenge for them was to support staff with change.
- Staff at the Beverley MIU said they had met the Chief Executive and he had visited the unit. Staff told us the management team was very visible. Nurse practitioner staff in the unit reported to the divisional nurse manager. Staff felt well supported.

## Culture within the service



# Urgent and emergency services

- The culture of the organisation had changed positively since our 2014 visit. In 2015 we reported on actions taken to address previous allegations of bullying which had been followed up in the department and action taken. At this inspection staff we spoke with, with one exception, said they did not feel bullied.
- The trust had appointed staff as anti-bullying champions and provided training to support these members of staff in their support role. Most staff in a focus group stated the culture had changed substantially for the better. Staff were more aware of each other. Staff with concerns could go to a champion in another department for impartial advice. Staff talked about the trust charter and what were and were not acceptable behaviours. People felt more confident and supported to address issues and expectations of staff were clearer.
- We found an improved and largely positive culture in the emergency department at this inspection. The attitude and behaviour of staff was positive. Staff had a better perception of the organisation and of the emergency department. Senior managers in the department described the department as having achieved reputational change. There was no longer a blame culture. Positive changes in the culture of the department were noticed in staff survey responses. An improved culture had resulted in better staff retention.
- Qualified nursing staff that we spoke with were aware of the duty of candour requirements and confirmed that the department and the wider trust encouraged them to be open and honest following a reported incident and to ensure appropriate verbal and written apologies were provided for patients. However, we found that not all unqualified staff were aware of the duty of candour requirements.
- One member of nursing staff told us they did not feel able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes, although they said they had not experienced this behaviour personally.
- At the Beverley MIU, staff told us they enjoyed working in the unit and felt the staff team worked well together.
- The development of the recently completed relatives' area had followed consultation with a relatives' forum and followed their recommendations.
- Comments from patients and the public were also received through the local Healthwatch organisations. Healthwatch had visited the emergency department in 2015 and 2016 and shared its survey responses and recommendations to the trust.
- For the Beverley MIU, the responses of patients and relatives were consistently positive. We observed in the reception that the family and friends card was visible but staff were not aware of feedback from the survey. We were unable to ascertain that the friends and family test was completed consistently at the unit.

## Staff engagement

- The trust's strategy for 2016-2021 was developed in consultation with staff as well as partners and other stakeholders.
- Staff we spoke with said they felt more involved and improvements in communication with staff had made the difference. Staff had been involved in how to change things for the recently redesigned emergency department.
- Staff in a focus group told us that all staff had been consulted about the trust values through an online survey. Support staff in a focus group said there were no forums for administrative and clerical staff. Nursing staff in a focus group said they had not been consulted directly and there had been short notice for staff events related to this. Staff engagement required further development at trust level.
- Managers in the department told us staff were consulted about changes to the department through staff meetings, the staff forum and staff surveys. Managers also recognised that mechanisms to consult with particularly more junior staff required development.

## Innovation, improvement and sustainability

- The recently redeveloped emergency department represented a significant improvement in the facilities for the hospital which meant emergency care being provided in a suitable environment for patients and staff. Following the opening of the extended department in April 2015 we reported in 2015 on further phases of work which were planned to complete. At our 2016 visit we found these were completed.







## Public engagement

- We found patient experience in the emergency department was audited weekly and the results of audit were shared with staff. At our inspection, the patient experience score for May 2016 was 92.3%.

## Urgent and emergency services

- The trust used its golden hearts awards scheme to reward staff initiative. In 2015 the emergency team won a golden hearts award for its partnership working.

# Medical care (including older people's care)

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

## Information about the service

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

Between January and December 2015, there were approximately 65,000 medical episodes of care carried out in this trust with approximately 38,000 at this hospital. Day cases accounted for 28% of all episodes, emergency admissions 71% and elective admissions 1%.

In 2015, there had been a reconfiguration of acute medical care and three medical wards from Castle Hill Hospital had transferred to the Hull Royal Infirmary site. A new respiratory ward (Ward 500) had been added. The elderly care pathway had been redesigned.

Medical services were managed within the Medicine Health Group, which was made up of four divisions, emergency medicine, general medicine, elderly medicine and specialist medicine. Hull Royal Infirmary provided medical care in 14 medical wards, and covered a number of different specialties, which included general medicine, care of the elderly, respiratory medicine, diabetes/endocrinology, gastroenterology, neurology and stroke care.

During the inspection, we looked at 25 patient records and 16 prescription charts. We spoke with 30 patients and relatives, and approximately 50 staff including doctors,

nurses, therapists, health care assistants, ward managers, matrons, administrative assistants and student nurses. We visited Ward 1 (short stay ward), Ward 5 and Ward 500 (respiratory), Ward 50 (nephrology), Ward 70 (diabetes/endocrinology), Wards 9 and 90 (elderly care), Ward 11 and Ward 110 (stroke/neurology), Ward 100 (Gastroenterology), the Elderly Short Stay Unit on Wards 8 and 80, the Elderly Assessment Unit on Ward 200, the Acute Medical Unit (AMU), the Ambulatory Care Unit (ACU) and the Endoscopy Unit.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific 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.

A focussed inspection of Hull Royal Infirmary was carried out in May 2015. All five domains were inspected for medical care services. Safe, effective, caring and well led were rated as 'Requires improvement' and responsive was rated as 'Inadequate'. The service was rated overall as 'Requires improvement'.

The main issues of concern from the last inspection were; incident reporting policies were not being followed, medicines management and checking of resuscitation equipment was not in line with trust policy and guidance, and call bells were not in reach of patients on elderly care wards. There were delays to patients being discharged, a high number of patient bed moves out of hours and



# Medical care (including older people's care)

patients being cared for on non-speciality wards. A previous inspection had identified a bullying culture and although most staff thought there had been an improvement, there was still further work to do.

## Summary of findings

At the 2015 inspection we rated medical care services as 'Requires improvement' overall. This rating was the same in 2016 because:

- Staff were not always assessing and responding appropriately to patient risk. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care; however, some staff were unclear about what to do if a patient's score increased.
- Falls risk assessments were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment. We found poor compliance with the completion food charts and fluid balance charts.
- Fridge temperature checks were not always performed and we found that when recorded as out of range, no corrective action had been taken. Controlled drugs were appropriately stored with access restricted to authorised staff however, on most wards; we found daily and weekly checks were not consistent with trust standard operating procedures.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients, as well as new ward support roles, such as discharge facilitators.
- The trust was not meeting the 18 week referral to treatment standard for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed. There were still issues with bed capacity and medical outliers were affecting other services. During the inspection, we found several medical patients being cared for on the gynaecology ward.

# Medical care (including older people's care)

However;

- Leadership had improved. There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered. We found an improved staff culture, staff were engaged and there was good teamwork. There was a drive for continual change and improvement within the Medicine Health Group although further work was needed to embed the changes and to continue to improve standards.
- Staff were caring. Feedback from patients and relatives was positive. We saw good interactions between staff and patients and staff maintained patients' privacy and dignity when providing care. Patients and relatives felt well informed and involved in decision making about their care. We found that patients' access to call bells had improved and the trust were auditing this regularly.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years where compliance had been 68.7% and 74.9%. There were mixed results in national audits; however, action plans were in place to improve areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.
- We found good practice in order to meet the individual needs of patients. The environment on elderly wards had been adapted for patients living with dementia. Recreational co-ordinators had been introduced in medical elderly wards to provide patients with activities. A learning disability liaison nurse supported patients with a learning disability.

## Are medical care services safe?

Requires improvement



At the previous inspection in 2015, we rated safe as 'Requires improvement'. At this inspection we also rated safe as 'Requires improvement' because:

- Staff were not always assessing and responding to patient risk appropriately. The trust used a national early warning score to identify deterioration in a patient's condition which required a higher level of care. We found examples of patients with high scores indicating they should have been escalated but had not been. Some staff were unclear about what to do if a patient's score increased.
- We found that risk assessments for falls were often not completed or not fully completed. This was particularly noted on the acute medical wards where some patients over 65 years of age did not have a completed falls assessment.
- We had concerns about the completion of nutritional risk assessments and fluid balance charts in patient records.
- Nurse staffing shortages were evident across the majority of medical wards and the trust's safer staffing levels were not met. The trust recognised this was an issue and had put in place twice daily safety briefings to minimise risk to patients as well as new ward support roles, such as discharge facilitators.
- We observed on several medical wards, that fridge temperature checks had not always been performed. We also found many examples of when the fridge had been recorded as out of range and no corrective action had been taken.
- Controlled drugs were appropriately stored with access restricted to authorised staff. However, on most wards, we found daily and weekly checks were not consistent with trust standard operating procedures.

However;

- Incident reporting was good and there was good sharing and learning from incidents.
- We observed good infection prevention and control practice and ward areas were clean, tidy and well organised.

# Medical care (including older people's care)

- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- Compliance with mandatory training for staff in medical care services was generally good at this hospital with most clinical areas in medical care exceeding the trust target of 85%.

## Incidents

- There were no never events reported in medical care 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 categorized 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.
- Twenty-seven incidents had been reported as serious incidents 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).
- Serious incidents were all investigated. We looked at examples of incidents, which had been investigated and found that staff had completed thorough root cause analyses and action plans. The trust held meetings to review the serious incidents reports.
- Incidents were investigated at ward level and fed back to staff individually and at ward meetings. Most staff received feedback about incidents and could give us examples of incidents and changes that had occurred as a result.
- The trust produced a monthly lessons learnt bulletin, which was circulated to staff electronically and was available on the intranet for sharing with the ward teams. Staff commented positively on this during the inspection.

- Staff told us about action and learning from incidents. For example, in response to a serious incident related to a pressure ulcer on Ward 8, staff had attended meetings with the ward manager and tissue viability nurse. They also received additional tissue viability training both at the bedside and online.
- 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 concerns when they were short staffed as this was highlighted within the daily safety brief completed by the trust.
- 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 duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had a 'Being Open when Patients are Harmed Policy' which set out the process for duty of candour.
- Most staff we spoke with understood the principles of duty of candour however; some junior members of staff such as health care assistants were not as 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.
- A relative we spoke with told us they had been provided with a duty of candour letter following their relative's fall. The letter said the incident would be investigated, although there was no information about who would contact them following this.

## 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

# Medical care (including older people's care)

(blood clots), and 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 stable. Overall, this showed an improving picture for harm free care.
- On inspection, we observed safety thermometer information displayed on all wards. For example, Ward 50 displayed data showing there had been five patient falls, no pressure ulcers, no MRSA and no Clostridium difficile infections in May 2016.
- The trust produced a monthly safety bulletin, which was circulated to all staff.

## Cleanliness, infection control and hygiene

- The areas we visited were clean and ward cleanliness scores were displayed in public areas.
- Hand washing facilities were available at the entrance to and throughout the wards we visited with signage to remind people the importance of handwashing. Personal protective equipment including aprons and gloves, and sanitising hand gel were also available.
- We observed good infection prevention and control practice on all wards we visited. Staff used appropriate personal protective equipment when completing clinical tasks. They complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- Each ward had an infection control link practitioner who attended infection control study days and cascaded information to the ward manager and the team.
- Monthly infection control audits were carried out to identify gaps in practice. Handwashing and ward cleanliness audit findings were displayed on Ward 50 and showed 100% and 99.8% compliance in May 2016.
- Staff completed infection prevention and control training as part of their mandatory training programme. The overall compliance with this training for medical care staff at this hospital was 72.9%, however most staff

groups exceeded the trust target of 85%. The staff group with the lowest compliance with this training was the administration and clerical staff group, who did not meet with trust target in many clinical 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. Sharps were correctly disposed of.
- Equipment we inspected appeared clean and was identified as being clean using cleaning assurance stickers. However, we observed a health care assistant using a reusable blood pressure cuff on several patients without cleaning it in between. We mentioned this to the member of staff and found they were not aware this was required.

## Environment and equipment

- Most areas we visited were clean, tidy and well organised.
- The endoscopy unit had a waiting room, assessment room and separate changing rooms and sub-waiting area for male and female patients. There were three procedure rooms and separate recovery areas for male and female patients.
- Arrangements for the decontamination of equipment in the endoscopy unit were being upgraded in line with recommendations by the Joint Advisory Group (JAG). Work was ongoing to refit a designated area with new decontamination equipment; this was planned to open in October 2016.
- On all wards we visited, staff had signed to confirm they had carried out daily checks on resuscitation trollies. The trollies we checked were all in order and ready for use.
- The equipment we checked had been serviced correctly and dates recorded. Electrical equipment had been safety tested.
- The trust carried out an environmental review of clinical areas. The review rated each ward and outlined areas for improvement if it fell below standard. We saw that for areas identified as needing rechecking or a weekly check, this was carried out and documented.
- Ward 8 had a folder to identify daily which patients required glucose blood monitoring and at what time. We checked the monitoring machine to ensure it was working correctly however, we found the testing solution was out of date.

# Medical care (including older people's care)

## Medicines

- All patients had a drug administration record. Within the record, it allowed the prescriber to identify the patient's allergies and venous thromboembolism (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 looked at 16 prescription charts and found they had been fully completed and were legibly written. Allergies were recorded and VTE prophylaxis was documented. Start and stop dates were recorded and where medicines were omitted, a corresponding code was entered detailing the reason for this.
- 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 were needed was recorded on most charts. Antibiotic prescribing was reviewed at least every three days and there was an automatic end after five days requiring the chart to be rewritten if required.
- We saw that nurses did not always follow trust guidance when administering medicines. For example, on both Ward 8 and Ward 9 we saw nurses sign to confirm the dose had been given prior to administering the medication. Although one nurse said this was not normal practice, the other nurse thought this was normal practice as she had observed this during her supernumerary status. We raised this with the ward managers at the time of inspection.
- We observed on several medical wards that fridge temperature checks had not always been performed and there were many examples of where the fridge had been recorded as out of range and no corrective action had been taken. For example, Ward 5 had recorded the fridge being out of range 26 times in April, May and June and no appropriate action was taken. The fridge on Ward 8 had three checks missed in April and was recorded as being out of range seven times in May with no action taken. This meant that drugs might not have been stored at the correct temperature required.
- The pharmacy team completed audits on the wards to measure compliance with fridge monitoring, 24 hours controlled drug checks and resus trolley checks to ensure patient safety was maintained. The audits showed most wards achieved 100% compliance with fridge checks. This did not reflect our observations during the inspection.
- We found some vacutainer butterflies (used for venepuncture) in the peritoneal dialysis room were out-of-date which were removed on our request.
- Controlled drugs were appropriately stored with access restricted to authorised staff. However, on most wards we found daily checks were not consistent with trust standard operating procedures. For example, the Acute Medical Unit (AMU) missed five checks in March, one in April, and four in June. On Ward 9, we found that the weekly checks had only been completed five times in a six month period. This issue was raised with the ward manager at the time.
- 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.
- We found the appropriate risk assessment and patient agreement had been completed for patients who were self-medicating.
- 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, 66% of medicines were reconciliated within 24 hours, this increased to 77% in May and 76% in June. This fell short of the trust target of 80%.

## Records

- Care plans were divided into care bundles, which related to certain risks such as falls, nutrition, pressure areas, and venous thromboembolism. The care bundles were generic assessments with an area for individualised care to be added for each patient.
- Intentional rounding documentation was in place. Regular checks and scheduled tasks or observations such as pain, positioning and comfort, were carried out at set intervals. We saw that apart from two, these were appropriately completed.
- We reviewed 25 sets of patient records, which represented a sample of the services we visited. Most of records we reviewed were completed appropriately in line with professional standards, with relevant risk assessments and descriptions of staff interaction with the patient. However, we had concerns about the completion of nutritional risk assessments and fluid balance charts.



# Medical care (including older people's care)

- Nutritional assessments were partly completed on the patient records that we observed. The trust used a validated nutritional screening tool on the wards. 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. Daily totals were added up to identify the overall malnutrition risk to the patient and whether the patient needed referring to a dietitian. We observed six records where this part of the food chart was not fully completed.
- We saw during our unannounced visit and our inspection that there was poor compliance with completion of fluid balance charts. We saw at least 10 records where fluid balance charts had either not been completed at all, were partially completed or had not been totalled up.
- Most medical and nursing notes were paper records and were stored securely on each ward in a lockable trolley. Each ward had access to an electronic display board, which held patient information such as admission details, discharge planning, acuity, nursing and medical history and risk assessment details.
- We saw on two occasions, patients records left unattended at the nurses' station on the Elderly Assessment Unit.
- Documentation standards on each ward were audited as part of the safer care weekly audits.
- There was good compliance with information governance training. Overall compliance for staff in medical care services at this hospital was 85.5%, which exceeded the trust target of 85%. The lowest compliance was for medical staff in neurophysiology, which achieved 50%.

## Safeguarding

- The trust had policies and procedures for safeguarding children and adults at risk. Both policies were in date and required to be reviewed in December 2016. This included guidance on the 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's daily safety brief.
- Staff completed safeguarding children level one and vulnerable adults training as part of their mandatory training. Compliance with this training was good at 86.6% for safeguarding children and 88.4% for vulnerable adults training. Both exceeded the trust target of 85%.

## Mandatory training

- The trust's mandatory training programme included: information governance, moving and handling, major incident training, safeguarding children, vulnerable adults, infection control, conflict resolution training and resuscitation. The trust target for mandatory training was above 85%. Training could be completed either face to face or online. Staff were also required to complete statutory training such as fire safety and safety training.
- Compliance with mandatory training for staff in medical care services was generally good at this hospital with most clinical areas in medical care exceeding the trust target of 85%. Compliance in nursing staff was particularly high with many areas achieving 100%. However, we were concerned that resuscitation training had the lowest compliance at 64.5%.
- Ward managers monitored mandatory training. They told us that compliance was improving but staffing numbers affected their ability to achieve better compliance. Some staff told us they were completing on-line training from home.

## Assessing and responding to patient risk

- The trust used a National Early Warning Score (NEWS) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care.

Nurses and care support workers recorded patient observations in each patient's notes, which enabled their NEWS to be calculated. NEWS was mainly recorded in patients' paper records however; Wards 11 and 110 had been trialling an electronic system for the last year, which automatically alerted when a patient's NEWS was high and needed escalating. Staff told us this system worked well.

- We had concerns about the correct escalation of patients when their NEWS was high. On our unannounced inspection on 11 July 2016, we visited

# Medical care (including older people's care)

Ward 5 and 500 and found four patients out of eight were recorded with a high NEWS, however, no action or escalation plan was documented in the patient's notes. For example, one patient on Ward 5 had a NEWS of 11 recorded at 6pm and this had not been escalated as per the trust guidelines. A doctor did not see the patient until 9.30am the following day.

- Three nurses we spoke with were not clear about when a patient's NEWS indicated that they should escalate the patient. One patient had a NEWS of seven and the nurse did not know if this was of concern or not. Two nurses we spoke to said they used their professional judgement to decide whether to escalate a patient.
- Patients with chronic conditions were given a higher baseline NEWS. We saw this documented in patients' notes.
- The trust audited compliance with NEWS. We looked at audit data provided by the trust for three months from April to June 2016. The audits measured whether patient observations had been completed, whether patients' NEWS had been correctly calculated and whether appropriate action had been taken and documented in response to the NEWS. Twenty patients' notes were audited per month. The audit showed good compliance for most medical wards at 100%, although in June 2016 the Acute Medical Unit (AMU), Ward 500, Ward 110 and Ward 8 dropped below 100%. Ward 110 was the lowest was at 83%.
- Patient risk assessment documentation for falls, pressure areas, nutrition and venous thromboembolism were included in care records. The trust used a falls risk assessment tool for patients over the age of 65 years or those identified at risk of falling. We found these assessments were not completed or not fully completed in eight records out of 25. This was particularly noted on the acute medical wards where four patients over 65 years of age did not have a completed falls assessment.
- If a patient required assistance to mobilise or transfer, this should trigger a multifactorial assessment. We found on four occasions that although this section was ticked, there was no evidence that a falls multifactorial assessment had been carried out. We requested falls audit information from the trust but this was not supplied.
- We saw that patients had falls bundles in place. This included a bed rail assessment, footwear assessment, moving and handling assessment and intentional rounding.

- Patients identified as being at high risk of falling were discussed at the daily safety huddle. The ward sister for Ward 9 told us that all patients were considered as a high falls risk for the first 24 hours after admission. Patients at high risk of falling were cohorted into bays nearest to the nurse's station. Falls sensors were available and patients were given yellow socks and a yellow wristband to wear to signify they were at high risk of falling.
- We saw good use of the SSKIN care bundle, which included five simple steps to prevent pressure ulcers.
- 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 NEWS referral system. The team supported patients nursed on wards with tracheostomies and delivered Non-invasive Ventilation (NIV) outside of critical care.

## Nursing staffing

- Information submitted by the trust showed the Medical Health Group had 42.3 whole-time equivalent (WTE) nursing vacancies from their 772.69 WTE establishment.
- The senior leadership team identified nurse staffing levels as an area of concern and it was identified on the trust's risk register. 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.
- There was an ongoing campaign to recruit additional qualified nurses. The trust recruited overseas nurses and had made 72 job offers to student nurses due to qualify in Autumn 2016.
- Staff on the wards often completed extra shifts to reach the required staffing levels and ward managers commented how good staff were at covering the extra shifts. Whenever possible, the same bank staff were used to provide continuity to the patients and bank staff.
- The trust recognised that nurse staffing was an issue and had introduced new non-registered roles to support nursing staff. Discharge facilitators helped manage patients discharge processes and ward hygienists took the lead in cleaning equipment. This allowed nurses and health care assistants more time for other duties.

# Medical care (including older people's care)

- The trust was introducing the 'safer nursing care tool' as recommended by the National Institute for Health and Care Excellence (NICE). This tool calculates safe nurse staffing levels based on patients' level of sickness and dependency. At the time of the inspection, this was being piloted on the Elderly Assessment Unit (EAU) and Wards 8, 80 and 90. This informed the safety brief giving the number of patients and their acuity for each ward.
- The trust aimed for staffing ratios of 1:8 on general medical wards; however, this was often not met. Nurse staffing was reviewed twice daily at the safety brief in line with acuity. The safety brief meetings were held at 10am and 3pm and were chaired by a nurse director (on a rota) and attended by a representative from each zone. Staffing levels and patient acuity were discussed as well as patient falls, safeguarding and infection control issues. Each ward was discussed and given a risk status of red, amber or green. If necessary, staff would be moved from one ward to another to ensure staffing levels were as safe as possible.
- The trust produced a monthly safer staffing report that identified average registered nurse fill rates for all wards. In these reports, we saw that in March, six out of 14 medical wards had a fill rate of below 80%. The lowest fill rate was for Ward 90, which was 64%. There was a similar pattern for the April, May and June however, for these months the Acute Medical Unit (AMU) had the lowest average fill rate of 58%. AMU had a high turnover of patients with acute conditions therefore; we were concerned by the low fill rate for this unit.
- Staff shortages were evident across the majority of medical wards and safer staffing levels were not met. Staff were aware how to escalate their concerns regarding staffing.
- The ward manager was often expected to work in the planned numbers of staff more than their allocated allowance due to the staff shortages. This was confirmed in the safe staffing report where the supervisory charge nurse capacity was regularly below 10% for most medical wards and dropped to 0% for Ward 50 in April and May and Ward 70 in April. Ward sisters told us they found it impossible to fulfil their role as they were often covering the ward.
- Planned and actual nurse staffing numbers were displayed on large whiteboards on each ward. This included registered nurse to patient ratios.
- Ward 500 had five whole-time equivalent (WTE) registered nurse vacancies. The ward sister told us these posts had been filled with newly qualified staff who would start later in the year however, it would be months before they were able to undertake their full duties. On the day of our visit, there were two registered nurses, one of which was the ward sister, to care for 24 patients.
- On Ward 50, planned staffing levels were met on the day of our visit. Nurse to staff ratios were 1:6 in the morning, 1:9 in the afternoon and 1:9 overnight.
- There was a six bedded Respiratory High Observation Bay (RHOB) on Ward 5. Patients with a higher acuity were cared for in this bay. Recommended nurse staffing levels were a nurse to patient ratio of 1:3, which took into account the acuity of the patients. We visited the RHOB on two occasions and found that nurse staffing levels were met. On a third visit to Ward 5, nurse staffing levels were not met. There were four nurses in the morning and three in the afternoon to cover both the RHOB and the 20 bedded ward. The matron had made the decision to transfer three patients from the RHOB to other wards and close these beds. This meant that one nurse would be able to care for the remaining three patients in the RHOB and two nurses to care for 20 patients on the ward.
- Ward 70 had five nurse vacancies and staff on short and long term sickness. Bank and agency staff or borrowed staff from other wards were used to cover vacant shifts.
- The Elderly Assessment Unit (EAU) had 21 beds and seven nurse vacancies. Nurse staffing was not on display on the day we visited. The planned level of registered nurses was four in the morning, four in the afternoon and three at night. The actual level was three in the morning, three in the afternoon and two at night, there was one nurse short on every shift.
- Actual staffing levels were below the planned level during our visit. The matron was covering shifts to make staffing levels safe. Stroke co-ordinators also helped on the ward when available.
- Ward 8 nurse staffing was fully established although staff were moved to support other wards that had low staffing numbers.
- Advanced nurse practitioners (ANPs) worked within the Ambulatory Care Unit (ACU) to provide additional medical / nursing support.
- From information supplied by the trust, bank and agency spend for the months of January, February and March 2016 for the Medicine Health Group for this



# Medical care (including older people's care)

hospital, were highest on the Acute Medical Ward (AMU), Ward 1, Ward 70, and Ward 110. The percentage of total pay bill spends for bank and agency staff exceeded 20% on one or more months for these wards.

- Formal handovers took place twice a day. We observed a nurse handover on Ward 500 and found it to be systematic and thorough. 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 a shift transition. This was followed up by a bedside summary when necessary.

## AHP staffing

- Planned hours for Allied Health Professional (AHPs) staff in March 2016 for the Medicine Health Group, were 842. However, the actual hours completed was 504.5 leaving a deficit of 337.5 hours.
- Planned hours for unqualified staff were met at 280 hours.
- The physiotherapy team for Ward 500 was fully staffed. There was one band 6, two band 5 therapists, and one assistant.

## Medical staffing

- The proportion of consultants was lower than the England average at this trust. The proportion of middle grade doctors was about the same as the England average however, the proportion of junior doctors was higher.
- There was consultant presence on AMU Monday to Friday 8.30am to 10pm. General internal medicine consultants were on call from 5pm to 9am. Junior doctor cover was available over the 24 hour period, seven days a week.
- The Ambulatory Care Unit had medical cover from 8am until 10pm. Medical cover consisted of a consultant with registrar support. Between the hours of 10pm and 1am, staff provided medical assistance from the Acute Medical Unit.
- Day cover on medical wards was provided by junior doctors from 9am to 5pm and middle grade doctors from 9am to 10pm. At night, there were two middle grade doctors and junior doctors with bleep holders. At weekends, one middle grade doctor and junior doctors

provided cover. All medical specialities had access to an on call consultant 24 hours a day, seven days a week. The hospital at night team supported the medical staff out of hours.

- There were concerns about gaps in the junior doctor rotas especially for out of hours. When possible, gaps in medical rotas were covered by locums. We saw from data provided by the trust between April 2015 and March 2016 that locum and bank medical staff usage was highest in acute medicine and the department for medical elderly. The highest usage was in March 2016 when the percentage of the total pay bill spend for bank and agency staff was 56.6% for acute medicine and 50.7% for the department for medical elderly.
- The trust had several vacancies for junior doctors and was showing further vacancies from the beginning of August. The main areas for concern at this hospital for medical services were gastroenterology, which was showing a 60% fill rate and had two vacancies, and acute medicine, which had a 76.2% fill rate and five vacancies. The trust's medical staffing team was working hard to fill these posts and informed us that suitable applicants had been sourced for two of the vacant acute medicine posts and were awaiting clearances.
- Long standing vacancies within the consultant establishment in the department of medical elderly was on the Health Group risk register. One vacant consultant post had been used to recruit two Advanced Nurse Practitioners (ANPs) to support the consultant body.
- Medical staff sickness was consistently low with the highest percentage at 1.5% in August 2015.
- Formal ward handovers took place twice a day at 8am and 8pm, with informal handovers occurring during the shift change. We observed an evening medical handover on the Acute Medical Unit. The senior doctor present (specialist registrar) briefly went through the patients on the unit and flagged those triggering concerns. The registrar then discussed how many patients were waiting to be seen and allocated jobs out to the junior doctors. There was no formal recording of which doctors were present, or which patients had raised concern, although this was recorded on the electronic board. We noted the electronic board system had not been completely filled out therefore, there was a potential to miss things.

## Major incident awareness and training

# Medical care (including older people's care)

- The trust had a major incident and business continuity plan. Medical departments had their own individual business continuity plans. Policies were also accessible for winter plan, escalation plan, severe weather and pandemic flu.
- Staff were required to complete a once only training session in major incident awareness as part of their mandatory training. Overall compliance with this training was good at 94.3% for medical care services.
- Staff explained how to access the major incident and continuity plans on the intranet and had an awareness of their role.

## Are medical care services effective?

Good



At the previous inspection in 2015, we rated effective as 'Requires improvement'. At this inspection we rated effective as 'Good' because:

- We saw examples of good multidisciplinary team working. We thought the weekly ward round on Ward 70, which included a vascular surgeon, podiatrist, endocrinologist and therapists was particularly good practice.
- We observed consistent use of a red tray system to identify patients who needed help with meals or their dietary intake monitoring. Red water jugs were also in use to help staff identify patients who required help with their fluid intake and were at risk of dehydration.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years where compliance had been 68.7% and 74.9%.
- Staff had a good understanding of consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff gave good explanations to patients and gained consent prior to completing a procedure.
- There were mixed results in national audits. We saw action plans to improve in areas of poor performance. The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.

However;

- The trust was a CQC outlier for sepsis. This meant that there had been a higher number of deaths than expected for patients with sepsis. In the trust quality improvement plan, we saw a project to raise awareness of the Sepsis Six, implement the sepsis care bundle and reduce death from sepsis.
- Local audits were carried out and effectively identified areas for improvement, however robust action plans were not in place to ensure improvements were made as a result of these audits.

## 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. We saw in the minutes of speciality governance meetings that audits measuring adherence to NICE guidance were being undertaken. For example, NICE guideline CG186 Multiple sclerosis in adults: management.
- 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 displayed on notice boards in wards areas and combined in the trust's Safe Care Summary Report.
- Protocols and policies were available on the intranet and staff knew where to find them. The policies we reviewed all had identified author/owner and all had future review dates.
- The peritoneal dialysis team were involved in the nationwide Peritoneal Dialysis Outcomes Practice Patterns Study (PDOPPS) to support national and local learning.
- Outside every ward, its compliance with the fundamental standards audit (3Gs) was displayed. This audit measured the ward against standards across a number of areas including nutrition, record keeping, infection control and tissue viability. Each area was given a rating then the ward received an overall rating. These effectively identified areas for improvement, however robust action plans were not in place to ensure improvements were made as a result of these audits.

## Pain relief

- We saw pain relief was prescribed on prescription charts.

# Medical care (including older people's care)

- Nursing staff used and documented an evidence based pain score to assess patients' needs. We saw from patient care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- The trust scored 7.8 out of 10 in the National Inpatients Survey 2015, for the question 'did hospital staff do all they could to help control your pain'. This score was about the same when compared with other trusts.
- Most patients we spoke with said they received pain relief when required, however, the relatives of one patient we spoke with who was being cared for on Ward 90, told us that their relative's pain relief had on occasion been missed. They also told us that when first admitted to the Elderly Assessment Unit (EAU) with severe back pain, their relative had waited for several hours before receiving any pain relief medication.

## Nutrition and hydration

- The trust used a validated nutritional screening tool on the wards. We saw in patients' notes that their nutritional needs had been assessed however, food charts and fluid balance charts were not always fully completed by staff.
- The hospital used a red tray system to identify patients who needed help with meals or their dietary intake monitoring. Red water jugs were also in use to help staff identify patients who required help with their fluid intake and were at risk of dehydration.
- Protected meal times were in place and we saw staff assisting patients with their meals. However, one member of staff on Ward 8 told us that protected meal times did not always occur and it was difficult trying to feed all patients who needed assistance. The food would remain on the patient's table and could go cold until a member of staff was available to feed them. The ward manager was aware that mealtimes could be difficult.
- 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 during the day.
- Patients on the Elderly Assessment Unit (EAU) had food and drinks in reach and were eating breakfast independently. The catering assistant gave patients a choice of having their drink in a mug, beaker or cup and saucer.
- Patients we spoke with were happy with their meals. One patient said there was an excellent choice of main courses. One patient thought there were not enough fresh fruit options.
- We saw a notice board in the kitchen on Ward 8, which identified patients requiring a high calorific diet.
- Staff had completed training to support patients who had difficulty in swallowing. The dietitian and speech and language team provided assistance when needed.

## Patient outcomes

- In the National Diabetes Inpatient Audit 2015, the trust was in the top 25% for England for eight of the 18 indicators. However, the trust was in the worst 25% for England for having a high percentage of prescription errors (31.4%).
- The endoscopy service met the requirements of the Joint Advisory Group on GI Endoscopy (JAG) accreditation.
- In the Sentinel Stroke National Audit Programme (SSNAP), the trust scored D for SSNAP level for the first three quarters from January to December 2015, but improved to a score of C in the last quarter. The trust's score for the team-centred scanning indicator improved from C in the first two quarters to A in the latter two quarters.
- Hull Royal Infirmary had mixed performance in the Heart Failure Audit 2013/14. The hospital scored better than the England average for two of the four in-hospital care indicators, and four of the seven discharge indicators.
- There was poor performance in the Myocardial Ischaemia National Audit Programme 2013/14. A lower proportion of Hull Royal Infirmary's patients with nSTEMI (non-ST segment elevation myocardial infarction) were seen by a cardiologist or member of their team and a lower proportion were admitted to the cardiac unit or ward. The proportion of patients with nSTEMI that were referred for or had angiography was not available for the hospital. There was no data for the trust for thrombolytic door to needle time. We saw that the trust had plans to increase the quality of data provided to this audit.
- We saw that when performance was below the standard required in national audits, an action plan was formed and clearly documented.

# Medical care (including older people's care)

- The risk of readmission at Hull Royal Infirmary from December 2014 to November 2015 was lower than expected for elective and non-elective care overall. Risk of readmission was higher than expected for non-elective geriatric medicine and stroke medicine.
- The trust was a CQC outlier for sepsis. This meant that there had been a higher number of deaths than expected for patients with sepsis. In the trust's quality improvement plan, we saw a project to raise awareness of the Sepsis Six, implement the sepsis care bundle and reduce death from sepsis. Data from the trust indicated that this was improving.
- 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.
- Wards displayed 'fundamental standards' results which were colour coded against local compliance targets such as care of vulnerable people, medicines management, nutrition and hydration and patient experience.
- Overall compliance with appraisals for the Medicine Health Group (across both sites) for 2015 to 2016 was 79.9%. This was an improvement on the previous two years when compliance had been 68.7% and 74.9%.
- Preceptorship packages for new members of staff were in place and an allocated amount of supernumerary time in order to progress with competencies. There were two steps to this package. Step one provided incremental development for newly registered practitioners and step two was designed to develop the capabilities of the practitioner within the specialty in which they work.
- Junior medical staff commented that training was excellent and they felt well supported by consultants. 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 through to rehabilitation.
- Nursing staff told us that there was good access to training and development and they were being supported with revalidation.
- New staff on Ward 110 had a stroke training day. We were told this included recognising signs and symptoms and an online training package.
- Physiotherapy staff were required to complete an induction and a six month probationary period. The team carried out peer review sessions using a standard template to improve performance. We saw there were clear objectives set for band five rotational physiotherapists.
- Therapists had developed competencies for ward based rehabilitation staff of all grades to support patient care to complete the care certificate.
- An e-learning package on falls prevention had been developed for staff.
- Medical wards provided placements for student nurses. Trained mentors were allocated to both student nurses and newly qualified nurses to provide support.

## Competent staff

- There was no specific supervision policy for nurses. Managers told us that they relied on a number of organisational processes to provide assurance on managerial, clinical and professional competency. This included local and trust induction for all new staff, annual appraisals, local preceptorship and Nursing and Midwifery Council (NMC) revalidation.
- We were concerned that an agency nurse working on the Respiratory High Dependency Unit (RH DU) on Ward 5 did not have the skills to provide Non-invasive ventilation (NIV) for these patients. Staff told us that the agency nurse was there to support the experienced nursing staff.
- Staff on Ward 70 were concerned that staff were often moved to other wards to cover for sickness and they did not always have the correct skills.

## 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 patients' care between teams and seek advice from colleagues. Therapists had an individualised activity plan for each patient, this fed into the MDT meeting.

# Medical care (including older people's care)

- A multidisciplinary team (MDT) of doctors, nurses, care support workers, physiotherapists, occupational therapists, dietitians and specialist nurses cared for stroke patients on Ward 110. An MDT meeting was held every Tuesday afternoon.
- On Ward 70, a weekly ward round was held to review patients on the ward. The team comprised of a vascular surgeon, podiatrist, endocrinologist and therapists. We thought this was an example of very good practice.
- Ward 8 held daily MDT meetings, which involved medical and nursing staff, therapists, social workers and mental health staff. Staff from the intermediate care team occasionally attended.
- Patients who were identified at risk of malnutrition were referred to the dietitian. We saw evidence of dietetic input documented in patient's notes.
- Multidisciplinary safety huddle were carried out daily on the wards. We observed a safety huddle on Ward 9, which was attended by nursing, medical, physiotherapy and occupational therapy staff. Patient safety was discussed including patients requiring one to one supervision as they had a high risk of falling.
- Staff spoke positively about close MDT working and felt they had good working relationships between professional groups.

## Seven-day services

- The trust was working towards a 24 hour seven day week working. Further work on the acute medical pathways was underway as part of the urgent and emergency care programme. We were informed that changes had been made to junior medical rotas to increase doctor presence at weekends and overnight.
- The Ambulatory Care Unit (ACU) opening hours had recently been extended from 8am to 10pm to 7am to 1am every day including weekends. This was with support from both medical and nursing staff to enable a better patient experience.
- Peritoneal dialysis nurses provided seven day cover between 7am – 7pm. They provided services to in-patients, out-patients and day cases.
- The physiotherapy team offered a seven day service across the wards. Physiotherapists were available at the weekend and were on call out of hours.
- Nurse practitioners worked out of hours and helped support staff on the wards.

- Consultant cover was available over the 24 hour period for patients with a gastrointestinal bleed. Nurses in the endoscopy unit were on call after 6pm and would come into the unit if a bleed occurred out of hours.
- The Hyper Acute Stroke Unit (HASU) was a four bedded area within Ward 110. Thrombolysis was carried out on the HASU by the consultant.
- 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.
- Information provided by the trust, indicated that 11 out of 14 diagnostic services were available seven days a week. Staff on the Acute Medical Unit (AMU) told us that CT head scans were available out of hours.

## Access to information

- The trust used the same electronic patient board on each ward; this allowed up to date information to be stored and informed the nursing handover record for staff. Staff could complete electronic referrals and record patient pathways. However, the trust used three different IT systems and some staff found this inefficient and slow to work at times.
- 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.
- Staff were able to access blood results and x-rays using electronic results services.
- Medical and nursing records were accessible on all wards.

## 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 it was more likely that patients required a DoLS in place.



# Medical care (including older people's care)

- The DoLS protocol was on display on some of the wards. We looked at the paperwork for two patients with a DoLS in place. This was appropriately completed and reviewed daily for one patient however; some daily reviews had been missed for the other patient.
- We observed staff obtaining verbal consent and giving 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 would identify any patient that had a DoLS in place.
- There was good compliance with staff training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Overall compliance for staff within medical care services for DoLS and MCA training was 86.8% and 87.6% respectively. Therefore, both achieved over the trust target of 85%. The lowest compliance was for health care assistants in chest medicine, who achieved 62.5%.

## Are medical care services caring?

Good



At the previous inspection in 2015, we rated caring as 'Requires improvement'. At this inspection we rated caring as 'Good' because:

- Feedback from patients and relatives was positive. We saw good interactions between staff and patients.
- Staff maintained patients' privacy and dignity when providing care.
- Patients and relatives told us that staff kept them informed of their treatment and progress and involved them in decision making.
- There was good emotional support available through the chaplaincy service and there was a multi-faith prayer room within the hospital.

However:

- Although the availability of call bells to patients was generally good during our inspection, we saw on the Acute Medical Unit (AMU) that 17 out of 25 patients did not have a call bell within reach.

### Compassionate care

- The Friends and Family Test response rate for this hospital was lower than the England average from

March 2015 to April 2016. There were good test results across all medical wards for this period with wards consistently scoring between 90 -100%. The exceptions were Ward 80, which scored 50% in June 2015 and 72.7% in October 2015 and Ward 10, which scored 61.5% in September 2015 and 33% in October 2015. Ward 10 was the winter pressures ward and was closed at the time of our visit.

- It is important for patients to have call bells in reach in order to summon help when needed. On our last inspection, we noticed that this was an issue with many patients' call bells being out of their reach. The trust had carried out monthly call bell audits. We looked at the results of these audits from December 2015 to May 2016 and saw that there was a high compliance rate with call bell availability. Where call bells were identified as not being within reach there was an action to address this. In some circumstances, there was a documented reason why the call bell was out of reach, for example, it was a choking hazard for a patient with dementia. The availability of call bells to patients was generally good during our inspection however; we saw on the Acute Medical Unit that 17 out of 25 patients did not have a call bell within reach.
- Call bell response rates appeared good during the inspection. Patients told us they were normally responded to promptly. On the Elderly Assessment Unit (EAU), we heard four call bells ring, three were answered in less than two minutes, and one took longer than two minutes. Two patients we spoke with on Ward 8 were happy with their care and said they did not have to wait long for their call bell to be answered.
- Patients' dignity was maintained. We observed a consultant led ward round and saw that curtains were pulled around the patient to maintain privacy and dignity.
- Staff we observed spoke to patients in a caring and compassionate way. We overheard a student nurse on EAU assisting a patient with washing, care was personalised and they were having a conversation about the patients' family and their individual preferences. We observed a porter arriving to transport a patient and saw that he ensured the patient was comfortable and had a blanket before leaving the ward. A relative told us staff on Ward 8 were very kind.
- During the unannounced inspection, we carried out a Short Observational Framework for Inspections (SOFI) on Ward 80, Ward 90 and Ward 500. We observed good

# Medical care (including older people's care)

interactions between staff and patients. Patients responded positively to staff and it was clear from the patients' facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if there was anything they needed.

- One patient on EAU was shouting out and unable to express their needs, staff attended to the patient and offered reassurance. Another patient was wandering at their bedside; the nurse assisted the patient back to the chair, moved any trip hazards, reoriented the patient and reminded them about using their buzzer.
- Most patients and relatives we spoke with were satisfied with their care. They said that some staff on the ward, predominantly health care support workers were not attentive to the needs of patients, particularly those with dementia.

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

- Patients told us that their families were involved in their care and informed about treatment plans. We saw involvement in care decisions clearly documented in the medical records we looked at.
- One patient said, "Staff are brilliant". "They take time to answer our questions and concerns".
- We heard doctors explaining treatment options and plans to patients and relatives and answering their questions.
- We saw examples of nursing staff involving patients. For example, a nurse was assisting a patient to pack their bag. The nurse involved the patient and asked how they would like things packed.
- One patient told us that staff had involved her in discharge plans and had considered the needs of her husband who was unwell when putting her care package together.

## Emotional support

- As part of the safety huddle on Ward 9, we heard a doctor request bereavement support for a relative who was not coping with a recent bereavement.
- A psychiatry liaison team from the local mental health trust worked with the hospital and offered support to patients with physical and mental health problems.

- A chaplaincy service, which consisted of chaplains and volunteers, was available to support patients, their families and carers during their time in hospital. There was a multi-faith prayer room available within the hospital.

## Are medical care services responsive?

Requires improvement



At the previous inspection in 2015, we rated responsive as 'Inadequate'. At this inspection we rated responsive as 'Requires improvement' because;

- The trust was not meeting the 18 week referral to treatment indicator for some pathways. From April 2015 to March 2016, the percentage of patients that started consultant-led treatment within 18 weeks was consistently worse than the England average.
- There were still issues with bed capacity and medical outliers were affecting other services. During the inspection, we found several medical patients being cared for on the gynaecology ward.
- Although we saw improvements in the access and flow of medical care services, such as reduced length of stay on wards and a reduction in the number of bed moves especially at night, further improvements were needed.

However;

- There was some good practice in order to meet the individual needs of patients. The environment on elderly wards had been adapted for patients living with dementia. For example, dementia friendly signage and large wall clocks. Recreational co-ordinators had been introduced in medical elderly wards to provide patients with activities.

## 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.
- Partnership working was in place with community providers and other agencies to ensure the timely and safe discharge of patients requiring additional support.



# Medical care (including older people's care)

There was a multi-agency discharge hub on the hospital site, which arranged services to support patients to be discharged safely to their own homes or to an intermediate care bed in the community.

- The Health Group were engaging with commissioners in a complete re-design and new commissioning approach for services that would enable new integrated models of care with services in the community.
- GPs and patients had been involved in the design of the elderly care pathway.

## Access and flow

- In the last 12 months there had been no mix sex breaches reported by the Medicine Health Group.
- Data for the period April 2015 to March 2016 for showed that overall the trust was not meeting the 92% indicator 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 areas were cardiology at 71.8%, geriatric medicine at 84.6%, thoracic medicine and gastroenterology at 87% and dermatology at 88.9%. General medicine, neurology and rheumatology were achieving the 92% indicator within this period.
- The management team were aware of the failure to deliver the national 18 week referral to treatment time 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 this trajectory.
- Information regarding bed moves between March 2015 and February 2016, indicated that across medical services for Hull Royal Infirmary, 40% of patients had no moves, 45% were moved once during their stay, 10% were moved twice, 3% three times and 2% of patients were moved four or more times. This showed a slight improvement in the percentage of patients moved three times compared to the previous year.
- Nurses told us that they sometimes felt pressured to move patients to free up beds however, it was very rare to move a patient after 10pm. Information provided by the trust showed that between January and April 2016, 266 medical patients had been internally transferred between 10pm and 8am. This was an improvement compared to last year with 779 bed moves after 10pm.
- Issues with bed capacity led to medical patients being cared for on non-speciality or non-medical wards. During the inspection, we found several medical

patients being cared for on the gynaecology ward. This was affecting services and we found in the divisional report that pressures on the gynaecology ward from outlying medical patients were resulting in the cancellation of elective gynaecology procedures.

- The trust had criteria for medical patients outlying on the gynaecology ward. The criteria stated patients should have an agreed discharge plan of 24 to 48 hours. On our unannounced visit, the ward had eight medical outliers. Staff said the medical outliers on the ward were not in line with the criteria. For example, one patient was waiting for an MRI scan and did not have an agreed discharge plan. There was a doctor on the ward reviewing the patients and staff told us appropriate medical staff reviewed the outlying patients daily.
- Staff on Ward 50 told us that beds on the renal ward were sometimes filled with patients from a different speciality. This caused problems when a renal patient needed to be admitted for dialysis. We were also told that patients who were medically fit for discharge from the ward would sometimes be moved to another ward until their care package could be put in place. This was not ideal if the patient needed dialysis as they would need to be transported back to the ward. Staff said this was rare but it did sometimes happen.
- Data provided by the trust showed that in the last six month period from February to July 2016, there had been 25 medical outliers transferred to Castle Hill Hospital from Hull Royal Infirmary. This was a marked improvement on the previous year when up to 100 medical patients were transferred to this site in one month alone.
- There were 21 beds on the Elderly Assessment Unit (EAU). The number of beds had increased from 15 to 21 since the last inspection and chairs previously used for ambulatory care had been removed to accommodate the additional beds. Staffing levels had also been increased in line with the number of beds. The unit no longer accepted patients who needed ambulatory care.
- A consultant on EAU told us there were plans to introduce rapid access clinics for frail elderly patients and these clinics would not be based on EAU.
- At Hull Royal Infirmary, the average length of stay was longer than the England average for elective care but shorter than the average for non-elective care from January to December 2015. Elective gastroenterology and respiratory medicine had longer than average lengths of stay.

# Medical care (including older people's care)

- Data from NHS England for May 2016 showed there were 625 days delayed transfers of care for this trust. The main reasons for these delays were related to the completion of assessments and waiting further NHS acute care. This was a reduction compared to a delay of 756 days for the same period in 2015.
- The trust had introduced a new role of discharge co-ordinators onto medical wards. The aim of this role was to ensure the timely discharge of patients and free up time for the registered staff to concentrate on their tasks. This role had been extremely well received; staff said the role was effective in discharge planning.
- We saw evidence that Ward 80 had sustained a reduction in the length of stay by more than two days, over the period December 2015 to July 2016.
- Ward 10 had been the winter surge ward was not in use at the time of our visit. On our last inspection, the winter surge ward had remained open into the spring and was open when we inspected in May 2015.

## Meeting people's individual needs

- 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 were not always using an interpretation service. On Ward 110, we observed a relative being used to translate for a patient. This was not good practice as confidentiality may be breached.
- There was a full time dementia lead nurse role. The senior management team told us that the nurse was working with a local dementia board to produce a dementia strategy.
- Dementia training and education was not part of the trust's 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.
- Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This national scheme teaches staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- The Elderly Assessment Unit (EAU) and elderly care wards had a dementia friendly environment. They had dementia friendly signage and large wall clocks. Red

food trays and yellow cutlery was in use for patients with dementia. We saw information regarding dementia displayed on notice boards, which included contact numbers for support. Specific staff took on a dementia friendly role and felt passionate about this responsibility. This included encouraging others to learn more about dementia.

- Recreational co-ordinators had been introduced in medical elderly wards. Their role was to provide patients with activities and stimulation whilst in hospital. We saw that wards had access to activities for patients living with dementia such as twiddle muffs, photo boxes and memory pictures. Ward 9 had a bus stop and bench for dementia patients who were agitated and believed they needed to go somewhere. Nurses told us this had a calming effect.
- Clinical psychologists and the learning disability liaison 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.
- A patient with learning disabilities was being cared for on Ward 500. Their carer had been able to stay with them overnight to offer reassurance and provide consistency for the patient.
- 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.
- There were a range of clinical nurse specialists who supported patients in a range of different settings, for example, diabetes specialist nurses.
- There was no day room on Ward 50. Patients and relatives could use the seminar room; however, this was not very comfortable or patient friendly.

## 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. 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. Forty-six (5.4%) of complaints were re-opened.

# Medical care (including older people's care)

- 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 33 complaints specifically relating to the Acute Medical Unit (AMU) and 64 about patients with dementia. These specialties were in the top 10 most complained about.
- Information provided by the trust identified in November 2015 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.
- We reviewed the response to a serious complaint from a patient and found the response to be fair and thorough. A face to face meeting had also taken place to resolve any outstanding issues. The response letter to the complainant included an apology for the distress and upset caused and detailed changes which had been made to prevent the situation reoccurring.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. We saw 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



At the previous inspection in 2015, we rated well led as 'Requires improvement'. At this inspection we rated well led as 'Good' because:

- We found an improved staff culture; staff said it had changed for the better. A programme of professional and cultural transformation training was ongoing for all staff, which included new staff joining the organisation.
- There was a clear vision and strategy for the Medicine Health Group with an operational plan on how this would be delivered.
- Staff were engaged and told us that there was good teamwork.
- There was a drive for continual change and improvement within the Medicine Health Group.

However;

- Ward sisters/charge nurses were often counted in the nursing numbers providing patient care and did not have dedicated time to carry out their management duties.
- Leadership had improved however further work was needed to embed the changes and to continue to improve standards. Some staff found it difficult to keep up with the pace of change.

## Vision and strategy for this service

- The Medicine Health Group had a five-year plan, which clearly set out their overall goals. The plan fitted with the trust's strategy for 2016 to 2021.
- There was a clear programme of change and vision for the Medicine Health Group, which we saw, in the Health Group's operational plan 2016/17 and 2017/18. The group's strategic vision was that "every patient will receive high quality, safe and responsive care irrespective of their age, social status and the time and day of the week that they access our services".
- The operational plan included objectives, which set out the key actions, measurable outcomes and timescales for completion. This included the planned programme of transformation across a number of specialties that would implement integrated pathway redesign.
- Most staff we spoke with were familiar with the trusts organisational goals of 'Great Staff - Great Care - Great Future.'

## Governance, risk management and quality measurement

- The senior management team for the Medicine Health Group were clear on their greatest risks and we saw this clearly documented on the risk register. Control measures were put in place to reduce the level of risk. Each speciality service had their own risk register and high risks could be escalated onto the Health Group register. The risk register held most of the issues we had identified such as staffing and delivery of the national 18 week RTT however, the management of the deteriorating patient and the accurate completion of records were not included.
- Within the Medicine Health Group, an integrated governance committee was held monthly. Items discussed at this meeting included incident management, serious incidents, the risk register, current

# Medical care (including older people's care)

audit plans and complaints. The meeting was attended by the divisional nurse, quality and safety managers, business manager, pharmacy and governance lead and chaired by the nurse director. We saw from copies of the minutes that actions with completion dates were recorded.

- Monthly governance meetings were held for medical specialities for example, diabetes and endocrinology, neurology and stroke medicine.
- An audit programme was in place for each speciality within medicine. Quality audits such as the fundamental standards audit (3Gs), measured each ward against standards across a number of areas which also included infection control.
- The results were monitored by the Health Group however, they not always completed in the agreed timescales.
- Wards had regular team meetings and staff felt they could raise issues. However, these did not always happen due to staffing constraints.

## Leadership of service

- Staff we spoke with told us they were more confident in the current trust board. Some staff said they had seen and spoken to the Chief Executive on a recent walk around.
- A medical director, an operations director and a director of nursing, led the Medicine Health Group. The group was subdivided into four divisions; elderly medicine, emergency medicine, specialist medicine and general medicine. A clinical director, a divisional manager and a divisional nurse managed each division.
- Staff told us that senior managers were visible and approachable. They said they felt well managed and their line managers at ward level were supportive.
- 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.
- Senior managers were proud of their staff and of what they had achieved. They recognised that the pace of change needed to be managed in order for improvements to be sustainable.

- Nurse directors met with the Chief Nurse every Tuesday and would alert the Chief Nurse to any major issues as they arose.
- The matron for Ward 110 visited the ward daily for an update and regularly carried out a walk round to speak to patients.
- There was a lead consultant for dementia and elderly medicine. Ward sisters told us that the consultants provided excellent leadership and support and they have a genuine passion for patient care.
- Ward sisters/charge nurses were often counted in the nursing numbers and were not able to carry out their management duties because they were providing direct patient care.
- A ward sister from Castle Hill Hospital had moved to Ward 110 to provide leadership to the ward. Staff told us this had made a positive difference.

## Culture within the service

- There was an ongoing programme of professional and cultural transformation training for all staff. New staff also received this training at induction to understand the expectations of them as staff working at the trust.
- The trust had appointed staff as anti-bullying champions and provided training to support them in their role.
- The majority of staff we spoke with told us the culture had changed for the better and there was no longer a blame culture. They felt they could raise concerns and that these would be listened to and addressed.
- One member of staff told us he had never come across any bullying or harassment but was aware of historic issues. He believed there had been a positive change in culture in recent times.
- Sickness rates for registered nurses between January and April 2016 were similar to the England average.

## Public engagement

- The trust's strategy for 2016-2021 was developed in consultation with patients and stakeholders.
- There was a newly established patient and public council, which was chaired by a patient representative.
- A draft patient experience strategy, which included medical care services, was in the process of being reviewed by stakeholders and the public and patient council. The final version of the strategy was due to be presented to the trust board for approval in September 2016.

# Medical care (including older people's care)

- Patients were involved in service user groups and patient stories were shared at every board meeting.
- The trust participated in the friends and family test.
- Ward 70 had a communication booklet for patients to provide feedback on the service they had received.

## Staff engagement

- We found staff were positive and there was a strong focus on teamwork.
- Ward sisters we spoke with said that staff morale had been low a year ago but had improved since then.
- Staff told us there were strong ward teams with everyone pulling in the same direction. The ward sister and a consultant on the Elderly Assessment Unit (EAU) told us that there was good teamwork on the unit.
- Staff on Ward 70 told us that managers had responded well to a request for improved storage and computer access. Both issues had been resolved efficiently.
- The trust held a yearly 'Golden Hearts' award ceremony to recognise great work from staff. A member of staff we spoke with told us she had received a golden heart in relation to her work on falls prevention.
- Staff had been involved in choosing the new values for the organisation of care, honesty and accountability.
- Staff received a Medicine Health Group newsletter, which was circulated to keep staff up to date with news and changes.
- Ward sisters we spoke with were positive about the senior leadership and the changes taking place. One ward sister said that some staff struggled to keep up with all the changes and recognised the need to support staff with this.







- Two members of staff told us they felt it was difficult to keep up to date with all the changes, especially the new paperwork.

## Innovation, improvement and sustainability

- There was a drive for continual change and improvement. The leadership team had taken on board areas requiring improvement identified at the last CQC inspection and had integrated them into their quality improvement plan.
- Senior managers shared with us that they had concentrated their initial efforts on improvements in emergency care, but were now focused on making changes to improve the acute medical pathway and elderly care.
- Staff told us the trust had been involved with the improvement academy to reduce the number of patient falls. New falls assessment documentation had been introduced because of this and falls risks were discussed at safety huddles.
- New roles had been developed within the Medicine Health Group to free up nursing time. Patient discharge assistants had been introduced across medical wards to progress and chase up complex and simple discharges. Recreational co-ordinators had also been introduced to provide patients with stimulating activities and there were plans to introduce nutritional assistants to wards.
- Advanced nurse practitioners (ANPs) worked within the Ambulatory Care Unit (ACU) to provide additional medical / nursing support.



# Surgery

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

## Information about the service

Hull Royal infirmary (HRI) is 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 provided non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, neurosurgery. It also provides elective vascular and neurosurgery.

The surgery service has eight wards surgical wards at HRI with 205 inpatient beds. The hospital has nine theatres in the main tower block, three ophthalmology (eye surgery) theatres, two-day surgery theatres and one clean procedure room.

Between January 2015 and December 2015 the Surgery Health Group carried out 57,579 surgical spells, this placed the trust in the highest quarter of all NHS hospitals nationally. Fifty-one percent of procedures were carried out as a day case with 38% emergency admissions and 11% elective admission.

During our inspection, we spoke with 60 members of staff including nursing, medical, and allied health professionals as well as 28 patients and three relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 30 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the Surgical Health Group.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific 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 also carried out unannounced inspections on 9 June and 11 July 2016.

A comprehensive inspection of HRI 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 was rated as requires improvement overall.

A focussed 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 overall as inadequate. 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
- 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

Last year we rated surgical services at HRI as 'Inadequate' overall. Following the 2016 inspection we rated surgical services at Hull Royal Infirmary 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 for medical review, but this had not always occurred.
- From our observations the five steps to safer surgery checklist was not embedded as a routine part of clinical roles within the theatres we visited.
- 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 information we reviewed and staff we spoke with we saw that only six consultant Orthopaedic ward rounds had taken place in the month of June 2016.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. 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 national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 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.
- The trust was a mortality outlier for the reduction of fracture of bone (upper and lower limb).
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.
- Due to the environment in the day surgical unit it was difficult to maintain privacy and dignity.

- 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 noted major improvements from the 2015 inspection to the theatre environment.
- 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 mainly positive or neutral and interactions with patients were positive.
- The Health Group had developed a clinical strategy; the strategy referenced national reports and recommendations and was aligned to the trust's values and strategy.



# Surgery

## Are surgery services safe?

Requires improvement



Last year we rated surgical services at HRI as 'Inadequate'. Following the 2016, inspection we rated surgical services at Hull Royal Infirmary as 'Requires improvement' for safe because:

- The escalation process for identifying and acting when patients deteriorated was not always effective. We found examples of patients with high early warning scores, indicating they should have been escalated for medical review, but this had not occurred.
- From observations the five steps to safer surgery checklist process was not embedded as a routine part of clinical roles within the theatres we visited.
- 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.
- There were staff shortages of nursing and medical staff; these shortages were evident in all surgical areas. 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.
- We found that nursing staff did not always complete accurately the falls and dementia risk assessments.

However,

- We noted the theatre environment had undergone major improvements following the 2015 inspection.
- We saw improvements in the timely investigations of incidents and the sharing of lessons learned.

### 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 categorised as a never event. One never event had been declared within the Surgery Health Group in the reporting period July 2015 to June 2016;

the retention of swabs post procedure from a previous episode of surgery. The Health Group had investigated, and a root cause was identified. In the period between the incident occurring and being reported, the trust procedures for swab checking and counting had already changed. No new recommendations were made within the report and staff we spoke with were aware of the incident.

- 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.
- The Health Group investigated all reduction of fracture of bone (upper and lower limb) patients who were not able to have an admission to theatre within 36 hours. We reviewed two root cause analysis reports; however, from the reports we reviewed, it was difficult to ascertain lessons learned to prevent the issues from happening again.
- 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 showed a backlog of 168 incidents required review. We discussed this backlog with the senior management

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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, staff investigating incidents were aware of what action needed to be taken to provide staff with feedback.
- Staff we spoke with said that learning from incidents was shared internally through safety briefs during shift handovers, quality and safety bulletins 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.
- On Ward 60, we saw a newsletter produced to share all incidents received for that ward on a monthly basis.
- There was evidence of changes in practice from incidents. For example, there had been an incident in another Health Group with alcohol hand gel; staff we spoke with were aware of this incident and had taken individual ward based actions to identify solutions. On one ward, falls had increased; to manage this staff had placed at risk patients together with a member of staff within the room, to increase observation of at risk patients.
- 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 and having open discussions with the patient about the reasons for cancellation and when patients had acquired pressure area 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 we spoke with 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 we 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.

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- 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.
- Staff on ward 12 had identified in the previous year an increase in pressure ulcers and had developed an educational package, competency-training tool and improved documentation to address this. No avoidable pressure ulcers had been identified since the training had taken place. Following the identification of an avoidable pressure ulcer on Ward 40, staff had undertaken a root cause analysis and had reviewed their own documentation to identify further learning; from this, staff were able to identify specific gaps in documentation.
- The trust reported zero cases of hospital acquired MRSA from July 2015 to April 2016. The trust reported 46 cases of hospital acquired C.Difficile 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 methicillin resistant staphylococcus aureus (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.Difficile 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 and complying with 'bare below the elbows' policies. We also saw staff challenging other staff about whether they had washed their hands.
- Hand hygiene audit data we reviewed showed 94.4% compliance in the reporting period April to June 2016. However, only three wards and three theatres audits submitted data, out of these only two areas 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.
- As the hospital was mainly for emergency surgery, staff did not carry out surgical site infection surveillance. This was completed for knee replacement and cardiac surgery on the Castle Hill Hospital site.

## Cleanliness, infection control and hygiene

- In 2015, the trust was asked to take action to ensure the results of Infection prevention and control (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, the trust had undertaken a significant refurbishment programme of the theatre suite this included undertaking testing of the specialised ventilation.
- Infection prevention and control information was visible on all wards we visited; this information included the number of days since last hospital acquired clostridium difficile (C.Difficile) infection and methicillin resistant staphylococcus aureus (MRSA) isolate.
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- 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 they were 96%, which was slightly below the 98% England average for 2015.
- We reviewed five pieces of clinical equipment and noted these to be clean and labelled.
- 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% below the 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.

## Environment and equipment

- In 2015, the trust was asked to take action to address concerns identified regarding the flooring and walls within theatres. The trust was also asked to review access and waiting areas for theatres and recovery area. During this inspection, we noted major improvements in the theatre environment. Work was still to be completed; however, the work carried out to date provided an improved environment for patients, staff and improved compliance with infection prevention and control standards.
- In 2015, the trust was also asked to review access and security arrangements for theatres and recovery area. This work was yet still to be completed so remained a risk.
- Equipment we reviewed had been electrically safety tested.
- In the majority of occasions, for the resuscitation equipment we checked staff had recorded that checks were completed. However, on ward 10, the trolley was unlocked and the drawers were found to be cluttered and untidy.
- Wards had individual resuscitation checklists to complete on a daily basis, these were stored in a file on wards we visited, to be compliant with the audit wards had to have completed the checks daily and have no more than two checks missing in the month. Scores for the Health Group had improved in the previous months.
- In the Day Surgery Unit, a potential issue with monitoring carbon dioxide levels in stage one recovery was identified. We discussed this concern at inspection and were reassured, by the operating department

recovery staff, that there were procedures in place to make sure patients were safe. Following the inspection we also received written confirmation that the issue was resolved and the monitoring equipment was in place.

- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation.
- Within the Day Surgery Unit, stock was stored on the floor within theatre corridors, a fire escape within this area was cluttered with rubbish and trollies, we reported this at the time of the inspection and staff took immediate action and removed the items.
- The environment within the day surgical unit did not allow a clean to a dirty flow. During the inspection, we witnessed dirty waste leaving theatre through the anaesthetic room corridor passing patients lying on trollies. The theatre suite only had one door entry and exit for patients, we saw post-operative patients pass waiting pre-operative patients.
- We reviewed the trolley used for difficult airway access within the Day Surgery Unit and noted that it was not easy 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 was 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 emergencies.

## 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. On ward four, daily balance checks had been missed on seven occasions in the month of April 2016.
- 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.

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- Emergency medicines were readily available and they were found to be securely stored and in date.
- The majority of medicines fridges were secure, however a fridge on Ward 40, was not locked during the inspection. Temperature records were monitored and maintained in most areas.
- Within the day surgical unit, we found medication for the current patient in theatre left on the worktop whilst a different patient was in the anaesthetic room; this practice had the potential for mistakes to be made when administering medication.

## 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 easy access for staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans.
- We reviewed 30 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 could be locked, or were stored in secure areas.
- The wards and departments used risk assessment records. Those we reviewed showed that documentation for falls and completion of dementia and delirium pathways were not always completed accurately, especially on Wards 12 and 120. We reviewed twelve sets of notes and found that two had been completed correctly; staff were able to explain the process of falls assessments. On the majority of occasions, staff completed pressure care assessments and intentional rounding documentation accurately.
- Completion of venous thromboembolism (VTE) assessment was 77.9% for March 2016 lower than the trust compliance rate of 100%.
- Individualised patient care plans we reviewed on Wards 12 and 120 were not always completed accurately.
- Ward quality assurance audits were carried out on a monthly basis; five sets of notes were audited each week and areas audited included tissue viability, IPC

and patient experience. Staff on Ward 60 had started to involve junior members of staff in the audits; staff we spoke with said that documentation had improved because of the auditing.

## 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%.
- Examples of safeguarding referrals made within the Surgical Health Group included patient neglect identified on admission and patient disclosure of female genital mutilation.

## 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%. On ward 12 over 90% compliance was recorded for all elements of training.
- 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. On ward 60 fire training was rated red with 74% compliance, mental health training was 71% and resuscitation training was 77%. All other aspects of training were rated green.
- 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



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- 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 used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. The hospital reviewed compliance with the safety checklist via audit, with five sets of notes checked every month, for every theatre. Results we reviewed showed 100% compliance, however an internal audit report provided to us by the trust reported 54% compliance in the reporting period November 2015 to January 2016. The report was completed for 50 patients in most specialities, a recommendation from this report (published in March 2016) was to re-audit one month later and set up a working group to review the form. Post the inspection, the trust confirmed that a working group had not been developed and no further audit had been completed. A new theatre assurance tool had been developed since the internal audit results and the results from June 2016, showed 100% compliance for the WHO audit compliance.
- During the inspection, we reviewed 16 sets of surgical notes containing WHO checklists and we observed 15 occasions when WHO checklists were completed. On the majority of occasions the 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 and final brief on two occasions and on another occasion a band two member of staff had signed for the instrument count. It was unclear whether a registered member of staff oversaw this. We also noted that on five occasions no verbal communication occurred on the appropriate use of antibiotic prophylaxis, pre-operative warming, blood glucose 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 clinical trigger response action flowchart outlined in the deteriorating patient policy required staff to escalate to foundation level two medical staff when the patients score triggered five or six. Within surgery, at this hospital, foundation, level two staff were not available and staff were escalating to foundation level 1 staff. The trust carried out internal audits of the NEWS and we noted on average a 96.8% compliance that appropriate action was taken for NEWS of seven 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 23 sets of notes we reviewed we did not see effective escalation of all deteriorating patients. For patients that had deteriorating early warning scores, documentation of escalation and review was available for nine patients, in six patients action was documented as being taken, however this action did not always reflect action identified in the related clinical policy. In six patients that had deteriorated action or escalation was not apparent from the notes. 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.
- We reported our concerns about the escalation of deteriorating patients to the senior management team at the time of the inspection. In the period between the announced and unannounced inspection the trust said they had completed case note reviews on two patients and planned to improve education on the area concerned and planned to implement an e-observations package in this area. During the unannounced part of our inspection, we attended the same ward again, Ward 12, and noted that NEWS charts were not completed accurately on two out of three sets of records reviewed.



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- We had concerns over consultant review of elective orthopaedic patients during June 2016. Evidence we saw showed that ward rounds had only occurred on six occasions. 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, we gave the trust a requirement notice to take action to ensure that there were at all times sufficient numbers of suitably skilled and experienced staff.
- At this inspection, across the surgical wards and departments there were 814.6 Whole time equivalent (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 some vacancies.
- The trust's planned nurse to patient ratios for ward areas was 1:8 day shift, and 1:10 night shift for all surgical wards. The surgical wards displayed for public view the planned and actual nurse staffing levels for each shift.
- The trust used the safer nursing care tool to assess nursing staff requirements per ward and department, per shift. We reviewed the safer staffing report dated May 2016 for surgical wards, and on average, there was a 78% fill rate for registered nursing (RN) staff per day shift and 85% fill rate for night shift. For care staff the average fill rates were 100% for a day shift and 133% for night duty. Data we reviewed ranged between 95% to 66% average fill rate for registered nurse RN day shifts and 92% to 77% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 252 registered nurse shifts reviewed, we saw that 97 shifts were staffed at below the established levels for day and night shifts. Staffing levels we reviewed on Wards 6, 7, 40 and 120 all showed periods of staffing levels below the establishment.
- 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.
- We had concerns about the staffs' understanding of the levels of acuity of patients nursed within the high

observation bay (HOB) and the related staffing levels. Staff we spoke with said the patients were classified as level two critical care patients. National guidance recommends that level two patients have one registered nurse to two patients. However, within the HOB unit, we saw one registered nurse to four patients. The trust's protocol for admission to this area classified the patients as level one and stated a 1:4 staffing level was acceptable. The patients we saw at inspection were all level one.

- The Surgery Health Group was actively recruiting to vacant posts, both local and international recruitment events had been undertaken, an intake of new staff 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 posts were vacant. They also had six; senior nurse and five junior staff nurse vacancies and two health care assistant vacancies.

## Surgical staffing

- For all surgical specialities a consultant was present on site 8am until 6pm Monday to Friday. Acute general

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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 24-hours a day by junior doctors; two registrars were present onsite 8am until 8pm and one present 8pm until 8am seven days a week covering general surgery. Trauma had resident registrars and on call registrars available. All other specialities have on-call registrars available. Core trainee and foundation level doctors were available 24 hours a day, seven days a week. Neurosurgical registrars were on site until 10pm; however, staff we spoke with said that they generally stayed onsite overnight due to new admissions and deteriorating patients. Overnight one junior doctor covered multiple areas without support from foundation level two doctors. Staff we spoke with said that they would contact the registrar if they were concerned.
- An on-call rota for the major trauma team had been agreed; however this had not been implemented at the time of the inspection.
- Trauma meetings were held every morning, to discuss all admissions who had been admitted overnight and any deteriorating trauma patients, prioritisation was then given to patients who were the most unwell and they were reviewed first.
- 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 departments had in their establishment budget monies for 372 WTE surgical medical staff. In post there was 342.7WTE including 152.5 WTE consultants and 190.1 WTE junior doctor and middle grade posts. We reviewed vacancy rates and this showed vacancies of 12 WTE surgical consultants (7.3%), 14.7 WTE junior doctor vacancies (approximately 7%), 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.
- Junior doctors we spoke with said that within vascular surgery significant gaps were apparent in the rota, especially from 5pm until 10pm. Whilst on the vascular ward we were told there was a gap of one week in every five for the 5-10pm timeslot when a junior doctor from other areas covered vascular surgery. Where possible these shifts were made available to locum booking, however not every shift was filled. General surgery registrars covered vascular surgery overnight (including some vascular registrars), with support from on call vascular consultants; the senior management team were aware of the issue.
- All junior doctors we spoke with said that consultants were accessible on an on-call basis; however, they felt there was a gap in experience especially for new juniors in post. They provided examples of the impact of this gap being patients not been clerked and assessed in a timely manner. Some junior doctors we spoke with said about a lack of timely senior review of patients of concern. The senior management team had highlighted on the risk register their concerns over patients not receiving a timely review due to insufficient junior doctor cover, they highlighted to us that all posts were filled for the new doctor intake in August 2016.
- To help address the gaps in the junior doctor rota, nurse practitioner roles had been developed to undertake some of the roles junior doctors undertake; these staff were available within neurosurgery.
- The senior management team were aware of junior medical staff concerns throughout surgery and had undertaken rota reviews to improve the workload and support within general surgery; however, they spoke with us that this review had led to a decreased level of support within vascular and neurosurgery.
- 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.
- Formal medical handovers took place twice a day with informal handovers occurring during the shift when staff changed, we did not observe these during the inspection.
- 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. We saw that only six consultant orthopaedic ward rounds had taken place in the month of June 2016.

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## Major incident awareness and training

- The trust had a major incident and business continuity plan. This was available to staff on the trust intranet.
- Staff we spoke to had an awareness and understanding of their roles in major incidents.

## Are surgery services effective?

Requires improvement



In 2014, we rated surgical services at HRI as 'Good' for effectiveness; this was not inspected during the 2015 inspection. Following the 2016 inspection, we rated surgical services at Hull Royal Infirmary as 'Requires improvement' for effectiveness because:

- National audit performance was variable; the national hip fracture audit 2015 showed that the trust performed worse than the England average for five out of eight indicators. The emergency laparotomy organisational audit 2015 showed that the trust score was worse than the national average for six out of the 11 outcome measures. We saw variable results in the bowel cancer audit 2015 and in the lung cancer audits.
- The trust was a mortality outlier for the reduction of fracture of bone (upper and lower limb).
- When audit results identified areas for improvement, actions plans were not always available or did not include further actions required to meet the recommendations of the report.
- At the time of the inspection, the trust did not provide a dedicated trauma consultant rota.

However,

- Patients' treatment was based on national guidance. Compliance against this guidance was monitored by the trust.
- Policies for the Health Group we reviewed were up to date
- We observed good multidisciplinary working between physiotherapy teams, dieticians, and ward staff.
- Patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Patients were consented for surgery in line with trust policy and department of health guidance.

## Evidence-based care and treatment

- We saw patients' treatment was based on national guidance, such as the National Institute for health and Care Excellence (NICE), the Association of Anaesthetics, and from the Royal College of Surgeons.
- The services 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 hip fracture and neurosurgery pathways. Physiotherapy led pathways were available for spinal surgery. The Health Group recognised that referral criteria within some pathways required standardising, and they were planning to address this in the coming months.
- The Health Group had a local audit programme and these were discussed during audit sessions for the Group.
- Wards and departments we visited took part in the audits of infection prevention and control practices, medication and documentation these audits, known as 3G audits, during 2015/2016. The outcome was that the surgical wards had been rated as outstanding (none), good (four), requires improvement (12) and inadequate (one).
- Some staff we spoke with were not knowledgeable about sepsis pathways and application of the protocol, one patient's notes we reviewed on Ward 60 had not been screened for sepsis despite them deteriorating and meeting the screening criteria.

## 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.

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## 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 a validated Nutrition Screening Tool - nutritional risk assessment documentation. Documentation we reviewed showed good levels of completion.
- Staff we spoke with provided examples of arranging cooked meals for patients for breakfast. However, the trust did not provide access to suitable and nutritious hot food, out of hours, when a patient had been to theatre or was not able to go to theatre. Staff and patients we spoke with said the provision of hot meals was limited, with only snack and cold foods being available after 6pm.
- We observed two meal services on Ward 12 and noted that three out of five patients requiring support with eating did not receive this within five minutes of being provided with warm food. However, on Ward 120 support required with eating was provided in a timely way.
- Patients had access to fresh water where appropriate and the majority of fluid balance charts we reviewed were accurately completed.
- 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.

## Patient outcomes

- At the time of the inspection, the trust was classified as a mortality outlier with the Care Quality Commission for reduction of fracture of bone (upper and lower limb) patients and for cardiac artery bypass graft. This meant that deaths within these two areas had been outside of the expected range. The trust had undertaken a case note review to determine if any of the deaths were avoidable and what lessons could be learnt. The trust had identified actions required to improve outcomes for patients with a reduction of fracture of bone (upper and lower limb), this was followed up by the national mortality team.
- At Hull Royal Infirmary, compared to the England average the risk of readmission following elective

surgery was worse in vascular surgery, about the same in ophthalmology, and better for neuro-surgery.

Non-elective surgery readmission rates were worse/higher than the England average in plastic surgery and about the same in trauma and orthopaedics.

- 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 to detailing improvements required.
- We found that the emergency laparotomy organisational audit 2015 showed that the trust scored worse than the national average (0-49%) for six out of the 11 outcome measures including consultant surgeon review within 12 hours of emergency admission 39% (national average 47%), preoperative review by consultant surgeon and anaesthetist 38% (national average 58%) and a consultant anaesthetist presence in theatre 37% (national average 65%). The trust was only rated green (70-100%) in one outcome measure and that was for direct postoperative admission to critical care. The remaining four outcome measures were all rated as amber (50-79%). 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 at 13.5% than the England average 15.4 %. We requested to review the trust action plan for the audit, an action plan was available; this only detailed two actions including a further audit not the actions required in the recommendations of the report.
- The trust participated in the national hip fracture audit. Findings from the 2015 report showed that the trust performed worse than the England average for five out of the eight indicators. Performance was better than the England average for four indicators. Best practice guidance recommends that surgery is carried out on

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patients with a reduction of fracture of bone (upper and lower limb) within 48 hours following attendance, the hospital performance was worse than the England average with only 49.6% of patients having surgery on the day or the day after admission (England average 72.1%). Data we received from the trust showed a marked improvement in the number of patients having surgery within 36 hours from 32.7% in quarter one 2015 to 69.4% in the quarter ending March 2016. The trust had recruited a trauma co-ordinator who now reviewed patients' access onto the trauma list. We reviewed the trust action plan for the audit and noted that the trust completed RCAs for any cases not operated on in 36 hours; however, due to the information shared within the investigation reports, we were unable to identify how learning from these incidents was being achieved.

- 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 performance against a range of clinical indicators via a performance dashboard. This data included compliance with NICE guidance and national audits.
- We reviewed the trust's trauma unit peer review report 2014/2015. This highlighted a number of areas of concern including the lack of provision of dedicated trauma consultant, dedicated trauma ward and collection of data. Since the peer review, the trust had identified a ward for major trauma patients, and improved education and data collection within the Health Group. An action plan was available and on review showed that and a business case for a major trauma consultant rota had been agreed, but was yet to be implemented.

## 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. All staff we spoke with said they had received an appraisal in the last year and thought these had been beneficial.

- Specific ward based induction was undertake on the orthopaedic wards this involved training on traction, mobility and physiotherapy needs.
- On Ward 40, we saw evidence of speciality based training being undertaken with sessions planned for sepsis, chest drains and orthopaedic trauma.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.
- A teacher practioner was available covering Wards 4, 40 and 70. They had developed induction booklets and training packages and assessments of competency.
- Staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.

## Multidisciplinary working

- There were established multi-disciplinary 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 Surgical 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 on the orthopaedic wards. They also attended ward rounds to review progress or discharge arrangements for the patients. The physiotherapy team also attended neurosurgical pre-assessment meetings to assess a patient prior to admission.
- Physiotherapy staff were integrated into the neurosurgical team and had physio-specific pathways.
- 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 junior medical cover was available seven days a week; consultants supported the on-site medical staff out of hours and were available on an on-call basis.



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- Registrars or foundation level one 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.
- Occupational and physiotherapy services were available seven days a week for neurosurgery patients.
- 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.
- The neurosurgical department has an electronic referrals system for the medical registrars. Staff working in this area said that this system has improved communication and reduced errors.

## 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 said that where this was not possible and due to the nature of the surgery, 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.
- On the neurosurgical unit, individualised care plans were used for the restraint of patients, these included a flowchart to aid decisions when the use of mittens for patients with delirium was being considered.
- 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 HRI as 'Good' for caring; this was not inspected in the 2015 inspection. In 2016 we rated surgical services at Hull Royal Infirmary as 'Good' for caring because:

- The majority of patients we spoke with provided positive feedback about their inpatient stay.
- We saw positive interaction between patients and staff. The short observational framework for inspection (SOFI) we carried out showed that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The NHS Friends and Family test (FFT) response rate was 33% similar to the England average of 31%. There were a high proportion of patients who would recommend the services.

## Compassionate care

- We spoke with 28 patients and three relatives during the inspection. We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.



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- 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.
- 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 33% similar to the England average of 31%. There were a high proportion of patients who would recommend the services data ranged from 88% to 100% in the reporting period March 2015 to February 2016.
- Wards and departments we visited displayed their friends and family results. We saw 96.6% of patients would recommend ward 12 in May 2016, and 85% for Ward 120.
- During the unannounced inspection, we carried out on four wards a short observational framework for inspection (SOFI). Through our observations, we saw that the majority of patient mood states were mainly positive or neutral and interactions with patients were positive.
- The majority of patients we spoke with were happy with the standard of care they received, 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 any call bells ringing for long periods. On Ward 12 we observed five calls bells all going off at the same time, four of these were answered within two minutes.
- We observed staff closing curtains/doors whilst delivering personal care. It was difficult to maintain confidentiality in the day surgical unit as the screening and admissions area did not have a door.
- We observed a therapy assessment session and this was delivered in a patient centred way, with language and tone of voice adjusted for the patient, so they could understand the instructions.

## 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 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.
- During the inspection, we observed a ward round on Ward 12 and witnessed good patient engagement and patient involvement in decision-making. Adequate time was taken to explain the plan to patients.

## Emotional support

- A multi-faith chaplaincy service was available for patients.
- Clinical nurse specialists were available within surgery and attended the wards to provide support and advice to patients and staff
- A psychiatry liaison team from the local mental health trust worked with the hospital and offered support to patients with physical and mental health problems.

## Are surgery services responsive?

Requires improvement



In 2014, we rated surgery services at HRI as 'Good' for responsiveness; this was not inspected in the 2015 inspection. Following the 2016 inspection, we rated surgery services at Hull Royal Infirmary 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 referral to treatment time 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 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.
- We saw mixed sex accommodation provided on the high observation area on Ward 40; this area admitted both female and male patients, patients in these areas were classified as level one dependency patients. National

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guidance indicates that it is acceptable to have level two patients in mixed sex accommodation; however patients who were categorised as level one must not be mixed. The trust's policy stated that level one HOB patients would be mixed sex but every effort would be made to ensure privacy and dignity was maintained in accordance with guidance. The trust said that this was in agreement with the local commissioners.

- The environment in the day surgical unit made it difficult to maintain privacy and dignity; the patient areas were separated by curtains which meant any procedures required or the gaining of consent prior to surgery could be heard by other patients and staff.

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. 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 non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, vascular, general surgery, plastic surgery, neurosurgery. It also provided elective vascular and neurosurgery.
- The Health Group had taken into account of 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 targets (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 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 indicators were not achieved by the trust in February 2016; these were the 31 day drug indicators, the 62 day standard and the 62 day screening indicator.
- A local trajectory for the trust to achieve cancer standards 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 71% for day surgery and 83.6% for main theatres for December 2015 to February 2016. The data ranged from 64.6% to 99.5% usage in the same period.
- 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 at 3.8% than the equivalent period a year early which was 2.4%.
- 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.
- No surgical patients waited over 52 weeks for treatment in March 2016.

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- The average length of stay data was similar (3.4 days) to the England average (3.3 days) for all types of elective admissions. If patients were stable and required longer admission, they were transferred to the Castle Hill Hospital site for further treatment and rehabilitation.
- 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.
- During the inspection, no wards had medical patients located on them (medical outliers).
- Staff provided telephone access to patients for advice and guidance post discharge following surgery.
- 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 who 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 Surgical 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 and support 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 12 were knowledgeable about the needs of patients living with dementia.
- Basic information for staff about patients was identified on boards behind the beds, 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 other equipment was stored on the Castle Hill site as this was the site for planned bariatric surgery. If required on the Hull Royal site, staff were aware of how to arrange transport.
- Discharged patients were given the ward telephone number following discharge to contact staff if they have any concerns post-operatively.

## Meeting people's individual needs

- We observed mixed sex accommodation whilst on inspection in the high observation bay on Ward 40 which admitted both female and male patients. Staff we spoke with said that this was acceptable because the patients were classified as level two critical care patients. However, the trust's protocol for admission into this area indicated that patients were level one-dependency patients as per the critical guidance. This national guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however patients categorised as level one must not be mixed. The patients we observed were all level one. The trust's policy stated that level one HOB patients would be mixed sex but every effort would be made to ensure privacy and dignity was maintained in accordance with guidance. The trust said that this was in agreement with the local commissioners.
- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available; however, on one area (Ward 40) there were no disabled toilets available in the male side of the ward, disabled toilets were only available within the female section of toilets.
- The pre-assessment team or the admitting ward reviewed patient's needs on admission, in regards to hearing difficulties.

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- Staff working in neurosurgery had identified that patients' who were post discharge with neck fractures had additional needs, such as waiting in outpatients departments for long periods was not in the best interests of these patients. Nurse practitioner staff had developed an aftercare programme for 12 weeks to support the patients with visits to a ward for their follow up clinic appointments.
- Adults and children were not separated to receive care in the recovery area of main theatres or within both areas of the day surgical unit. The senior management team was aware of this issue, however due to the provision of specialised ventilation within women's and children's theatres, staff were unable to prevent this occurring.
- Relevant information to patients was displayed on the walls of 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 patient's discharge.
- Two patients out of six spoken with on Ward 120 complained to us about the noise level of the nursing staff on the ward, especially overnight. During the inspection we did hear a high level of noise coming from the nursing office, this could be heard in the patient bays.

## 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 from April 2015 to February 2016. The top three complaint themes 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 surgery services at HRI as 'Requires improvement'. At the 2016 inspection, we saw there had been some improvements however, the rating for well-led at Hull Royal Infirmary remained as 'Requires improvement' because:

- Whilst the Health Group held governance meetings there was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed.
- Although 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.
- 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 to addressing staff shortages in the Health Group.
- We were unable to identify effective documentation of discussions around gaining assurance and removing risks from the register.
- The majority of audits for NEWS and WHO checklists, recorded 100%, however during the inspection we did not see evidence that the clinical practice required to produce 100% audit scores was embedded.

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.

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- There was a risk register in place. Risks for the Surgical Health Group were discussed at the integrated governance meeting and items requiring escalation to the Operational Quality Committee were clearly identified.

## Vision and strategy for this service

- In 2015, the trust was asked to take action to ensure there was 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- 2021. 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 directorate 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 manager 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 Health Group governance 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 Health Group. 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. 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 the 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 controls measures had been identified.

## 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 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.



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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 and they did not always feel supported and listened too.

- The trust had commissioned a review of the trust's spinal surgery service, following a number of near misses and never events. This review was carried out by the Royal College of Surgeons in June 2015. The review highlighted various recommendations which the trust were addressing.
- Most of the wards we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies. On Ward 60 we reviewed the notes of these meetings and found that relevant topics had been discussed for example; nutrition, revalidation of nurses and discharge planning.
- 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 better 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 said that things had improved since the new executive team had been in post.
- One member of senior nursing staff provided an example of where they had been concerned about issue-affecting patients and had highlighted this directly to the Chief Executive and swift action to rectify the issue had been taken.
- Staff spoke about their colleagues in a positive manner.
- Staff spoke with us about feeling able to raise concerns and feeling listened to by their immediate senior team.
- In the previous year the trust had recent a Yorkshire and Humber trainee survey 2015 this report highlighting 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 the rota 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 33%, which was better than the England average of 31%.
- An ex-patient of the neurosurgical unit attended the unit every Friday to talk to patients and families and provided support to people with a brain injury through his charity; this charity had also raised funds for additional equipment for the ward.
- Wards we visited had "You said, we did boards" which highlighted actions taken because of patient feedback, for example, a patient had said they were disturbed at night, the ward had launched a reduced noise at night campaign.

## 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. The trust had a staff award system in place called golden hearts. A neurosurgery consultant won the outstanding clinician award, and a member of the Health Group human resources team won the outstanding individual. The theatre department team leader had recently been awarded the good leader golden hearts award and the surgical service had been awarded the service improvement award.
- 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.
- An international award had recently been awarded to the ophthalmic unit: the ophthalmic unit of the year award 2015/2016. This was awarded for the ophthalmic unit most appreciated by its patients for quality of service.
- The urology services had introduced robotic surgery for prostate cancers in May 2015; this had since been extended to cover colorectal surgery.



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- 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.

# 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 managed the service.

There are two intensive care units (ICU) at HRI. ICU1 had 10 beds and ICU2 had 14 beds. The units are both general/neurosciences units and are adjacent to each other on the same floor. The units are staffed to care for 12 level three patients (who require advanced respiratory support or a minimum of two organ support) and 10 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 showed that between 1 April 2015 and 31 December 2015 there were 1213 admissions with an average age of 59 years. Fifty six percent of patients were non-surgical, 16% planned surgical and 28% emergency or unplanned surgical. The average length of stay on ICU was three days.

A critical care outreach team provided a supportive role to medical and nursing staff on the wards when they were caring for deteriorating patients or supporting patients discharged from critical care. The team was 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 and tracked patients from ICU to the ward. We spoke with five patients, three relatives and 24 members of staff. We observed staff delivering care, looked at 17 patient records and nine medication charts. We observed a nursing handover. 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

We rated critical care as 'Good' overall in 2014 and as 'Requires improvement' overall in 2016 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% national standard of nurses with a post registration qualification in critical care.
- During this inspection, we identified that controls for some of the risks on the risk register were limited and unsustainable. 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 of some of the risks on the risk register.
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.
- We had concerns about the sustainability of the consultant rota as intensivists worked additional shifts. There was no documented evidence that some patients were seen by a consultant within 12 hours of admission, twice daily ward rounds did not take place. Medical staff to patient ratio, during out of hours, exceeded recommendations. This was not in line with guidelines for the provision of intensive care services (2015).
- Planned nurse staffing levels were not consistently achieved and this impacted on the capacity of the critical care units.
- Only twenty five percent of nurses had completed a post registration critical care qualification which was lower than the minimum recommendation of 50%.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams which meant they may not always be immediately available

or on site. They were also part of the cardiac arrest team. We saw evidence of two incidents that had been reported due to the lack of a critical care outreach service.

- We saw evidence during our inspection of patients who were referred to critical care requiring level three care that had not been escalated in line with trust policy.
- 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 mechanisms of collecting patient or relative feedback.

However, we also found:

- 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.
- There was clear nursing and medical leadership on the units and in the critical care outreach team and staff had confidence in the units' leadership.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- We observed patient centred multidisciplinary team working.
- The service showed a good track record in safety. There had been no never events, or serious incidents.

# Critical care

## Are critical care services safe?

Requires improvement



We rated safe as 'Good' in 2014 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, twice daily ward rounds did not take place and the out of hours medical staff to patient ratio was higher than recommended.
- 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 86-97% in the day and 80-92% at night which included the use of bank and agency staff due to high levels of vacancies. This meant that planned staffing levels were not consistently achieved. Nursing documentation included quality and safety checklists, we found numerous occasions where these checklists had not been completed at night.
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams which meant they may not always be immediately available or on site. They were also part of the cardiac arrest team. Staff worked within the challenge of the environment but space and storage was clearly an issue.

However,

- 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 113 incidents between 1 January and 31 March 2016; 77% of these were graded as no harm, 19% as minor harm and 4% as moderate harm. The moderate harm incidents related to unavoidable deep tissue pressure damage. Themes of the minor and no harm incidents were low staffing levels, 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.
- Junior medical staff told us they received useful feedback after reporting an incident.
- A safety briefing formed part of the nursing handover; we observed one during our inspection and issues that were discussed included learning from incidents, safeguarding, treatment limits and patients with confusion or delirium.
- 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.
- Senior staff gave us an example of when they had applied the duty of candour following an incident of moderate harm.

# Critical care

- 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 unit displayed safety thermometer information visible to staff and visitors.
- Data for the units from July 2015 to May 2016 showed between 83% to 100% harm free care on the day the data was recorded.

## Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to visitors prior to entering the unit.
- All areas on the unit were clean and tidy.
- Equipment was visibly clean and was labelled with the date it had been cleaned.
- ICNARC data showed ICU2 had 5.1 unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2015. This was significantly higher than similar units; we discussed this with medical staff who explained this figure included patients who had an invasive line and may have been cared for on a ward prior to admission to critical care.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- There was evidence in the record that ten out of 13 patients we reviewed had been screened for MRSA in line with trust policy.
- 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 86% compliance in ICU1 and 89% compliance

in ICU2. The results showed concerns about commodes, dust, storage of equipment and the catheter algorithm, however, no comparative results or action plan were provided.

- Records for flushing taps to prevent Legionella were not available to view on ICU2; the records on ICU1 had not been completed since 7 June 2016.
- 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 environment did not comply with national building standards (HBN04-02 guidance on designing critical care units, including bed space requirements and the location of a unit in a hospital), however, this was noted on the risk register in line with guidelines for the provision of intensive care services (2015) and due to be reviewed the month following our inspection.
- 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 showed three gaps in the four weeks prior to our inspection.
- Disposable items of equipment were stored appropriately. We found more than 10 pieces of out of date plastic disposable equipment; these were dialysis and cannula accessories and adaptors. The nurse in charge addressed this immediately and removed the items.
- The service kept up to date environment and equipment maintenance records.
- We checked over 40 pieces of electrical equipment; all of them had up to date safety test stickers on.
- Staff told us they did not experience delays in obtaining equipment or with equipment maintenance.
- 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.

# Critical care

- There was a lack of storage space on both units. At the time of our inspection one of the bed spaces on ICU2 was being used as a storage area and the linen cupboards were used to store items other than linen, for example communication boards.
- During our inspection we observed that one of the fire exits was partially blocked with chairs. Senior staff told us some staff had recently completed simulation training that involved fire evacuation and the training had been put into practice during a recent evacuation due to a fire on the floor below.
- 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%. Within 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.

## 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.
- Emergency medications were stored in a sealed container in the drug fridge.
- 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 nine medication records. Eight had been completed in line with national and trust guidance; on one record the doctor's instructions whether to continue with a medicine was unclear.
- 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 for 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 a 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.

## 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



# Critical care

- The critical care outreach team was available 24 hours a day, seven days a week. The team consisted of senior nurses who were supported by a consultant intensivist for one session a week. They supported patients stepped down from critical care and reviewed patients alerted to them through the NEWS referral system. The team also supported patients nursed on wards with tracheostomies, delivered non-invasive ventilation outside of critical care units and were a member of the cardiac arrest and trauma team.
- 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 4,671 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 1,368 patients from both units. 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.
- We had concerns that the escalation of NEWS on some wards was not in line with trust policy and there was a lack of treatment escalation plans completed by ward staff. We saw two patients during our inspection that were referred to critical care requiring level three care that had not been escalated in line with trust policy. When critical care staff reviewed these patients their assessment found them to be inappropriate for admission to critical care. The critical care outreach team had been involved in work to address this with the resuscitation and deteriorating patient committees and a trial of electronic observations had taken place on some wards.
- Patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.
- At the beginning of their shift, we observed staff completing bedside safety checks.
- We observed a support worker immediately seek advice from a member of the senior team when a patient's ventilator alarm sounded.
- The units accepted paediatric admissions while waiting for the dedicated intensive care transport service for

children. This was approximately 30 admissions a year. One intensivist was a paediatric anaesthetist and there was a paediatric link nurse. The unit had appropriate, in date paediatric equipment and a resource file.

- During our inspection, we followed the transfer of a patient with a new tracheostomy from critical care to a ward. We found the tracheostomy care bundle had not been completed by the agency nurse or the co-ordinator on discharge from critical care. This was a risk to patient safety as the date of the tracheostomy and the size of the tracheostomy tube was not documented. The nurse on the ward had received training to care for patients with a tracheostomy and had set up the appropriate safety equipment.

## 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 one nurse to two patients' ratio for level two patients.
- The units displayed the planned staffing figures; however, the actual staffing figures were not on display.
- 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 across the trust 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 86-97% in the day and 80-92% 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 trust used an agency that supplied staff that were trained in critical care. The units made block bookings of regular staff to work on the unit. Senior staff told us agency staff received an induction to the unit; however, there was no record to show an induction had taken place. Agency staff worked in a bed space adjacent to trust staff for support.

# Critical care

- The units employed trust bank staff who had previously worked on the units. The use of bank and agency staff was not greater than recommendations in the guidelines for the provision of intensive care services (2015).
- The critical care outreach team was staffed by one nurse on site 24 hours a day. The member of staff was part of the trauma and transfer teams 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.
- We observed a unit handover where clear patient information was provided. The nurse coordinator allocated nurses to patients and considered continuity of care and the experience and skill mix of the staff.

## Medical staffing

- Critical care had a designated clinical lead consultant.
- 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.
- Overnight and at the weekend the consultant to patient ratio exceeded the recommended 1:8 to 1:15 as one consultant covered both units.
- There was no evidence that consultants completed twice daily ward rounds which was not in line with the guidelines for the provision of intensive care services.
- Two anaesthetic trainee doctors were on site overnight; one was based on the unit and was supported by the on-call consultant intensivist.
- 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.
- Senior staff described the process to manage peaks in demand. This included a clear risk assessment with decisions made by senior staff in conjunction with bedside staff.
- Staff knew how to access the major incident and continuity plans on the intranet.

## Are critical care services effective?

Good



In 2014 we rated critical care services as 'Good' for effective. In 2016 we rated effective as 'Good' because:

- Care and treatment was planned and delivered in line with current evidence based guidance.
- Most patient outcomes were in line with 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 units had an up to date delirium policy.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.

# Critical care

- The trust's tracheostomy care bundle and resources were in line with National Tracheostomy Safety Project guidance.
- The units were participating in the provision of psychological support to people in intensive care (POPPI) research project. This was a national randomised controlled trial to find out if psychological training for nurses improved patients' well-being after a stay in the intensive care unit.
- The physiotherapy team completed a national rehabilitation outcome measure 'Chelsea Critical Care Physical Assessment Tool' a scoring system to measure physical morbidity in critical care patients.
- A physiotherapy lecturer practitioner planned to undertake a study to understand the physical problems patients suffered on the ward following a stay in critical care.
- The critical care outreach team worked with staff on the units to complete an unplanned admission to critical care audit and a readmission within 48 hours of discharge audit.

## Pain relief

- A pain management specialist nurse visited the unit and reviewed patients who were receiving pain relief infusions. Staff referred other patients that would benefit from review.
- The service had a pain link nurse who attended relevant meetings and training.
- We observed staff assessing pain using the trust scoring system and giving support to patients who required pain relief.
- Two patients told us their pain was well controlled, that staff regularly checked their levels of pain and that they did not have to wait for additional medications if they needed them.

## 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 dietitian was not available.
- A dietitian visited the unit daily. We were informed a speech and language therapist attended the unit when staff referred patients.

- During our inspection we observed water was available and within reach for patients who were able to drink.
- A white board in the patient kitchen showed details of specific patients' dietary requirements. High protein and high calorie snacks were available for patients.

## Patient outcomes

- We reviewed the intensive care national audit and research centre (ICNARC) data from 1 April to 31 December 2015; the risk adjusted acute hospital mortality was 1.02. This was in line with similar units.
- The units had a 1.8% unplanned readmission in 48 hours rate. This was higher than the 1.3% 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 76.9% of nurses and 62.5% of additional clinical services staff on the units had received an appraisal. This was worse than the trust target of 85%.
- The unit 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

# Critical care

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.
- The trust supported trainee ACCPs to complete an advanced practice module at a local university, advanced life support, faculty of intensive care medicine and non-medical prescribers training.
- Nursing staff told us they had been supported to attend training courses on respiratory care, renal care and completing a root cause analysis.
- Some support staff had been trained to set up ventilators ready for patient use and take patient observations with supervision.
- Teacher trainers, critical care outreach and physiotherapists delivered the Hull interdisciplinary tracheostomy course. The course was due to be advertised externally at the time of our inspection.
- Senior staff had completed a debriefing course to support staff following traumatic events.
- 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.
- Two physiotherapy teams worked on the units; one for neurosurgical patients and one for general critical care patients. Nurses told us they had access to occupational therapy and speech and language therapists when required. A dietitian and pharmacist visited the unit daily.
- We saw in records that when staff made referrals to the multidisciplinary team they responded promptly within 24 hours.

- There was no microbiology ward round due to lack of resource; however, staff could access microbiology advice when required.
- A ward clerk worked two hours on each unit Monday to Friday. At the time of our inspection there was no cover for sickness or weekends, however, recruitment for additional ward clerk support was underway.
- Each unit had a full time ICNARC data entry coordinator.
- Senior staff were supported by a secretary who completed administration work for the unit, follow up clinic and the patient support group.
- Both physiotherapy teams had introduced weekly rehabilitation ward rounds with consultants and goals were documented in the patient record. One of the five records for patients who had been on the units for more than 10 days we reviewed had an up to date rehabilitation goal documented. This suggested the practice had not yet been embedded.
- Staff referred patients to the trust's rehabilitation consultant for review when a need was identified.

## Seven-day services

- A consultant intensivist was available and completed a ward round 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

- The ward clerk admitted and discharged patients on the trust's electronic patient management system. If a patient was to self-discharge they would send an electronic discharge summary to the patient's GP.
- 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.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

# Critical care

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- 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.
- Junior medical staff reported mental capacity was assessed as part of the daily review. This section of the patient record had not been completed on 19 out of 20 days in one of the records we reviewed.
- MCA training information provided by the trust was not site specific. The trust target was 85%. Across 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%. Across 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 was applicable for critical care. Staff were aware of the restraint policy and could explain the process they would follow if mittens were needed to be used for patient safety.
- During our inspection one patient was wearing mittens. Staff had completed a delirium assessment on the patient. The guideline for the use of hand mittens in neurosurgical patients in the patient's record was out of date (due to be reviewed in 2005). The record also contained an up to date individual risk assessment and observation chart, however, these had not been fully completed. We observed staff had removed the mittens the following day as the patient was more settled.
- A member of security staff was undertaking patient watch duty with one patient on the unit. They told us they had received a full day of training for this role.

## 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 most patients was positive about the way staff cared for them.
- 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.
- Staff showed a good understanding of end of life care. Patients, relatives and received support from chaplaincy staff.
- Staff had been nominated for trust awards 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.
- Most patients we spoke to were very happy with the care they had received. They described the staff as kind, caring and helpful. They felt safe and able to ask for anything they may have needed.
- Staff had been nominated for trust awards for examples of care such as arranging a wedding on one of the units in an hour and a half and arranging an end of life patient's transfer home so they were able to pass away in their own environment.

## 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 in the records where patients and their relatives had been involved in making decisions about their care and treatment.



# Critical care

- We observed staff explaining to patients and visitors what was happening during care delivery.
- One patient with a tracheostomy who was unable to communicate verbally informed us they felt communication from staff on the unit was good.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff told us they received a good level of support from the specialist nurse for organ donation. We observed staff contacting the specialist nurse for advice.
- During our inspection we observed staff fully involving relatives in decisions about changes to treatment plans.

## 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.
- During our inspection we observed a chaplain visit the unit. Staff welcomed them and they visited a patient and their relatives.
- We observed staff respond appropriately to the emotional needs of relatives.
- Staff showed a good understanding of end of life care. We observed a patient being moved from the main ward area to an individual cubicle to maintain dignity at the end of life. The patient was transferred by experienced members of the nursing team.
- A former patient's spouse had set up a critical care patient support group that met regularly and offered telephone support to patients or relatives when they needed it.
- 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'. At the 2016 inspection the rating was 'Good' 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.
- There had been no mixed sex accommodation breaches 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 42 cancelled elective operations across both sites due to a lack of critical care capacity.

## 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 2 and 3 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. Staff could meet visitors in private by using the separate quiet room; this had just been decorated at the time of our inspection. 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



# Critical care

the service. We saw evidence in a patient's record that an interpreter had been present when the consultant had discussed resuscitation with a family of a patient who lacked capacity.

- Staff could access leaflets in different languages if required.
- Staff told us they felt able to support patients with dementia and learning disabilities and would seek support from the nurse in charge on the unit if they needed it.
- The chaplaincy team visited the unit regularly and staff told us they were able to meet patients' multi faith needs.

## 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.
- Records for two patients showed staff recorded the time of the decision to admit the patient to critical care; both patients arrived in critical care within four hours. This was in line with guidelines for the provision of intensive care services (2015).
- Information provided by the trust showed that between March and May 2016 the average bed occupancy for ICU1 was 78% and 71.5% for ICU2. This was lower than the England average. However, senior staff told us the bed occupancy data was based on a number of level 3 beds that they were unable to staff and was not an accurate reflection of the units activity.
- 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 no mixed sex accommodation breaches;
  - The ICNARC data from 1 April to 31 December 2015 showed the unit had transferred 0.6% patients due to non-clinical reasons. This was not in line with guidelines for the provision of intensive care services (2015); however, this was in line with similar units and the network average.
- The ICNARC data from 1 April to 31 December 2015 showed the delayed discharge rate was 2.4%. This was lower than similar units' rate of 4.6%.

- The ICNARC data from 1 April to 31 December 2015 showed the out of hours discharge to the ward rate was 1.8%. This was lower than similar units' rate of 2.6%.

## 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 trust provided a copy of a complaint received in March 2016. The response included an apology and an investigation into the concerns raised in the 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 able to make changes to their practice.

## Are critical care services well-led?

Requires improvement



At the 2014 inspection we rated well led as 'Good'. In 2016 we rated well led as '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.
- Staff gave us examples of a lack of action of 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.
- We identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.
- The service had limited mechanisms of collecting patient or relative feedback.

However,

# Critical care

- 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.
- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions.
- 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 were proud that the units had maintained good outcomes in the ICNARC data despite the challenges they faced with staffing and the environment.
- 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, risk to

services and patient safety due to nurse vacancies and non-compliance with building guidance. The risk register showed that limited controls were in place to mitigate these risks.

- Staff gave us examples of a lack of action of 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.
- During our inspection we identified risks to the service that were not on the risk register. For example, non-compliance with guidelines for provision of intensive care services (2015), particularly a rehabilitation after critical illness service, critical care outreach staffing and service suspension and lack of escalation of NEWS scores.

## 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.
- 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.
- A small number of staff raised concerns about the lack of support that was offered by some senior staff members during times of pressure. However, during our inspection we observed senior staff offering support to staff at a busy and stressful time on one of the units.
- 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 senior managers in the trust assisting in patient transfers from other areas of the hospital to critical care when they had been made aware there was no capacity in critical care.

# Critical care

- 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.
- Junior medical staff told us they felt supported by consultants at all times.

## 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 to be able to give holistic care 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.
- Senior staff had worked to reduce sickness in the service, information provided by the trust showed registered nurses sickness was 4% and other staff 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.
- A patient and 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.







## Staff engagement

- Senior staff acknowledged the psychological needs of their staff. Staff had the opportunity to have post traumatic incident debriefing sessions. The consultants were involved in and actively instigated this process.
- Regular staff meetings were held. We saw evidence in the minutes that incidents, training, clinical supervision and equipment were some of the topics discussed.

## 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 (ACCPs). Feedback from the ACCPs 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.

# Maternity and gynaecology

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 offered a range of maternity services for women and families within the hospital and community setting across Hull and East Yorkshire. Services ranged from specialist care for women with increased risks to a home-birth service and midwifery led care for low risk pregnancies.

The labour ward had 15 delivery rooms and a four bedded recovery area for women following an elective caesarean section. The delivery rooms were used for low risk midwife-led deliveries and higher risk consultant-led deliveries. One of the delivery rooms had a birthing pool. There was direct access to two obstetric theatres from the labour ward.

There were 16 teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics, general practitioner (GP) practices and children's centres.

Antenatal care was provided on ward 33 (Maple ward) which had 25 beds. Postnatal care was provided on ward 31 (Rowan ward) which had 32 beds and provided transitional care. A midwifery-led antenatal day unit (ADU) provided care for women from week 16 of pregnancy

Gynaecology inpatient services were provided on ward 30 (cedar ward) which had nine inpatient beds and a 10-bedded day unit for day case procedures. A nurse-led emergency gynaecology unit was available to women with acute gynaecology problems. A nurse-led early pregnancy unit (EPAU) was available for women up to week 16 of pregnancy.

The maternity service at Hull and East Yorkshire Hospital NHS Trust delivered 5,221 babies between January 2015 and December 2015.

The service offered medical and surgical termination of pregnancies (TOP). Between April 2014 and March 2015 the service carried out 507 medical TOP and 625 surgical TOP.

During our inspection we visited the labour ward, maple ward, rowan ward, the antenatal day unit, cedar ward, the early pregnancy unit, antenatal clinics and obstetric theatres. We spoke with 12 women, and 42 staff including senior managers and service leads, ward managers, midwives, community midwives, consultants, doctors, nurses, anaesthetists, midwifery support workers, administrators and domestics. We reviewed 14 sets of maternity records and a further 10 sets on our unannounced visit.

In February 2014 CQC carried out an announced comprehensive inspection and found the overall rating of the service was good. However, the safe domain was rated as required improvement because the availability of consultants on the labour ward was below the national recommendations. In May 2015, CQC carried out an announced focused inspection to review medical and midwifery staffing and safeguarding training. The service was rated as good.

# Maternity and gynaecology

## Summary of findings

At the comprehensive inspection in 2014 we rated the service overall as 'Good'. At the 2016 inspection this changed and overall we rated maternity and gynaecology services as 'Requires improvement'.

- We found process for recognising deteriorating patients were not always reliable. It was not clear from observation charts how frequently observations should be repeated if a patient was unwell.
- The service did not meet the national benchmarking for midwifery staffing. Data was not collected on the number of women who received 1:1 care in labour to provide assurance about midwifery staffing levels.
- We found that some governance arrangements did not always allow for identification of risk.
- Lessons learnt following a recent never event were not embedded.
- We found that in some areas the approach to service delivery was reactive especially in relation to how the service had implemented the Growth Assessment Protocol (GAP).

However:

- Clinical areas were clean and tidy with sufficient equipment to meet the needs of patients.
- Patient outcomes were in line with national averages when compared to similar services.
- Women spoke positively about their experience and said they felt well supported and cared for.
- The trust had engaged with the public and sought their views over the development of the midwifery lead birthing unit.
- We saw strong leadership at a local level. Staff felt supported and felt that their concerns would be listened to.

## Are maternity and gynaecology services safe?

Requires improvement



At the previous CQC inspection we rated safe as 'Good'. At the 2016 inspection this rating had changed to 'Requires improvement' because:

- The service had not provided assurance that lessons had been embedded following a recent never event.
- We had concerns that the system in place for recognising deteriorating patients was not robust. It was unclear from observation charts how frequently observations should be repeated leading to staff using their clinical judgement.
- The service did not meet the national benchmarking for midwifery staffing. The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ratio of 1:28. Between January 2016 and March 2016 the ratio of midwives to births was 1:32. The service did not collect data on 1:1 care in labour and therefore did not have assurance about midwifery staffing levels.
- Actual staffing levels on Rowan, Maple and Cedar ward were below planned staffing level.
- We found guidelines for safeguarding children were out of date.
- Records and confidential patient information was not also stored securely.

However:

- Clinical areas were clean and tidy and we observed good practice in relation to infection prevention. The service scored well on cleanliness audits.
- Medications were stored securely in appropriately locked rooms and fridges. Fridge temperatures were checked and recorded daily.

### Incidents

- The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trusts

# Maternity and gynaecology

electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.

- Between May 2015 and April 2016 there were 991 incidents reported within maternity and gynaecology services to the National Reporting and Learning System (NRLS). 890 (89.8%) resulted in no harm, 59 (6%) resulted in low harm, 38 (3.8%) resulted in moderate harm, 3 (0.3%) resulted in severe harm and 1 (0.1%) resulted in death. Themes of incidents reported included: staffing resources, shoulder dystocia, 3rd/4th degree perineal tears and post-partum haemorrhages (PPH).
- There were 14 serious incidents reported to the NHS strategic executive information system (STEIS) between May 2015 and April 2016. There was no apparent theme to the incidents. Examples of incidents reported included unplanned maternal admission to intensive care unit. For each serious incident the service completed a root cause analysis (RCA). A root cause analysis is a structured method used to analysis serious incidents.
- We reviewed three RCA and found actions plans and lessons learnt were identified in line with the serious incident framework guidelines 2015. For example, ensuring accurate completion of fluid balance charts and correct recording of observations on MEOWS charts. Actions included providing feedback to staff.
- 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.
- In maternity and gynaecology services, between May 2015 and April 2016 there had been one never event reported.
- The never event related to a retained foreign object post procedure in October 2015. We reviewed the RCA and subsequent recommendations, which included supervisory investigation of the staff involved, feedback on lessons learnt, assessing the feasibility of introducing plastic bags used in theatre to count swabs and embedding the culture surrounding swab counting.
- As an immediate response the service introduced a sticker to record pre and post swab counts and wrote to all midwifery and medical staff to ensure they followed the correct procedure. The service introduced new perinatal records which included a section for recording pre and post procedure swab counts. We reviewed 15 sets of records where women underwent a perineal repair and found that pre and post swab counts were not completed in nine sets.
- The service produced a video following the never event that was used as part of a training package to support lessons learnt from never events within the organisation. 11 midwives, five midwifery assistants and two student midwives had completed the training. We asked staff about lessons learnt from incidents, only one midwife referred to the never event. We were not assured that learning from the never event had been embedded.
- Senior midwives and medical staff held weekly maternity case review meetings to discuss individual cases and identify lessons learnt. Examples of incidents discussed in February 2016 included, post-partum haemorrhages (PPH) over 1.5 litres, admissions to intensive care unit (ICU) or high dependency unit (HDU), shoulder dystocia, still births, and unexpected transfer to neonatal intensive care unit. A written summary of the meeting was placed on HEY247 (intranet) so all staff could review any learning points.
- Staff were able to give examples of lessons learnt from incidents. For example, one observation chart was now used for women attending antenatal clinic rather than using a separate observation chart for each attendance. This enabled staff to monitor any changes or trends in a woman's blood pressure.
- Staff said feedback from incidents was shared in a number of ways including; ward meetings, HEY247 and face to face feedback. Staff said labour ward discussed 'topic of the week' at handover to share any lessons learnt. We observed a handover on labour ward and the 'topic of the week' was not shared.
- Maple and Rowan ward had a monthly newsletter that was emailed to all staff and included lessons learnt from incidents and complaints. We saw examples of the ward offering an education session to midwives to update staff on the situation, background, assessment, recommendation (SBAR) handover tool. This was in response to three separate incidents reported because the SBAR tool was not fully completed when women were discharged to the community midwifery team.



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- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). We reviewed the minutes from these meetings and found outcomes from serious case reviews were discussed and recommendations were made to improve care and treatment.
- 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 spoke about duty of candour and understood the importance of being open and honest with patients. Staff were able to give examples of when the duty of candour had been applied for example following a medication error. It was also evident in the serious incident investigations we reviewed that the duty of candour had been applied.
- The labour ward did not submit or display the maternity safety thermometer, however, we did see information displayed about key performance indicators including; the number of post-partum haemorrhages, the methods of delivery and the number of episiotomies.
- Between January 2016 and March 2016 the service used the maternity safety thermometer to survey 116 women. The report showed that on average 70% of women experienced harm free care and 76% of women perceived feeling safe. When compared to data collected between May 2015 and July 2015 the percentage of harm free care and perceived feeling of safe had deteriorated. For example between May 2015 and July 2015, 79% of women experienced harm free care and 88% of women perceived feeling safe.

## Cleanliness, infection control and hygiene

### Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- The full safety thermometer was not displayed on the wards we visited. Wards only displayed information on the number of falls and pressure ulcers. At the time of our inspection, no falls or pressure ulcers were reported on any of the wards we visited.
- We reviewed safety thermometer data for ward 30 and found the percentage of harm free care reported in April and May 2016 was 100%. In June 2016 the percentage of harm free care fell to 89%.
- The maternity safety thermometer allowed maternity services to monitor and record the proportion of mothers who have experienced harm free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a check used by midwives and doctors to assess the health of a new-born) of less than seven at five minutes and those who are admitted to a neonatal unit.
- From June 2015 to June 2016 there were no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA), two cases of Clostridium Difficile (C. difficile) and one case of Methicillin Sensitive Staphylococcus Aureus (MSSA) within maternity and gynaecology.
- The service completed a RCA for each case of C. difficile to identify any lessons learnt. Examples of lessons learnt included educating all doctors within obstetrics and gynaecology on the importance of contacting microbiology before prescribing certain antibiotics and ensuring women were promptly isolated.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of the ward and there was clear signage encouraging visitors and staff to wash their hands. We observed staff encouraging visitors to use hand gel when they entered clinical areas.
- In April 2016 the infection, prevention and control team carried out an audit of the labour and delivery ward. The audit compared current practices against 40 infection control standards. The ward was not compliant with 13 standards. Areas identified as not compliant included, the storage of equipment and supplies, the management of sharps, clean equipment been appropriately labelled and the management of clinical waste. The audit did not include an action plan or any recommendations. The labour ward since employed ward hygienists who were responsible for the cleanliness of the ward and kept cleaning rotas up to date.

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- Weekly cleanliness reports were submitted for all clinical areas. In March 2015, the labour ward achieved 99.5% compliance, gynaecology theatres were 99.1% compliant and Rowan Ward was 99.2% compliant.
- We observed staff using personal protective equipment when required, and they adhered to 'bare below the elbow' guidance. Women we spoke to said they had observed all disciplines of staff washing their hands and using hand gel.
- Single rooms were available in all areas if a patient needed to be isolated.
- All areas we visited appeared visibly clean, staff cleaned equipment after use and used green cleaning assurance stickers to indicate it was clean and ready for use.
- Cleaning rotas were displayed in all delivery rooms on the labour ward. We looked in four delivery rooms including the birthing pool and saw the cleaning rota was up to date.
- All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% in June 2016.
- Treatment rooms in the antenatal day unit had cleaning checklists that were completed and up to date.
- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- Women were screened for MRSA before undergoing elective caesarean sections as part of the pre-operative assessment.
- We saw evidence in records of women been offered the seasonal flu vaccination at antenatal appointments.
- In the 2015 CQC Maternity Survey, the service scored 9.2 out of 10 for the cleanliness of rooms and wards and 8.7 out of 10 for the cleanliness of toilets and bathroom facilities. Both results were similar scores to the England average.
- All staff groups were above the trusts target of 85% for infection, prevention and control training with the exception of medical staff who were 83.3% compliant.
- television (CCTV) cameras were installed at the entrances to the labour ward, Rowan ward and Maple ward. This complied with Health Building Note 09-02 – Maternity care facilities (2013).
- There was adequate equipment on the wards to ensure safe care; staff confirmed they had sufficient equipment to meet patients' needs. Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour.
- Specialist equipment for women with a high body mass index (BMI) was available when required
- There were two dedicated obstetric theatres located just off the labour suite, this enabled easy access.
- We checked 12 pieces of equipment including; blood pressure machines, infusions pumps, cardiac monitors and suction machines. All equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing.
- Each directorate had a planned preventative maintenance programme which identified the frequency of equipment testing.
- The labour ward was situated on the second floor and could be accessed via a lift or stairs. Midwives had a priority key for lift access that could be used in an emergency so women could quickly access the ward. Staff said this was tested on a regular basis.
- The labour ward had 15 delivery rooms and a four bedded recovery bay for women who had undergone an elective caesarean section and fitted the criteria for enhanced recovery. All the delivery rooms had en-suite facilities and a wet room. Delivery rooms 1 to 5 were used for women with higher risk scores as they were closer to the nurse's station. Rooms 10, 11 and 12 were used for women at lower risk.
- A birthing pool was available on the labour ward; safety nets were stored in the room. Staff ran yearly emergency pool evacuation simulation as part of their mandatory training.
- The labour ward had a separate room for bereavement and for women and their family, who were experiencing the loss of an infant.
- Resuscitation trolleys were easily located on the main corridors in each of the areas we visited. We checked the adult resuscitation trolleys in all the clinical areas and found daily checks had been completed in line with best practice in all clinical areas with the exception of Beech ward. We found three days in June and two days in April when staff had not completed daily checks.

## Environment and equipment

- All entrances to the labour ward, Rowan ward and Maple ward were locked and admission was only possible via a telecom system. Staff and visitors gained entry and could only exit via a swipe card system. Closed-circuit

# Maternity and gynaecology

- The labour ward had emergency neonatal trolleys and obstetric trolleys outside of delivery rooms for women who were in labour. This ensured any emergency equipment was accessible.
- Daily checks for neonatal resuscitaires on labour ward were completed. However, we found one neonatal resuscitaire on rowan ward that had two days in June where daily checks had not been completed.
- The neonatal unit was situated in close proximity to the labour ward. Staff we spoke with informed us that paediatric staff could attend emergencies quickly.
- Cedar ward had nine inpatient gynaecology beds and a 10-bedded day unit for day case procedures.
- Patient led assessments of the care environment (PLACE) assessed how the environment supported patients' privacy and dignity, food, cleanliness and general building maintenance. The service completed PLACE audits on cedar, rowan and maple ward in June 2016. The audit results were positive and found that the environment on the wards supported good care. A PLACE audit was not undertaken on the labour ward.
- The labour ward did not have a formal handover room. Staff used an empty delivery room leading to staff having to stand.

## Medicines

- Maternity and gynaecology services did not report any serious incidents relating to medication errors that resulted in serious harm.
- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- We checked the storage and administration of controlled drugs in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded.
- Intravenous fluids were securely stored in all the clinical areas we visited.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge temperatures were checked and recorded daily. There were no gaps in recording.

- Staff understood their responsibilities for raising concerns if the fridge temperature went out of range and said they would contact pharmacy.
- We checked 16 prescription charts and found these had been fully completed, patients were getting their medication promptly and any allergies were clearly recorded. We found one chart where a dose was omitted and it was not documented why this was not administered.

## Records

- Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GP's. Results from antenatal tests were documented in these records.
- The service used paper records and had recently introduced new documentation from the perinatal institute.
- Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.
- Each month a supervisor of midwives (SOM) undertook a spot check record audit of five sets of records. The results were reported at the monthly SOM meetings and any trends or good practice were disseminated to clinical areas. The records were randomly selected from the maternity case review meetings and audited against 20 specific aspects of antenatal, intrapartum and postnatal care.
- Medical records on the labour ward and maple and rowan ward were stored securely in line with the trusts data protection policy.
- The 'fresh eyes' approach was used to review CTG's and we saw evidence of this in patient records.
- We reviewed 14 sets of records and found each woman had a named midwife responsible for their care, individualised care plans for pregnancy and labour were documented and VTE risk assessments were completed.
- On rowan ward we found a folder stored behind the nurses station that contained confidential information relating to the perinatal mental health liaison team. The folder contained 11 letters for 11 different women. There was a risk that this confidential sensitive information could be accessed. We informed the ward manager who moved the folder and assured us it would be stored securely.

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- Records were not securely stored on the day unit on cedar ward. Records were kept in a trolley behind the nurse's station, this was often unattended. We also found unattended medical records left out on the nurse's station. There was a risk that people could easily access confidential patient information.

## Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding women and children and worked alongside staff to ensure that systems and processes were in place.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- All midwives could make safeguarding referrals via an electronic referral system. Staff were able to give us examples of safeguarding referrals made including domestic abuse and female genital mutilation (FGM). Purple forms were placed in women's records to highlight any safeguarding referrals; we saw evidence of these forms in patient records.
- Training records showed 88.6% of nursing and midwifery staff and 84.6% of medical staff in the Family and Women's Health Group had completed safeguarding children level 2 training.
- Additional information provided by the trust showed 100% of nursing staff in gynaecology had completed safeguarding children level 3 training; however 0% of medical staff had completed the training. In obstetrics, 73.6% of midwifery staff had completed safeguarding level 3 training, no information was provided for medical staff in obstetrics.
- The trust had a policy in place for the management of women with female genital mutilation (FGM) and their new-born infant. The trust reported each case to the Family and Women's Health Group Board via the Divisional Monthly Report and submitted data on the number of cases of FGM to the Department of Health. From January 2016 to the time of our inspection, 13 cases of FGM were reported.
- The labour ward displayed a poster with information about FGM and highlighted the mandatory reporting duty and what staff needed to know.
- FGM training was included in the caring for vulnerable women study day. In total 194 midwives out of 218 midwives had attended the training. This equated to 90%.
- Caring for vulnerable women study days had introduced the topic of Child sexual exploitation (CSE) in June 2016, this included trafficking and modern day slavery. To date, 12.7% of midwives had completed the training. The remaining midwives were allocated to training dates later in the year. The service was due to commence CSE briefing sessions in October 2016.
- The service did not have any routine questioning or formal risk assessment for patients where CSE was suspected. Staff said they would be able to identify the signs of CSE. There was no written information available on CSE; staff said they would print information from the internet.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The overarching policy for children was called 'Policy for situation where abuse or neglect of children is suspected'. However, four specific guidelines we reviewed on the trust's intranet were out of date including:
  - 'Safeguarding children: children and domestic violence' expired in September 2015.
  - 'Safeguarding children in whom illness is fabricated or induced' expired in June 2015.
  - Safeguarding children: managing allegations or concerns against staff' expired in June 2014.
  - 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.
- We observed handover on the Rowan and Maple ward and observed staff raising safeguarding concerns and discussions regarding referrals to the safeguarding team.
- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. However, Rowan ward did not run any live drills of the abduction policy.
- The service used pressure relieving mattresses that alarmed when babies were moved from their cots. It was noted on the risk register that the current

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mattresses were no longer been replaced or repaired if broken. The service was looking at introducing security tagging and had visited other trusts to look at how this could be implemented.

- Girls under 13 years of age who presented to the pregnancy advisory unit were automatically referred to the safeguarding team.
- We saw safeguarding information leaflets displayed on the Cedar ward and the labour ward.
- Midwives routinely asked about domestic violence at booking and at subsequent appointments. The antenatal day unit had placed a poster about domestic violence in the female toilet. Women used the toilet to give urine samples, and the poster asked women to place a black dot at the bottom of the specimen bottle if they had concerns about domestic violence. The midwives would recognise this and take the women into a private room to discuss further.

## Mandatory training

- The trusts mandatory training programme included fire safety, information governance, infection control, conflict resolution, resuscitation, moving and handling training, major incident training, safeguarding children, vulnerable adults and safety training. The trust target for mandatory training was above 85%. Compliance with mandatory training was reported in the monthly Family & Women's Health Group, women's services divisional report. In April 2016, overall compliance was above 85% for all clinical areas with the exception of gynaecology nurse specialists (71.43%), obstetrics/gynaecology medical staff (82.31%) and midwifery education staff (44.9%).
- Staff told us they could access trust mandatory training either via an electronic learning system or could attend face to face training.
- All staff could access their mandatory training record via HEY247. Staff received alerts to indicate when training was due. Ward managers were able to monitor mandatory training compliance and there was an escalation process in place for staff that were not compliant with mandatory training.
- Midwives attended an annual mandatory day two training programme. Training included CTG interpretation, safeguarding, supervision, contraception, neonatal resuscitation, venous thromboembolism (VTE), sepsis, antenatal screening, mental health and safe sleeping (introduced in 2016). Training records from 1

January 2016 to the 30 June 2016 showed 81 out of 214 midwives had attended the training. The remaining midwives were allocated to training dates later in the year.

- The labour ward held monthly training with the anaesthetic staff and ran emergency drills of clinical scenarios for example, the management of a deteriorating patient or a massive obstetric haemorrhage. The service used a simulation doll to simulate clinical scenarios.

## Assessing and responding to patient risk

- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing.
- Patients on the Cedar ward were assessed using the NEWS score. We reviewed four sets observation charts and found that observations were recorded and scores calculated correctly.
- Patients on the labour ward, Rowan and Maple ward were assessed using the MEOWS score. We reviewed MEOWS charts and found it was unclear from the observation charts when a patient should be escalated and how frequently their observations should be repeated. The observation charts advised staff to "contact a doctor for early intervention if the woman triggers one red or two yellow scores at any one time". However, there was no further guidance on how frequently observations should be repeated.
- We spoke with five midwives and they all said they would use their clinical judgement to determine how frequently patients' observations should be repeated, they were not aware of any guidance.
- The escalation policy in the trusts guidance on maternity early recognition of severe illness and referral to high dependency care in pregnancy/postnatal period was not clear. The guidance stated that if one yellow score was identified this should instigate more frequent observations, and if a red score was triggered women should be referred to medical staff.
- We discussed this with senior staff and as an immediate action they were going to display an escalation ladder in clinical areas. On our unannounced visit we only saw this displayed on rowan ward.



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- The service had not audited MEOWS charts in the last six months. The service audit plan for 2016/17 included 'audit of early recognition of severe illness in pregnancy and postnatal period guideline'.
- Staff could describe the process for escalating concerns if a patient was deteriorating, staff told us they would contact on call registrar or consultant and they could also contact the critical outreach team. Paediatricians were available if staff had concerns about a baby.
- The trust used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. The trust had a modified maternity WHO checklist. We found inconsistencies in the completion of the WHO checklist. We reviewed the records 14 women, eight of which had been to theatre. The WHO checklist was incomplete in five sets of records. On our unannounced visit we reviewed a further 10 sets of records, four women had been to theatre and in two sets of records the WHO checklist was incomplete
- The trust audited compliance with the WHO checklist. Between January 2016 and March 2016 the audit found 100% compliance with the WHO checklist
- We observed two surgical procedures and found during the first procedure arrangements were in place to ensure checks were made prior to, during and after in accordance with best practice principles. However, on the second procedure the obstetrician did not ensure checks were made after the procedure.
- The trust had a policy for the emergency transfer from homebirth to hospital and postnatally to another unit.
- We saw evidence the unit used the 'fresh eyes approach' a system that required two members of staff to review foetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation.
- Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors, this determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics.
- Consultant obstetricians were available out of hours for emergency caesarean section and if a patient's condition gave rise for concern.
- Un-booked women who presented labouring were delivered as per the trusts protocol and referred to the safeguarding midwife.
- The antenatal day unit had introduced a red, amber and green (RAG) system to prioritise women. Any women who presented with reduced fetal movements, epigastric pain, severe headache, nausea and vomiting or hyperemesis management were categorised as red and were seen within 15 minutes. Women who required presentation scans, blood pressure checks, CTG's or had been referred from antenatal clinic were categorised as amber and were seen within an hour. Women who needed a post 42 week fetal well-being check after declining induction or had a possible urinary tract infection were rated as green and were seen within two hours. Women who presented with antepartum haemorrhage, meconium stained liquor or any labouring women were escalated to the labour ward.
- Medical cover on the antenatal day unit was available from doctors who worked on the labour ward. Staff reported that medical reviews of women were often delayed due to the unavailability of doctors. We reviewed incident data and found 14 incidents related to delays in medical reviews. No patient harm was reported as a result of these incidents.
- The service had an agreement in place with the local ambulance service to attend babies born before arrival at home.
- The wards used a green symbol outside of a patient's room to indicate any patients who were at risk, for example patients with mental health problems.

## Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). The service did not meet the national benchmark for midwifery staffing. Between January 2016 and March 2016 the ratio of midwives to births was 1:32. This was also above the trust target of 1:30.
- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations outlined in the National Institute for Health and Care Excellence (NICE) safe staffing guidelines. The staffing establishment was last reviewed in 2015.
- The service had completed a business case to review the midwifery establishment and work towards the recommended ratio of 1:28.



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- The service did not collect data on the number of women who received one to one care in labour. There was no audit process in place to ensure the provision of one to one care.
- Senior staff said that despite the midwife to birth ratio been higher than the national recommendations, they were assured women received one to one care through the friend and family survey results and the CQC maternity report.
- We spoke with four women and they all said they had received one to one care in labour.
- Between April 2015 and March 2016, 95 incidents reported were related to staffing resources, inappropriate staffing levels and lack of suitably trained/skilled staff.
- Cedar ward had 2.45 whole time equivalent (WTE) nurse staffing vacancies and Rowan and Maple ward had 2.19 WTE midwifery staffing vacancies. The service was actively recruiting to the vacancies. Staff felt the “remarkable people, extraordinary place” recruitment strategy had been effective and the service retained student midwives.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing levels.
- Staffing levels were reviewed twice daily via an online trust safety brief and reported monthly via the maternity dashboard to the Health Group board and chief nurse. Staff were aware of escalation protocol should staffing levels fall below the agreed levels. The service offered staff overtime or would move staff from other areas for example, community midwifery.
- From May 2015 to May 2016 the average sickness rate for midwifery staff was 5.9%. A review of individual wards showed that the labour and delivery ward had the highest levels of staff sickness (8.9%).
- Locum usage was the highest amongst community midwifery. In January 2016, the percentage of locum staff was 1.9%, in February 2016 it was 1.8% and in March 2016 the percentage rose to 4%.
- Staffing fill rates were reported in the trust’s monthly safe staffing reports. In April 2016 on Cedar ward registered nurse fill rates were 66% for day shifts. The fill rates for healthcare assistants were 109% for day shifts. The service had attempted to fill some of the registered nursing shifts with healthcare assistances to mitigate any risk to patients. On Maple ward the fill rates for midwives were 78% for night shifts. On labour ward the fill rates for midwifery assistants on a day shift were 68%. The fill rates for midwives on a day shift were 118%. We reviewed the safe staffing report for May 2016 and June 2016 and found that the fill rates were the same.
- We reviewed planned and actual staffing levels between 25 January 2016 and the 18 April 2016. On the labour ward, actual un-qualified staffing hours were below the planned hours. However, we saw actual qualified staffing hours were above the planned staffing hours to mitigate for the reduction in un-qualified staff. For example, between the 22 February 2016 and 21 March 2016 non-qualified planned staffing hours were 1215.5 and the actual non-qualified staffing hours were 719.5. However, the planned qualified staffing hours were 2932 and the actual staffing hours were 3210.75.
- On Rowan ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 1976.4 and the actual qualified staffing hours were 1650.1. Non-qualified planned staffing hours were 783 and the actual non-qualified staffing hours were 654.5.
- On Maple ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 1874.3 and the actual qualified staffing hours were 1712.5. Non-qualified planned staffing hours were 977.8 and the actual non-qualified staffing hours were 795.8.
- On Cedar ward we saw the actual staffing hours were below the planned staffing hours for both qualified and un-qualified staff. The ward did not increase the number of non-qualified staff to mitigate for the reduction in qualified staff. For example, between the 21 March 2016 and 18 April 2016 planned qualified staffing hours were 979.5 and the actual qualified staffing hours were 597.8. Non-qualified planned staffing hours were 674.6 and the actual non-qualified staffing hours were 451.8.
- The service had two obstetric theatres and a dedicated theatre team for all elective caesarean sections. If a second team were needed for an emergency caesarean section, a midwife would go into theatre to scrub. RCOG standards for The Safer Childbirth: Minimum Standards

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for the Organisation and Delivery of Care in Labour (2007) state midwives should not be undertaking the 'scrub' role and recommended that there is a dedicated theatre team.

- We observed a morning handover on the labour ward and on the antenatal/postnatal ward. The handover was detailed and concise. Staffing and patient allocation was discussed however; the handover did not include the 'topic of the week' which we were told was used to communicate wider issues which needed dissemination, for example, learning from incidents.

## Medical staffing

- Between January 2014 and June 2015 there were, on average, 102 hours of consultant cover per week on the labour ward. Between December 2015 and March 2016 there was an improved level of cover to 109 hours per week. This was above the trust target of 98 hours per week.
- The medical staffing skill mix was similar to the England average. At the trust, consultants made up 36% of the medical staffing compared to the England average of 35%. Middle grade doctors (with at least 3 years' experience) made up 6% of the medical staffing compared to the England average of 8%. Registrars made up 52% of medical staffing compared to the England average of 50% and junior doctors made up 6% of medical staffing compared to the England average of 7%.
- Trust information stated there was designated consultant presence on labour ward Monday to Friday, 8:00am to 19:00pm. Resident on call cover was available from 20:30pm to 8:30am. The same level of cover was provided for gynaecology patients.
- Staff reported the consultant obstetricians were available when needed and patients said they received consultant and medical care which met their needs.
- A consultant anaesthetist was allocated to the labour ward and was available 24 hours a day, seven days a week.
- At weekends and on bank holidays the on-call consultant carried out twice daily ward rounds. Out of hours, the on-call consultant was required to attend within 30 minutes when needed.
- Daily antenatal and postnatal ward rounds took place daily in line with current guidance and staff reported consultants were contactable when required.

- There was no designated medical cover for the antenatal day unit. When a doctor was required staff would contact the registrar for obstetrics or gynaecology. Staff said there could be delays in medical staff attending if the situation was not urgent.
- Within obstetrics and gynaecology medical staff, the vacancy rates were 2.2%.
- From January 2016 to March 2016 the locum usage within obstetrics and gynaecology staff ranged from 10% in January 2016 to 9.9% in February 2016 to 10% in March 2016.
- At times of increased capacity within the trust, medical outliers were cared for on the cedar ward. Staff said patients were reviewed daily by the medical team and they were able to obtain medical assistance to the ward if they were concerned about a patient's clinical condition.
- We observed a medical handover on the labour ward. The handover was comprehensive and advised on prioritisation of work. It involved the multidisciplinary team.

## Major incident awareness and training

- Escalation policies for maternity services were in place and there was a clear process to implement plans during times of shortfalls in staffing levels.
- Maternity services had not been suspended at the trust, however staff were able to describe the arrangements and there was a robust escalation policy in place.
- The trust had a major incident policy that identified the roles and responsibilities of staff in different clinical areas. Not all staff were clear of their role in such events.
- The labour ward had carried out major incident training and had simulated a fire on the ward.
- The multidisciplinary team including medical staff, midwives, midwifery assistants and operating department practitioners attended yearly Yorkshire Emergency Training (YMET). This enabled staff to maintain skills in a range of emergency situations, for example shoulder dystocia, cord prolapse, breech delivery, PPH, eclampsia and adult resuscitation.

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## Are maternity and gynaecology services effective?

Good



At the 2014 we rated effective as 'Good' and this was maintained at the 2016 because:

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Information about patients' care and treatment was routinely monitored and collected via the maternity dashboard. Outcomes for patients that used the service were in line with national averages when compared to similar services.
- Women were well supported and had been educated about feeding. The service had achieved the United Nations Children's Fund (UNICEF) baby friendly initiative level three accreditation.
- The implementation of the saving baby's lives in Northern England (SABINE) care bundle had reduced the number of stillbirths.

However:

- Some clinical guidelines had expired.
- Not all staff involved in the care of children and young people could explain Gillick competence and Gillick competence was not considered in the trust's guidance on supporting pregnant women with complex social factors.

### Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. All Staff could access guidelines, policies and procedures on the trusts intranet website.
- In March 2016 the service completed an audit of massive obstetric haemorrhages; to ensure compliance with trust guidelines and RCOG guidelines. The audit reviewed 16 case notes of women who experienced blood loss of more than 1500mls. The audit found that in 100% of cases consultants were present when needed, there was clear communication amongst the

relevant members of staff, the placenta was checked and documentation was clear. Fluid balance charts were initiated in all cases but 25% were found to be incomplete and in some cases there was a delay in commencing the massive obstetric haemorrhage protocol. The audit recommended further training for staff on the estimation of blood loss.

- The service completed an audit in March 2016 to ensure the management of multiple pregnancies were in accordance with trust guidelines. The audit found that the trust was above 80% compliance with the guidelines. Recommendations included improving documentation on uptake of first trimester screening and to consider introducing a care check list into patients' records to improve documentation. Timed actions from the audit were due for completion in September 2016.
- We reviewed 50 policies, guidelines and pathways on the trust intranet. They all had a version number and a review date. Eleven were out of date. For example, management of obstetric haemorrhage had a review date of November 2015 and maternity early recognition of severe illness and referral to high dependency care in pregnancy/post-natal period had a review date of November 2015.
- The trust had implemented changes to practice following the saving babies lives in Northern England (SABINE) study. The midwifery teams were using growth assessment protocol (GAP) which was based on standardised fundal height measurements and plotting on a customised growth chart.
- The care of women undergoing a caesarean section was seen to be managed in line with NICE Clinical Guideline 132. The service used stickers in women's records to record the category and timing of caesarean sections. In March 2015 the service audit practice against local and national guidelines. The audit reviewed 82 sections that were classified as a category one. A category one caesarean section should occur within 30 minutes as it is a situation where an immediate life threat to a woman or baby has been identified. The audit found 14 cases were delayed and performed over the 30 minute guidance time. Reasons for delays included, awaiting the on call consultant to arrive (1), women initially declining caesarean section (1), medical staff busy (1), graded incorrectly (1), and no reason documented in 8 cases. Actions from the audit included disseminating the results to staff, and to repeat the audit in 2016/2017. No other actions were included with the audit.

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- The service had introduced a carbon monoxide (CO) monitoring clinic in line with NICE PH26, smoking: stopping in pregnancy.
- We found staff adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary consent forms (HSA1 and HSA4).

## Pain relief

- Women received information of the pain relief options available to them, this included, nitrous oxide and oxygen (Entonox®) piped directly into all delivery rooms, access to a birthing pool and epidurals.
- In January 2015 the service completed an audit of pain relief and satisfaction in patients following caesarean section. The audit review practice against NICE guidelines and local policies. The audit surveyed 50 women and reviewed the drug and anaesthetic charts of 50 women. The audit found 90% of women were satisfied with analgesia on day one post caesarean section, 78% of patients had opioids prescribed as needed (PRN), 100% had regular paracetamol and non-steroidal anti-inflammatory drugs prescribed and 94% had antiemetic's prescribed. Recommendations from the audit included changing local guidance on regular opioid prescription which was due for review in May 2015.
- Women said staff gave them the opportunity to discuss different options of pain relief when completing their birthing plans.
- Six women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed. One woman said she did not receive adequate pain relief during induction of labour.
- Women who had undergone gynaecological procedures said they received sufficient pain relief and nursing staff responded to requests for pain relief promptly.
- The service provided a 24-hour anaesthetic and epidural service. Two of the women we spoke with had received an epidural and said they received them in a timely manner.

## Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital between April 2014 and March 2015

ranged from 65.4% and 67.8%. This was below the England average of 76%. The percentage of women breast feeding on discharge from the hospital during the same period ranged from 51.6% to 68.2%.

- The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service achieved level three accreditation following reassessment in May 2016. The report recognised the significant improvements the trust had made and found 83% of women said staff had offered to show them how to hand express, 92% of women understood baby led feeding and how to recognise feeding cues and 80% of women confirmed they were aware of how to recognise effective feeding.
- The service had an infant feeding coordinator who was responsible for the coordination of quality infant feeding practices in accordance with the UNICEF UK baby friendly initiative (BFI).
- Seven women said they felt well supported and educated with feeding. Women had been shown how to make up formulas and were supported with breastfeeding.
- Rowan ward had a milk kitchen to allow new mums to bring formulas onto the ward and be educated on the correct way to make up feeds.
- All midwives and midwifery assistants had completed baby friendly initiative (BFI) training.
- Rowan ward had a DVD for women to help educate and support them with feeding.
- Women had no concerns about the food and told us that different dietary and religious requirements were catered for.

## Patient outcomes

- The trust monitored and recorded patient outcomes on a monthly performance dashboard. The trust had started to participate in a Yorkshire and Humber regional maternity dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues. This was in accordance with recommendations of the Royal College of Obstetricians and Gynaecology 2008.
- The trust did not have any active maternity outlier alerts, 'outlier alerts' are a description used to describe when a service lies outside the expected range of performance.

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- Between January 2015 and December 2015, HRI delivered 5221 babies. Of the 5221 deliveries, 98.7% of these were single deliveries and 1.3% were multiple births. This was comparable to the England average.
- Between January 2015 and December 2015, 63.7% of births were normal vaginal deliveries. This was above the England average of 60%. Data that the trust submitted the monthly maternity dashboard showed that between January 2016 and March 2016 the percentage of normal deliveries remained above the England average.
- The number of elective caesarean deliveries between January 2015 and December 2015 was 11.7%. This was similar to the England average of 11.3%. Data from the trust maternity dashboard showed the percentage of elective caesarean deliveries had increased to 12.9% in January 2016, 12% in February 2016 and 14.1% in March 2016. This was in line with the trust target of 13.9% but above the England average of 11.3%.
- The number of emergency caesarean deliveries between January 2015 and December 2015 was 13.8%; this was lower than the England average of 15.3%. Data from the trust maternity dashboard showed the percentage of emergency caesarean sections had increased above the national average of 12.1% in January 2016 to 16.2%. The percentage reduced to 10.9% in February 2016 and increased again in March 2016 to 13.6%.
- The increased number of emergency and elective caesarean sections had increased the average caesarean section rate to 27.3% between December 2015 and March 2016. This was above the trust target of less than 26.2%.
- Staff were aware that the number of caesarean section deliveries was above the England average. As a response to this the service were working towards offering a midwifery led vaginal birth after caesarean section (VBAC) clinic and medical staff reviewed cases to look at the decision making process in relation to emergency caesarean section.
- The percentage of instrumental deliveries (forceps and ventouse) at the trust between January 2015 and December 2015 was 10.2%. This was lower than the England average of 12.8%.
- Between December 2015 and March 2016, 44 deliveries resulted in 3rd or 4th degree perineal tears. This was in line with the trust target of less than 20 deliveries a month.
- Between December 2015 and March 2016, 23 women suffered a postpartum haemorrhage (PPH) (a blood loss following delivery of over 1500mls). This was in line with the trust target of less than 10 deliveries a month.
- There were four unplanned maternal admissions to the intensive care unit between December 2015 and March 2016. The unit reported one maternal death. As a response to this the trust completed a root cause analysis. Contributing factors that were disseminated for learning included ensuring VTE risk assessments were correctly assessed and scored.
- Shoulder dystocia occurs when a baby's shoulder becomes stuck behind the mother's pelvic bone. The number of shoulder dystocia increased for two consecutive months in December 2015 and February 2016 to seven and six respectively. This was above the trust target of less than six a month. All the cases were discussed at the weekly maternity care review and staff said there was no obvious reason for the increase.
- Between April 2014 and March 2015 the trust report 27 stillbirths, this was a reduction from 32 stillbirths in the previous year. This improvement in the rates of stillbirth was attributed to the implementation of SaBiNE care bundle (focusing on reducing the number of stillbirths) and introducing customised growth charts to monitor babies' growth during pregnancy.
- The percentage of births to mothers aged 20-34 between January 2015 and December 2015 was higher than the England average and accounted for 81.4% of deliveries, in comparison to the England average of 75.6%. During the same period, the percentage of births to mothers aged 20 and under at HRI was 4.8%. This was higher than the England average of 3.5%.
- Between April 2014 and March 2015 the service carried out 507 medical terminations of pregnancies (TOP) and 625 surgical TOP.
- We reviewed the trust performance data for antenatal and new-born screening 2015/2016. The service was above target for all antenatal and new-born screening targets with the exception of antenatal sickle cell and thalassaemia screening – timeliness of test and new-born blood spot screening avoidable repeat tests.
- The trust was aware of the significant drop in compliance with antenatal sickle cell and thalassaemia screening. The trust was a national outlier. Actions taken by the trust included running extra clinics on a weekend and making changes to the referral system so that women were appointed by gestational age. To reduce



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the rate of new-born blood spot screening avoidable repeat tests the service had worked with the neonatal team and delivered training on blood spot screening to staff.

## Competent staff

- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. The national recommendation is for a ratio of SOMs to midwives of 1:15. Between January 2016 and March 2016 the ratio of supervisors to midwives was above the recommended local supervising authority (LSA) ratio of 1:15. In January 2016 the ratio was 1:16 and in February and March 2016 the ratio was 1:18. To address this, the service had supported midwives to complete the preparation of supervisor of midwives course. Three midwives completed the course in May 2016.
- All midwives said they had a designated SOM. Staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- Appraisal rates were reported in the services monthly divisional report. In May 2016, 85% or more staff had completed an appraisal in most clinical areas with the exception of labour ward (81%), antenatal clinic/ antenatal day unit (79.3%) and specialist midwives (66.7%).
- The majority of staff we spoke with said they had completed an appraisal or were expecting one in the future. Staff said the appraisal process was valuable and allowed them to discuss their development and learning needs.
- Senior staff told us core midwifery staff worked in each area, whilst other staff rotated between departments and this included the community midwives. This meant staff had the knowledge and skills to be able to work in different areas and flexibly meet the needs of the service.
- Newly qualified midwifery staff had a period of 'preceptorship', where they received additional support and went through a competency programme. The programme was a well-structured development package that ensured midwives developed their competencies. It included training in suturing, epidural top management, cannulation and scrubbing for theatre.
- We spoke with midwives who were working through their preceptorship programme and they felt supported; they also told us they had been supernumerary for two weeks and were allocated a 'buddy'.
- Medical staff, midwives, midwifery assistants and operating department practitioners attended yearly Yorkshire Emergency Training (YMET). This enabled staff to maintain skills in a range of emergency situations, for example shoulder dystocia, post-partum haemorrhages, cord prolapse and management of the deteriorating patient. From 1 January 2016 to the 30 June 2016, 142 staff had completed the training including 103 midwives. The remaining staff were allocated training dates later in the year.
- Midwifery assistants completed annual observation training to develop skills in identifying the signs of pre-eclampsia, taking manual blood pressures, documentation and escalation.
- Midwives on Rowan ward were allocated shifts on the special care baby unit to develop competencies in administering intravenous antibiotics to babies.
- Community midwives held yearly skills and drills training and covered topics specific to the community setting for example, resuscitation at home and suturing.
- The trust had a comprehensive theatre training package for midwives. It provided theoretical and practical knowledge required for midwives to extend their scope of practice in obstetric theatre. All 43 core labour ward midwives had completed the training, and 25 out of 54 rotational midwives had completed the package. The remaining midwives were allocated onto future training dates.
- Midwives working on the antenatal day unit had completed scanning training delivered by a consultant in fetal medicine. Competencies were reviewed annually.
- Midwifery and medical staff completed CTG training as part of the mandatory day two training package. There was an interactive computer based training system that covered CTG interpretation and fetal monitoring. It was used alongside CTG training.
- The consultant obstetricians provided support and mentorship for junior doctors. Junior doctors told us they had the opportunity to attend training sessions and participate in s. They felt well supported by the ward team and could approach senior colleagues for advice if needed.



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- On a weekend women who required inpatient gynaecology treatment were cared for on ward 35. Staff had completed a training programme covering, guidelines of care for major gynaecology surgery and gynaecology emergencies, documentation, equipment required for gynaecology procedures and specialist medication. The trust did not provide data on the number of staff who had completed the training. The gynaecology triage nurse was available to support staff if required.
- The early pregnancy assessment unit was nurse-led. Staff said they felt well supported in their role and had completed a comprehensive competency package. We reviewed the competency package and saw evidence of a comprehensive framework. Staff had to gather a portfolio of evidence before been deemed competent to work independently.
- Staff said they felt encouraged to gain professional competencies and attend courses. We heard examples of staff attending a two day conference on early pregnancy.
- Staff on the early pregnancy assessment unit had weekly clinical supervision sessions with the consultant where complex cases were discussed and any updates to practice were shared.
- Nursing staff and midwives said they felt supported in the revalidation process.
- There were midwives with special interest. These included safeguarding, antenatal and new born screening, practice development, infant feeding coordinator and a healthy lifestyle midwife. The service also had a vulnerabilities midwife who saw women with substance misuse, mental health problems, alcohol abuse, learning difficulties and teenage pregnancies.
- Staff said they could access support and advice from specialist nurses/midwives and confirmed there were systems in place to request support from other specialities such as pharmacy, the acute care team and physicians.
- Staff described accessing the critical care outreach team if they were concerned that a patient was deteriorating.
- The vulnerabilities midwife worked closely with community midwives, and there was a process in place for women who did not attend antenatal appointments.
- We saw effective use of the SBAR handover tool when women were transferred between the labour ward and Rowan ward.
- Midwives on labour ward and Rowan ward worked collaboratively to deliver care to patients on the enhanced recovery pathway.
- Anaesthetists attended the multidisciplinary team handover on labour ward and were made aware of any high risk women.
- Women who suffered from symphysis pubis dysfunction (SPD) were referred to a dedicated obstetric physiotherapist. A red pillow system had been introduced onto the wards to identify women who suffered from SPD.
- Staff said they had good support from the neonatal unit, and midwives had spent time on the unit to develop competencies in administering intravenous antibiotics.
- Women with a suspected mental health illness were referred to the perinatal mental health team for further assessment and treatment.

## Multidisciplinary working

- We saw evidence of multidisciplinary working within clinical areas. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.
- On discharge from the unit discharge letters were sent onto GP's, community midwives and health visitors detailing summaries of antenatal, intrapartum and postnatal care. An electronic discharge summary was also completed on an electronic patient record system.

## Seven-day services

- Access to a dedicated obstetric theatre team was available at all times, seven days a week. A consultant anaesthetic was allocated to the labour ward Monday to Friday. Out of hours an anaesthetist was available 24 hours a day, seven days a week.
- Consultants carried out ward rounds twice a day, seven days a week. Out of hours, the on-call consultant was required to attend within 30 minutes when needed as per the trust policy. Staff reported consultants were contactable when required and this included out of hours and weekends.
- There was an on-call rota of SOM. They were available 24 hours a day, seven days a week and provided midwives with support.
- The antenatal day unit was open from 8:30am to 8pm Monday to Friday and from 8:30am to 5pm Saturday and

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Sunday. The unit saw women from 16 weeks pregnant. Scans were available each day as the staff were qualified to scan women. Out of hours, any phone calls were transferred to the maple ward.

- The early pregnancy unit was open seven days a week, 7:45am to 5:45pm Monday to Friday and 7:30am to 3pm Saturday and Sunday. This meant women who may experience the early signs of pregnancy loss could be seen in a timely manner. Out of hours any phone calls would be transferred to the cedar ward or to the gynaecology triage nurse.
- Cedar ward had nine inpatient beds and a 10-bedded day-case unit. The ward open from Monday to Friday and was closed on a weekend. If patients needed inpatient care over the weekend, women were transferred to ward 35. A specialist gynaecology triage nurse was available 24 hours a day on a Saturday and Sunday to offer support to ward 35 and triage any emergency gynaecology patients.
- Women undergoing a medical termination of pregnancy (TOP) attended cedar ward on a Saturday. This offered the women more privacy and dignity.

## Access to information

- Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent electronically to patients GP's, health visitors and community midwives. Staff said they also faxed copies. Staff said if a woman had complex needs they would contact the relevant professional and give a verbal handover in addition.
- All staff could access test results using an electronic system.
- Patients who used the services had access to informative literature. At booking all women received a pack that contained information about health lifestyles, fetal movements and VTE.
- Information leaflets were available in ward areas on a variety of subjects such as contraception, induction of labour, going home with pre labour rupture of membranes at term, breech deliveries and your baby's movement in pregnancy.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could

access the site and find information on antenatal and new born screening, healthy lifestyles and infant feeding. The website also had a list of other useful websites that women and families could access.

- Women undergoing a surgical TOP received a discharge letter summarising the procedure.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) was part of mandatory training for staff. Training data provided by the trust showed 71.4% of nursing, midwifery and health visiting staff had complete deprivation of liberty (DOLS) training. This was below the trust target of 98%. All staff groups were over 85% compliant with mental capacity act (MCA) training with the exception of medical staff in gynaecology where 82.9% of staff had completed the training.
- In August 2015 the service undertook a patient information and consent audit. A sample of 10 patients records were identified from the obstetric department and were audited against the trusts patient information and consent to examination and treatment policy. The service was 100% with 22 of the 30 standards. In 40% of records there was no record of the discussion held with patients and in 20% of records the patients name was not printed. The audit had an associated action plan. .
- Women told us they were given sufficient information to enable them to make an informed choice about the delivery of their baby.
- Staff we spoke with were able to explain the process of ensuring patient consent was gained and demonstrated an understanding of the MCA. At the time of our inspection there were no patients subject to a Deprivation of Liberty application.
- We saw evidence in patients records of consent forms been completed for women undergoing caesarean sections and instrumental deliveries. Consent forms detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for termination of pregnancy (TOP) was carried out within the legal requirements of the Abortion Act 1967. We reviewed three sets of records and found women were correctly consented for the procedure and forms were signed by two doctors.

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- Staff could not articulate what was meant by Gillick competence and were unable to provide evidence of how they would ensure a patient had the maturity to make a decision about their care and treatment. The one exception was staff in the pregnancy advisory service that used Gillick competencies as part of their pathway to assess if a patient could make decisions about their treatment.
- The trust had guidance on supporting pregnant women with complex social factors, this included women under the age of 16. Initial guidance published in March 2016 did not refer to Gillick competency. The trust provided an updated version of the guidelines (July 2016) that included guidance on Gillick competency.

## Are maternity and gynaecology services caring?

Good



At the 2014 inspection we rated caring as 'Good' and this remained as 'Good' at the 2016 inspection because:

- Women spoke positively about the care and treatment they had received. Feedback from women was consistently positive and women said they felt well supported and cared for. The service scored about the same as other trusts in the CQC survey of women's experiences of maternity services.
- People felt involved in their care and were supported in making decisions.
- Staff provided emotional support and responded compassionately. Family's emotional needs were valued by staff.

### Compassionate care

- The trust received 175 responses to the CQC survey of women's experiences of maternity services 2015. The trust scored about the same as other trusts for care received during labour and birth, staff during labour and birth and care in hospital after birth.
- Data from the NHS Maternity Friends and Family Test showed that between January 2016 and March 2016 on average 95% of women would recommend antenatal care at the trust. This was slightly below the England average of 96%. 100% of women would recommend their birth experience this was above the England

average of 97%. On average 96% of women would recommend the postnatal ward. This was above than the England average of 94%. On average 94.5% of women would recommend postnatal community care.

- We saw letters and cards of appreciation and positive comments about people's experience displayed on the labour ward.
- We spoke with 12 women, all of whom spoke positively about their experience. Women told us they felt well cared for and that the midwives made them feel safe. Women told us staff were always available if they needed them, staff introduced themselves and promptly responded to buzzer including during the night.
- Women who were over 16 weeks pregnant could contact the antenatal day unit if they had any concerns. We observed good interaction between midwives in the antenatal day unit and women who were ringing for advice. We heard staff providing encouragement and reassurance to women who were anxious and worried.
- Gynaecology services included an early pregnancy assessment unit for women who were under 16 weeks pregnant. The unit had a private room that could be used for sensitive meetings for women who had experienced a miscarriage.

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

- Women said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.
- From patient records we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.
- Results from the CQC survey of women's experiences of maternity services 2015 showed that the service scored 8.3/10 for being involved in decisions about their care during labour and birth and scored 9.5/10 for the partner being involved as much as they wanted. These results were similar to other trusts.
- Rowan ward allowed partners to stay to provide support in certain circumstances and only if the woman was in a side room. Partners could visit Rowan ward from 9am to 9pm.
- The local supervising authority (LSA) report 2015 found the service met the standard for care planning and

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supporting women's choices including place of birth. The service provided evidence of birth plans that SOM's had completed to support women with complex and difficult birth choices.

## Emotional support

- Families' emotional needs were valued by staff. The labour ward had a separate bereavement room away from the main delivery suite, so women and their families experiencing pregnancy loss had privacy. Staff said families could use the room for as long as they needed. The chaplaincy service could also provide support if requested.
- The service did not have a specialist midwife with a specialist interest in bereavement. However, staff had received bereavement training and support from the Stillbirth and Neonatal Death Society (SANDS), a charity that provides support for bereaved parents and their families. The service was in the process of recruiting a midwife with a specialist interest in bereavement.
- The labour ward offered bereavement photography as part of a memento package to families who had experienced a stillbirth or neonatal death. The free service was run by a group of volunteers who had experienced infant loss.
- The trust and Hull SANDS held a memorial service on a twice yearly basis for families who have experienced the loss of a baby or child.
- Women who attended the pregnancy advisory service were supported in making an informed choice about their TOP options. Women were offered the opportunity to be referred to a counsellor, ensuring the emotional needs of women were met.
- Support was given to families for the sensitive disposal of fetal/placental tissue. Staff supported families and enabled them to make an informed choice with burial and funeral arrangements. Written information leaflets were also given to women.
- Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
- Women with a suspected mental health illness were referred to the perinatal mental health team for further assessment and treatment.

- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.

## Are maternity and gynaecology services responsive?

Good



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

- The needs and feedback from people were taken into account to plan and deliver services to ensure they meet the needs of the local population. Service users were involved in planning the service.
- The enhanced recovery pathway for women undergoing elective caesarean section enabled women to be discharged home the next day.
- Women using the service felt they could raise concerns and complaints and they would be listened to. Complaints and concerns were taken seriously by the service and were acted on in a timely manner.

However:

- Medical outliers on the gynaecology ward were having an impact on elective procedures.
- A lack of capacity in consultant antenatal clinics had resulted in an increased demand on the antenatal day unit.
- There was a lack of capacity within the scanning department following the implementation of growth assessment protocol (GAP).

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

- Community midwives carried out routine antenatal care. Clinics were based in GP surgeries or children's centres to bring care closer to home. Consultant antenatal clinics ran from Monday to Friday for higher risk women.
- Women had the option to either deliver at home or on the labour ward, the service had recognised the limited

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choice available to women following the closure of the separate birthing unit on another site in 2012. The service was planning on developing a midwifery lead unit on the labour ward.

- The enhanced recovery pathway for women following an elective caesarean section enabled them to be discharged home the next day.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the information on healthy lifestyles.
- The service was developing its transitional care beds on the Rowan ward. Transitional care was an area where babies who needed a little more support could stay with their mum rather than go to the Special Care Baby Unit. This meant mum and baby did not have to be separated.
- The labour ward had a dedicated bereavement room.
- Partners could visit the postnatal ward from 9am to 9:00pm. Partners could only stay overnight in certain circumstances and if the woman was in a side room.

## Access and flow

- Between October 2014 and December 2015 the bed occupancy was below the England average.
- Between May 2015 and April 2016 there were no maternity unit closures.
- The antenatal day unit was open from 8:30am to 20:00pm Monday to Friday and from 8:30am to 17:00pm Saturday and Sunday. Women from 16 weeks pregnant could self-refer or be referred by their midwife or GP for a range of problems such as reduced fetal movement. Scans were available each day as the midwives were qualified to scan women. Out of hours, any phone calls were transferred to the antenatal ward.
- The antenatal day unit had introduced a red, amber and green (RAG) system in a response to the increased activity on the unit. The system enabled midwives to prioritise women. It was introduced in February 2016 to improve patient flow through the unit. The impact on waiting times had not been audited but staff felt the system was more effective.
- Staff raised concerns about the lack of capacity in consultant antenatal clinics. We reviewed clinic rotas from the week commencing the 11 July 2016 to the week commencing 30 May 2016 and saw the weekly

number of available consultant clinics ranged from seven to 15. Staff said this impacted on patients because women would see different consultants leading to a lack of consistency and changes to birthing plans.

- We spoke to four women, and they all said they had seen different consultants throughout their pregnancy.
- Staff said the lack of consultant antenatal clinics had increased the demand on the antenatal day unit. We reviewed information on the number of women seen in the antenatal day unit and found that from 2014 to 2015 the number of women seen in the year had increased from 12,866 to 13,887.
- At the time of the inspection senior staff said the next available clinic appointment was in the third week in July. If a woman required an emergency appointment they would overbook the clinic or refer women to the antenatal day unit. The service had not completed an audit to assess if the number of clinic slots met the service needs.
- The service was below its target for booking appointments before 12 completed weeks' gestation. The trust target was over 93.2%. In December 2015 the service achieved 88%, in January 2016 the service achieved 79%, in February 2016 the service achieved 77% and in March 2016 the service achieved 88%. The trust said that the implementation of a new IT system had resulted in women not receiving appointments in a timely manner. The trust had introduced a direct access clerk that booked women within an hour for their booking appointment.
- The trust had implemented the growth assessment protocol (GAP) in October 2015 to improve patient safety in maternity and reduce the rates of stillbirths. Staff raised concerns that there was not enough capacity to offer women the required number of scans. Staff said women who required seven to 10 scans were only having three. We spoke to the senior leadership team who said this was identified on the service risk register and the number of scanning slots had been underestimated. They had submitted a second business case and were hoping to increase the capacity in September 2016 following the recruitment of sonographers.
- The service had introduced enhanced recovery for elective caesarean patients who met the criteria. Women stayed on the labour ward for 30 minutes post procedure and were then transferred to Rowan ward.



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Staff had not yet audited the pathway but estimated it had saved approximately 60 bed days a year. Women were been discharged home the next day in comparison to staying two days.

- Induction of labour took place on the antenatal ward. We reviewed incident data and saw between April 2015 and March 2016, three women had their inductions delayed. Women could attend as an outpatient for induction of labour with a balloon catheter (a mechanical process used to dilate the cervix and promote the onset of labour). This gave women more flexibility.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the labour ward by a midwife. Consultants reviewed patients in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- The early pregnancy unit provided care for women under 16 weeks pregnant and was open seven days a week, 7:45am to 17:45pm Monday to Friday and 7:30am to 15:00pm Saturday and Sunday. Midwives or GP could refer women or, women could self-refer if they had a history of three or more miscarriages or a previous ectopic pregnancy. Out of hours any phone calls would be transferred to the cedar ward or to the gynaecology triage nurse.
- From the trust divisional monthly report we saw the percentage of TOP carried out within two working weeks of initial assessment in October 2015 was 97.6%, in November 2015 was 98.3% and in December 2015 was 96.7%. This was highlighted as green on the trust dashboard, indicating it was in line with the trust target.
- Cedar ward was open Monday to Friday. On a weekend any remaining inpatients were transferred to ward 35. The service reduced the number of transfers by having an elective day case list on a Friday. The ward opened on a Saturday to provided care and treatment to patients undergoing a medical TOP.
- On a weekend a gynaecology triage nurse was available 24 hours a day.
- Staff said on a Saturday night and Sunday the trust opened Cedar ward and medical outliers were moved onto the ward. Staff said they would complete an incident form when this happened. We reviewed incident data and found between April 2015 and March

2016 there were nine incidents relating to the ward remaining open on a weekend. We spoke to staff who said this was challenging. For example, on a Monday the ward had a list of elective patients and no available bed at the start of the shift. Staff said they did usually manage to accommodate all the planned admissions however; this was impacting on the service.

- It was identified in the services divisional report that pressures on the gynaecology ward from outlying medical patients was having an impact on the elective gynaecology procedures. Between January 2016 and March 2016, 12 patients had their elective gynaecology procedures cancelled because a bed was not available on cedar ward due to medical outliers.
- The trust had criteria for medical patients outlying on the gynaecology ward. The criteria stated patients have an agreed discharge plan of 24 to 48 hours. On our unannounced visit the ward had eight medical outliers. Four elective gynaecology patients had their procedures cancelled. Staff said the medical outliers on the ward were not in line with the criteria. For example, one patient was waiting for a MRI and did not have an agreed discharge plan. There was a doctor on the ward reviewing the patients and staff said it had been escalated to bed managers.

## Meeting people's individual needs

- Women told us they felt their individual needs were met and they felt listened to and able to participate in decisions about their care.
- The service had a vulnerable women midwife who was responsible for women who misused substances, had mental health problems, women with complex social needs, refugees, teenage mums and women with learning disabilities. The vulnerabilities midwife visited clinical areas daily to offer advice and support to staff.
- A vulnerability tool kit was in place for all staff. It outlined what staff could do to address the needs and improve pregnancy outcomes for women with different vulnerabilities included, drug/alcohol misuse, mental health issues, learning difficulties, domestic abuse and women under the age of 16.
- The service had a healthy lifestyle midwife who was responsible for supporting women throughout pregnancy and postnatally to achieve a healthy lifestyle.
- In all areas we visited midwives described how to access interpretation services through either booking a



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planned appointment or using a telephone system called 'language line'. Community midwives and staff on rowan and maple ward had access to an I-pad which had a translation app.

- On the wards we visited we did not see any written information in different languages. Staff said they did not have access to any written material in different languages but they had access to an internet based tool for translation purposes.
- Midwives told us that bariatric equipment was available for women and was easily accessible.
- The rooms on the delivery suite were large and all had en-suite facilities which allowed wheelchair access.
- Rowan ward allowed partners to stay to provide support in certain circumstances and only if the woman was in a side room. Partners could visit Rowan ward from 9am to 9pm.
- Following pregnancy loss or TOP women were offered a choice in the disposal of the pregnancy remains. They were also offered support with funeral arrangements.
- Cedar ward opened on a Saturday for women undergoing medical TOP, this allowed all women to have a side room and offered them more privacy and dignity.
- The service worked closely with the Doula project. The project trained volunteers to offer support to vulnerable women.
- Families who experienced pregnancy loss were offered a post mortem.
- Midwives completed mental health risk assessments at booking and throughout women's antenatal and postnatal care. Women were asked if they had a history of mental health problems and the 'Whooley' questions. The questions are used as a screening tool to identify potential depression. A positive response triggered a referral to the appropriate agency for example, general practitioner, health visitors and the perinatal mental health team.

## Learning from complaints and concerns

- The service reported formal complaints on the monthly performance dashboard. Minutes from monthly clinical governance meetings demonstrated that complaints were discussed.
- The service had a system in place for handling complaints and concerns. Staff said they would try and resolve complaints at a local level and were aware of the procedure to follow.

- Between February 2016 and April 2016 the service received 20 complaints and 43 PALS concerns were raised. 16 of the complaints related to care and treatment, two complaints related to care and comfort including privacy and dignity, one related to communication/record keeping and one related to a safeguarding after a patient developed a pressure sore.
- The SOM team produced an attitudes and behaviour training DVD for staff in response to feedback from women via complaints.
- We reviewed three responses to complaints. On two of the occasions the trust met with the families and included a copy of a being open report which summarised the discussion. The response to complaints included actions to be taken for example, ensuring all midwives gave sufficient information to women on discharge regarding any possible complications.
- Sharing of lessons learnt from complaints was done during handover on the labour ward. Maple and rowan ward produced a monthly newsletter where lessons learnt from complaints were disseminated.
- Cedar ward had leaflets about the patient advice and liaison service to inform patients about how to raise concerns or make a complaint. Not all women we spoke to knew how to make a complaint but said they would raise any concerns with the staff.

## Are maternity and gynaecology services well-led?

Requires improvement



At the previous CQC inspection in 2014 well led was rated as 'Good'. We identified some concerns at the 2016 inspection that meant well-led was rated 'Requires improvement' because:

- Some of the governance arrangements did not enable the effective identification of risk and we found some risks were not clearly identified by the senior management team.
- Lessons learnt from the never event were not fully embedded with all staff. We saw evidence of pre and post swab counts not consistently been recorded in patient records. The services audit process was not robust enough to give assurance that lessons had been learnt.

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- The system's in place for recognising deteriorating patients were not robust. Within obstetrics, the observation charts lacked a clear escalation procedure. The service had not completed an audit of patients modified early obstetric warning scores (MEOWS). We found in some areas the approach to service delivery was reactive in relation to the implementation of growth assessment protocol (GAP). Senior staff said the number of scanning slots had initially been underestimated.

However:

- Staff felt engaged and listened to and spoke passionately about driving service improvement.
- We saw strong leadership at a local level and staff spoke positively about being able to raise concerns.

## Vision and strategy for this service

- The trust vision of 'great staff, great care, great future' was embedded in the service and staff were able to articulate what 'great staff, great care, great future' meant to them.
- The women's service division had an operational plan for 2016 to 2018. The strategic vision and goals was to provide safe, high quality care to patients.
- The service had key priorities for each Health Group. The priorities were timed and assessed against measureable outcomes. Senior staff were able to articulate these prioritise for obstetrics the priorities including reviewing obstetric scanning capacity and the development of the Midwifery Led Unit on the labour ward. Key priorities for gynaecology services included the development of outpatient procedures and the development of a procedural suite.

## Governance, risk management and quality measurement

- The trust had a clinical governance midwife who was responsible for facilitating governance and risk management and ensured policies and guidelines were up to date. The clinical governance midwife reviewed all incidents.
- The service had monthly clinical governance meetings. We reviewed the minutes of the meetings and saw that they were well attended. Issues discussed included feedback from incidents and serious incident action plans, complaints, patient safety alerts and the risk register was discussed and updated. Previous actions were reviewed and monitored.
- Local risk registers assisted the women's service division in identifying and understanding the risks. Risk registers were reviewed on a monthly basis and any concerns were escalated through the Health Group governance meetings. We reviewed the local risk register. There were 11 risks, all had risk scores attached to them, review dates and existing controls to mitigate the risks. Examples of risks identified by the service included, security tagging for babies. This was given a risk score of eight. Controls put in place included the use of pressure sensitive mattresses. The trust had visited other units to review tagging systems and was in the process of introducing a tagging system.
- There was some alignment between what staff had on their 'worry list' with what was on the risk register. For example, obstetric ultrasound scanning capacity.
- The service did not meet the national recommended midwifery staffing ratio of 1:28. As the service did not collect data on the number of women receiving one to one care in labour we asked how they assured themselves they had the correct staffing ratio. Senior staff said they used feedback from the CQC survey and feedback through friends and family surveys.
- We found that learning from the never event had not been fully embedded. We saw evidence of pre and post swab counts not consistently been recorded in patient records. The services audit process was not robust enough to give assurance that lessons had been learnt.
- During our inspection we raised concerns about the lack of a clear escalation procedure on the MEOWS charts and the lack of clarity relating to how frequently observation would be repeated. An audit of MEOWS had not been completed by the service. As an immediate action the trust advised they were to display the escalation ladder in clinical areas. On our unannounced inspection, we only saw this displayed on the Rowan ward.
- Following the implementation of GAP in October 2015 staff raised concerns that there was not enough capacity to offer women the required number of scans. Senior staff said the number of scanning slots had initially been underestimated and they had submitted a second business case to recruit further sonographers.
- Staff raised concerns about the lack of capacity in consultant antenatal clinics. We saw the number of weekly clinics ranged from seven to 15. The service had not completed an audit to assess if the number of clinic slots met the service needs.

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- Performance and outcome data was monitored and reported through the Family & Women's Health Group monthly divisional report. All areas had targets and it was highlighted if figures were outside of acceptable limits.
- The trust had started to participate in a Yorkshire and Humber regional performance dashboard; this would allow comparison with other hospitals in the region and help identify trends and patient safety issues.
- The service had completed a benchmarking exercise following the publication of the Kirkup report (2015). Following the review, evidence was provided to demonstrate how the service met the recommendations and areas where further action was required. There was no clear action plan for example, the service identified the need to improve the process of learning lessons from incidents and complaints, but there was no associated action plan to demonstrate how this was to be achieved and who was responsible.

## Leadership of service

- Maternity and gynaecology services were part of the women's division which formed part of the Family and Women's Health Group. A Clinical Director, Divisional Nurse Manager, Head of Midwifery and Divisional General Manager led the service and reported to the Medical Director, Nurse Director and Operations Director who formed the Health Group triumvirate.
- Senior staff had access to the trust board and felt listened to.
- We saw strong leadership at a local level and ward managers were aware of the challenges in delivering good quality care and identified strategies to address these. Staff spoke positively about the leadership at ward level and felt well supported and listened to. Staff said they felt confident to raise concerns and felt they would be listened to.
- Staff said they felt well supported by their line managers but the senior management, matrons and the head of midwifery were not always as visible in clinical areas.
- The labour ward had a rota of senior midwives who acted as shift coordinators and were supernumerary.
- Each midwife had a named SOM. The trust was not achieving the recommended ratio of 1:15 midwives to SOM. In January 2016 the ratio was 1:16 and in February

and March 2016 the ratio increased to 1:18. The service was putting actions in place to address this through supporting midwives in completing the preparation of supervisor of midwives course.

## Culture within the service

- Staff were encouraged to be open and honest. All staff were aware of the duty of candour and were able to give examples of when this had been implemented.
- The trust had introduced insight training which aimed to address bullying and improve the culture within the organisation. Staff said it helped them understand individual's behaviour and felt it had improve the culture, developed intrapersonal working relationships and improved group cohesion on the unit.
- The ward manager on Maple and Rowan wards sent thank you cards to staff to highlight good practice and give staff recognition for their hard work. Staff said this made them feel appreciated.
- Staff said that they enjoyed working at the trust and were proud of their department. The staff we spoke with said they felt supported and felt confident in raising concerns.
- Staff recognised that during times of heightened activity staff were under pressure but felt that everyone worked together as a team to make the workload more manageable. All staff said having more staff would improve this situation.
- Ward managers had an 'open door' policy to encourage staff to discuss any concerns.
- Student midwives spoke of a positive learning environment and said they had received good mentorship. They said they would work at the trust.

## Public engagement

- Data from the NHS Maternity Friends and Family Test showed that between January 2016 and March 2016 on average 95% of women would recommend antenatal care at the trust. This was slightly below the England average of 96%. 100% of women would recommend their birth experience this was above the England average of 97%. On average 96% of women would recommend the postnatal ward. This was above than the England average of 94%. On average 94.5% of women would recommend postnatal community care
- Following the closure of the midwifery lead birthing centre in 2012, some women reported a lack of choice

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about birthing locations. The service had responded positively to this and had engaged with members of the public in planning a new Midwifery Led Unit on the labour ward.

- Maple ward displayed 'you said, we did'. Examples displayed included women reporting not enough privacy in the four bedded rooms for private conversations, in response; the ward had allocated a room for private discussions.







## Staff engagement

- Staff told us they felt engaged and involved in service development; they felt their ideas were listened to. Staff said they had been asked about their concerns and suggestions for service improvements.
- The service had involved midwives and medical staff in a safety summit to discuss antenatal consultant clinics and the antenatal day unit. From the summit four work streams were formed. Staff said work was still ongoing to address the issues.
- We saw evidence of staff been engaged in improving services. The footprint of the maple and rowan ward was been changed to develop an area for transitional care. We reviewed minutes from the team meeting to discuss the improvements and saw the meeting was well attended and staff feedback was taken into consideration.
- Staff were engaged in developing the midwifery led unit on the labour ward and had visited other trusts to look at different ways of working.
- The service was seeking feedback from staff on the new birthing notes from the perinatal institute.

## Innovation, improvement and sustainability

- The perinatal mental health team/midwifery team had been shortlisted for the Royal College of Midwives Annual Midwifery Awards 2016 for effective partnership working in supporting women with perinatal mental health.
- The outpatient induction of labour with balloon catheter service had been accepted for publication in the International Journal of Obstetrics and Gynaecology and was presented as an E-poster presentation at the Royal College of Obstetricians and Gynaecologists conference.
- The service had introduced an enhanced recovery pathway following caesarean section. This was implemented in May 2016 and was associated with early discharge home and promoted normality.
- Development of a midwifery led unit within the labour ward. Staff demonstrated an outward thinking approach through visiting other units to gather ideas.
- The service was developing a business case to implement the role of a bereavement midwife.
- Midwifery staff were undergoing competencies to undertake intravenous antibiotic treatments for neonates to reduce and prevent unnecessary separation of baby and mum.
- The service was chosen as a pilot site for the National Society for the Prevention of Cruelty to Children (NSPCC) film to help parents care for a crying baby and cope with the stresses of sleeplessness and crying.

# Services for children and young people

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

## Information about the service

Hull Royal Infirmary is part of the Hull and East Yorkshire Hospitals NHS Trust. The Family and Women's Health Group provides a range of children's and young people's services for the population of Hull and surrounding areas. These include medicine (a 20 bedded ward), surgery (a 22 bedded ward), a paediatric high dependency unit (PHDU - four beds), and a neonatal unit. The neonatal unit is a 26-cot regional tertiary unit serving Hull, East Yorkshire and the Yorkshire and Humber region.

The paediatric assessment (PAU) unit was open 24 hours a day and contained 10 beds. It was used to assess children to decide if they needed to be admitted. Children and young people aged 0-16 years attend the unit from either their GP or from Accident and Emergency.

Children's outpatients delivered general clinics for childhood illness and surgical conditions, as well as the specialist clinics for gastroenterology, respiratory, cardiology, neurology, neonatology, endocrinology, immunology and allergy, rheumatology, oncology, hepatology, and dietetics.

The trust had 7,522 episodes of care for children between January 2015 and December 2015.

In May 2015, CQC carried out a focussed inspection. We rated the caring domain as good and rated safe, effective, responsive and well led as requires improvement. Overall, the service was rated as requires improvement. This was because the staffing levels did not meet best practice and national guidance. Incidents investigation did not take place in a timely manner and lessons learnt relating to

incidents were not effectively acted upon and audited. We also found that some facilities on the 13th floor were not effectively assessed to prevent harm for patients with mental health needs.

In June 2016, we inspected the paediatric outpatients, PAU, medical and surgical wards, day surgery unit, theatre recovery area, paediatric high dependency unit, and the neonatal unit.

We spoke with 11 parents, three children, and 58 staff. This included ward sisters, nurses, healthcare assistants, play staff, ward domestics, student nurses, doctors, operating department technicians, consultants and senior managers. We also held staff focus group meeting to hear their views of the service they provide. We observed care and treatment, inspected nine sets of care records and we reviewed the trust's audits and performance data.

# Services for children and young people

## Summary of findings

At the 2015 inspection we rated children and young people services as 'Requires improvement' overall. In 2016 this rating had improved and was 'Good' overall because:

- Nurse staffing was appropriate and was planned using an acuity tool. Multidisciplinary working took place and staff worked well as a cohesive team. Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Requirements around the duty of candour were being met.
- The service performed positively in infection prevention and control audits.
- Policies were based on national and local guidelines. Consent to care and treatment was obtained in line with legislation and guidance.
- Staff treated children, young people and their relatives/carers with kindness, compassion, dignity and respect. Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- We saw children and young people being assessed and treated in a timely way. A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- Playrooms and a schoolroom were available to meet the learning needs of patients.
- Following our inspection, the trust informed us they had decided to commission an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's needs.
- Staff spoke positively about their managers and the culture of the trust and were able to articulate the trust's vision and values.

However,

- Not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt and four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patients and how those needs would be met.
- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.
- Records concerning the administration of medications were not appropriately completed.



# Services for children and young people

## Are services for children and young people safe?

Requires improvement



At the 2015 inspection we rated safe as 'Requires improvement'. The rating in 2016 was 'Requires improvement' because:

- We had concerns that not all incidents, including 'near misses' and some safeguarding incidents had been classified correctly and therefore not fully investigated or possible lessons learnt
- Four safeguarding children guidelines were out of date.
- The care documentation did not clearly reflect the mental health needs of the patient and how those needs would be met.
- Records concerning the administration of medications were not appropriately completed.
- There were several unfilled junior doctors posts, which had resulted in the inability to meet the demands of the service.

However:

- Requirements around the duty of candour were being met.
- Nurse staffing was appropriate and was planned using an acuity tool.
- The service performed positively in infection prevention and control audits.

### Incidents

- We inspected the incident data provided by the trust. Between April 2015 and March 2016, there were 585 incidents reported by staff. Of these, 497 were not a risk, 83 were classified as a minor risk and four were a moderate risk and one major risk.
- Staff were encouraged to report incidents using the trust's electronic reporting system. The staff members we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.
- There were no never events in children's services reported. Never events are serious, preventable patient safety incidents that should not occur if the available preventive measures are in place.

- There were two serious incident reported to the NHS strategic executive information system (STEIS) between May 2015 and April 2016. Serious incidents (SI) are incidents that require further investigation and reporting. One SI from February 2016, related to the untoward outcome of a surgical procedure. A root cause analysis (RCA) had taken place, which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root cause of incident.
- The second SI was a closure of the Neonatal Intensive Care Unit (NICU) to external admissions, due to a suspected outbreak of Vancomycin Resistant Enterococci (VRE) infection in May 2015. The trust commissioned a peer review following the outbreak. The review was positive with a recommendation to continue with the reassessment of routine cleaning in high-risk environments.
- Between May 2015 and April 2016, five incidents were reported to the National Reporting and Learning System (NRLS). All of the incidents were either low or no harm. Due to low volumes of incidents reported, there was insufficient data to report on trends.
- We were concerned that not all incidents/near misses (including safeguarding incidents) had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt. For example, a young person had absconded from the hospital without the prior knowledge of their family or ward staff and due to their age and medical condition could have been at risk of harm. This had been graded as severity 'none' and as a consequence no investigation had taken place as to how this could have happened. We brought this information to the attention of the trust at the time of the inspection. Following the inspection, they informed us the incident had been retrospectively declared a serious incident investigation.
- At our previous inspection in May 2015, the trust required improvement in the timeliness of the incident investigation. We saw at this inspection how this had improved and the trust monitored the timeliness of the investigation approvals. The trust had a target rate for incident approval of 80% each month. On four occasions between April 2015 and February 2016 the rate was between 74 and 78%. This was identified at the divisional monthly meeting through the quality improvement overview plan and being monitored through the health governance group.

# Services for children and young people

- As part of the trust's quality improvement plan, they were strengthening their audits of incidents. We saw the risk management policy and procedures stated the line manager/ investigation officer would accurately grade the actual severity of the incident. They would also decide whether further analysis/investigation was required and the member of staff who completed the incident form would be informed. This role was new and helped to make sure incidents were graded correctly. We were informed the incidents we reviewed, had not received the manager/ investigation officer review.
- We spoke with one of the line managers/investigation officers. They told us they had received training to carry out their role and were aware of their responsibilities. We understood the role of this officer commenced at the beginning of June 2016.
- Staff on the ward told us they were aware of their line manager's role and when they had reported an incident, they had received feedback.
- Safety briefings were taking place and a 'Lessons Learned' newsletter sent to all staff across the trust. The June 2016 edition, included lessons learned from an incident that occurred in an outpatient clinic.
- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). We reviewed the minutes of the January to March 2016 meetings. We saw outcomes from case reviews discussed and where appropriate, recommendations made to improve care and treatment. They assessed practice against guidelines and fed back from and to the Governance forum.
- The duty of candour is a regulatory duty that relates to openness and transparency. It 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 spoke about duty of candour and understood the need to be open and honest with families when things went wrong.
- We saw eight examples of where the duty of candour had been applied. This showed the trust was open and transparent with families when things went wrong.

## Cleanliness, infection control and hygiene

- In November 2015, the trust commissioned a peer review following a suspected outbreak of Vancomycin Resistant Enterococci (VRE) infection. The review

commended the IPC team and staff on the unit for bringing the outbreak under control. Recommendations were made and included the continued reassessment of routine cleaning in high- risk environments.

- A National Specifications for Cleanliness Report audit took place weekly. A record from April 2015 to March 2016 showed the overall score (for the paediatric domestic, nursing and estates,) was between 95 and 100% compliance.
- The trust produced a weekly infection control monitoring report for the divisional nurse managers and infection control lead, to cascade to their teams. Additionally a 13-week summary report of the areas monitored was included in the Trust Board performance report.
- The service had an Infection Control/ Reduction Committee. We saw from the monthly paediatric governance meetings that the committee provided infection control feedback to the meetings.
- The areas we visited were visibly clean and equipment had dated stickers on them, which showed they were clean.
- We saw staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance to ward and patient areas. There was clear signage encouraging visitors and staff to wash their hands.
- Patient areas displayed 'How are we doing' boards. For example, on the paediatric assessment (PAU) we saw for the previous month (May 2016), the ward had scored 100% for ward cleaning and 92% in their handwashing audit.
- There had been no cases of MRSA and one case of Clostridium difficile infection in 2016/17. A Root Cause Analysis (RCA) took place to determine the cause. The investigation showed there had been no lapses in care identified.

## Environment and resuscitation equipment

- Access to the children's wards was via an intercom system. There were surveillance cameras in place that enabled staff to monitor people visiting and leaving these areas and keep the children safe. We noted one of

# Services for children and young people

the two intercoms was not working on the entrance to the paediatric wards. In the interim, the wards were sharing the intercom system and during the inspection, the faulty device was replaced.

- Each directorate had a planned preventative maintenance programme that identified the frequency of equipment testing.
- Safety testing of electrical equipment took place and had dated stickers on the equipment to show when it had been tested.
- Resuscitation and emergency equipment checks took place in each area we inspected. This meant the equipment would be available in an emergency.

## Medicines

- In general, medicines and intravenous fluids were stored securely. We noted that there was a broken lock on a refrigerator used for the storage of chemotherapy drugs in the outpatient area. We were informed that the lock had been reported for repair.
- There were appropriate arrangements in place for storing, recording and managing controlled drugs.
- All medicines, including those for emergency use were checked at regular intervals and records showed they were 'in date.'
- Records showed that medicines requiring refrigeration were stored at the correct temperatures. However, on the paediatric medical ward 130, we found that the room in which the drugs refrigerator was kept was warm. The temperature of the room was not monitored. The temperature of the room should be below 25°C for the safe storage of medicines.
- We reviewed seven prescription charts and found on three occasions the administration record had not been signed. This meant there was no record to indicate the child had received the medication. We also saw the instructions for an antibiotic on one chart was unclear. When we asked the doctor if he had followed the trust's prescribing policy, they re-wrote the prescription.
- A paediatric pharmacist visited the wards daily Monday to Friday to clinically check prescriptions and reconcile patients' medicines. The pharmacist had checked all seven charts we reviewed.
- On the Neonatal Intensive Care Unit (NICU), staff were proactive in reducing the risk of harm from medicines. For example, a senior nurse analysed all incidents on the relating to medicines between January and May 2016. They then produced a monthly risk update

bulletin for their ward colleagues. Another senior nurse responsible for medicines management attended the trust's medicine safety meetings. The nurse gave ward staff a written summary of issues raised at these meetings and learning was shared.

- The service used software that calculated the dose of emergency drugs for individual babies depending on their weight.

## Records

- We inspected nine nursing and clinical records. General record keeping was of a good standard. We saw the respective paediatricians and surgeons had completed medical records.
- Staff told us that five sets of case notes were audited each week as part of their monitoring, and 'HEY Safer Care.' Ward clinical observations audits were carried out in April, May and June 2016 across all children and young people's service. The results showed clinical observations had been completed 100% of the time in all areas.
- Nursing documentation included a paper based booklet containing an ongoing nursing assessment, care and discharge plans. The records contained a list of staff names, signatures, initials and designation of who had entered information into the document. This meant there was also a record of who had provided care.
- The care plans were pre-printed and contained generic care needs that were adapted by adding further actions to provide individualised care. The information referred to assessments and tools staff should use when making decision about the care.
- Records reflected the action taken to meet a patient's individual physical needs and goals. This meant it was clear what treatment and care the patient required and received.
- In February 2016, a mental health risk assessment tool was used for children and young people who may pose a risk of harm to themselves or other. The risk assessment tool was introduced with a view to improve the quality of service for these patients and was to be re-audited in August 2016. Staff told us that they had not received training on the use of the tool.
- We inspected two sets of records that contained completed mental health risk assessment documentation. We saw an example plan of care and in one of the records a meal plan. However, we did not see

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a mental health plan of care in either of the two records inspected. Therefore we could not be assured these patients were receiving care for their mental health conditions to meet their needs.

- The Children and young people's service was 85.5% compliance for staff having attended information governance training. The trust target for mandatory training was 85%.

## Safeguarding

- The trust had a safeguarding adult and children's lead nurse with a named nurse and a designated consultant in the Family and Women's Health Group for safeguarding children. The Named Doctors for safeguarding children sat within the Family and Women's Health Group
- On the 1 June 2016, the safeguarding children's team had transferred to the management of the Assistant Chief Nurse to centralise the trust's safeguarding arrangements. We were told this would strengthen monitoring and governance of child safeguarding procedures.
- The trust used the national safeguarding training guidance that set out the training and competency of staff working with children and young people.
- In line with safeguarding guidance, staff within the Health Group had completed safeguarding level 1 & 2 training. One hundred and nineteen staff out of 130 (91.5%) had completed level 1 training and 570 staff out of 646 (88.2%) completed level 2.
- Information provided by the trust following the inspection, showed the children's service had achieved 71.3% level 3 safeguarding training. They also stated they were on track for delivery of their training target by the end of August 2016. The information had been included on the trust risk register for monitoring purposes.
- The process for recording completed training had been reviewed and staff non-compliant with their training had been given a timescale to attend.
- Staff confirmed they had received safeguarding training, demonstrated their knowledge and were aware of their obligations to report safeguarding cases. They also confirmed the training included learning about female genital mutilation and child sexual exploitation.
- The trust had policies and procedures for safeguarding children and adults at risk. Both overarching policies were in date and were for review in December 2016. The

overarching policy for children was called 'Policy for situations where abuse or neglect of children is suspected'. However, four other specific guidelines we reviewed on the trust's intranet were out of date including 'Safeguarding children: children and domestic violence' which expired in September 2015.

'Safeguarding children in whom illness is fabricated or induced', expired in June 2015 and 'Safeguarding children: managing allegations or concerns against staff', expired in June 2014 and 'Safeguarding children: serious incidents and serious case review guidance' expired in June 2014.

- Staff we spoke with were aware of how to access to safeguarding documents.
- The computerised record system did not 'flag' where there may be potential safeguarding concerns from adults who may pose a risk to children. It did have the facility to show if there was a protection plan in place for the child or they had one previously.
- Following the inspection, the Chief Executive wrote to the CQC to provide assurance that since 4 July 2016, the safeguarding children practitioners performed a daily ward round (Monday to Friday,) in the paediatric inpatient areas. A review of all patients admitted and discharged over a weekend or bank holiday would take place the next working day. A document for capturing the ward rounds and reviews had been put in place.

## Mandatory training

- Compliance with mandatory training was reported in the monthly Family & Women's Health Group, children's services divisional report. The training matrix provided by the trust showed overall compliance was between 82.5, and 94.3% in neonatal and paediatric clinical areas.
- The trust had a corporate and local induction programme. As part of their statutory and mandatory training, all new employees (including medical and nursing staff,) received training via e-learning prior to attending the Welcome Day.
- Staff told us the trust were very good at allowing staff to attend training and included both face to face and on line sessions.

## Assessing and responding to patient risk

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- Staff were trained in European Paediatric Advanced Life Support (EPALS) and confirmed scenario training took place on the ward and in the trust's clinical skills laboratory, two to three times a year.
- The children's service used a Paediatric Advanced Warning Score (PAWS) tool to assist nursing and medical staff identify deteriorating patients. The documentation contained the action to take in response to deteriorating scores and the records inspected had been completed appropriately. Staff confirmed they all completed annual training in the use of the tool and trust data showed 55 staff had received training.
- The unit worked with Embrace, a paediatric medical transport service to safely transfer children who needed specialised care. The Embrace service could locate a bed in a specialist paediatric service if necessary and transfer the patient. Staff were aware of the guidance to follow in accessing Embrace and the paediatric anaesthetist would remain on the ward until the team arrived.
- At our previous inspection in May 2015, we identified risk assessments were not in place with regard to the environment on ward 130. This included the absence of a safe room for children and young people with mental health needs and a ligature risk assessment.
- In September 2015, the trust wrote to CQC and confirmed that the trust complied with HBN 23: Hospital Accommodation for Children and Young People in relation to ligature risk. The trust explained that a Child and Adolescent Mental Health Service CAMHS practitioner had been involved in the assessment of the environment, which included ligature risks, and the appropriateness of not having a designated safe room. They had also been instrumental in the development of an individual daily, risk assessment tool, which included an assessment of their need for supervision. The tool was used for children and young people with mental health needs, who posed a risk to themselves or others. The tool which was introduced in February 2016 and recently amended was to be audited in early August 2016. Staff told us they were using the tool even though they had not received training.
- We saw the risk assessments in place and were informed that training for staff, identified as an action from the previous inspection had been booked with CAMHS for September 2016.
- Following our inspection, the trust informed us that it was to commission an out of area review by an

independent mental health provider trust. This was to include a review of the risk assessments used, care planning and training needs to make sure the service is meeting people's needs.

## Nursing staffing

- The children and young people services used an acuity tool to determine staffing levels. The tool was developed with reference to the Royal College of Nursing (RCN) document 'Defining staffing levels for children and young people's services.'
- The guidance identified the appropriate level of nursing staff required to care for patients in a variety of clinical settings. For example, on a general ward the staff to patient ratio was one registered nurse to five children. On the Paediatric High Dependency Unit PHDU, there was a recommended ratio of one registered nurse to two children.
- We were told that the emphasis was more on acuity of the illness/needs of the patient rather than by age banding.
- The guidance stated the ward sisters and lead children's nurse used a combination of known activity/acuity levels and their own experience. This was then discussed with the nurse director and head of finance before being finally approved
- The actual staffing levels we saw on the wards were generally a reflection of the acuity tool numbers. We also saw a patient receiving one to one care where identified, due to their risk assessment and level of dependency.
- Acorn ward staff told us that on occasions they had experienced a shortage of staff at the weekend; this occurred if someone unexpectedly needed to go to theatre. We were told in this instance the 'bleep holder' would be informed and asked for assistance to transport patients to ensure the ward maintained staffing levels.
- The band 6 and 7 roles (sisters) were flexible in order to provide appropriate clinical cover as required as part of the escalation policy.
- Seven days per week there was one or two play specialists on duty. In addition, Monday to Friday there was a housekeeper and ward clerk for each area.
- A senior paediatric nurse carried the unit bleep covering a 24-hour period. Part of their role was to ensure that contact was made with each ward /area at defined intervals during their shift to highlight bed capacity and any immediate or potential staffing issues. The senior



# Services for children and young people

nurse was able to make decisions about re-deploying staff to ensure all areas were staffed safely in line with the acuity of the patients and the age ranges of these children.

- Staff told us that the use of bank staff and overtime hours was accessed when needed.
- Handovers occurred twice a day. The information included patients detail, reason for admission, current assessment, safety brief and ward updates including staffing levels.
- The Neonatal services used the 'Badger' system to record the acuity of the neonates and the required staffing levels. This was based on the British Association of Perinatal Medicines recommendations and the designation of cots
- Information provided by the trust following our inspection, showed the vacancy rate in June 2016 to be 9.34 whole time equivalent (WTE) nursing staff. The largest number of vacancies was in the Neonatal Intensive Care Unit (NICU) with 6.98 WTE vacancies. NICU had recruited to two vacancies, with the remainder being out to advert at the time of our inspection. The manager told us that staffing levels had generally been maintained in line with acuity in the interim. This had included the use of bank staff and overtime.

## Medical staffing

- The proportion of consultants for the service was lower than the England average and the proportion of junior doctors was higher.
- There were 12.2 whole time equivalent (WTE) paediatricians, four paediatric surgeons and 5.35 WTE neonatologists, a total of 21.55 WTE (26%, compared to the England average of 35%)
- There was a consultant paediatrician in the hospital from 9am to 5pm Monday to Friday, covering the paediatric wards (PAU, PHDU, ward 130, medical patients on Acorn ward) and the emergency department.
- Additional support from a consultant paediatrician in the PHDU was available from 9am to 1pm Monday to Friday.
- Outside of these hours, there was the Paediatrics service on call cover, from 5pm until 8pm. They were then available on- call off-site, unless needed in the hospital,

- At weekends, a consultant paediatrician was present in the hospital from 9am to 12 mid-day. They would then be on call for the hospital. In total, 12.2WTE consultants contributed to the on call cover rota.
- There was a consultant neonatologist of the week present on site Monday to Friday, 9am to 5pm. They covered the neonatal service (NICU, labour ward and postnatal wards) with additional support from a second consultant for the special care baby unit and the postnatal ward. This role was a minimum of three days of the week.
- Out of these hours, a consultant neonatologist was available on call and would be present in the hospital a minimum of three hours a weekday evening and four hours Saturday and Sunday. At present 5.35 WTE consultant neonatologists, contributed to this cover.
- We were informed that there were two tiers of junior doctors providing continuous on site cover and that this was compliant with rotas in both general paediatrics and neonatology separately. This provided a minimum of two junior doctors cover in both areas 24 hours a day.
- However, some doctors told us there were gaps in the rota and shortfalls in junior doctor allocation. The risk register showed in March 2016 the allocation of junior doctors to the speciality had resulted in several unfilled posts. Plans had been put in place in an attempt to mitigate against this risk, these included: an attempt to recruit locum trust doctor posts and consultants to work twilight shifts on locum pay in order to support the service. The risk was to be reviewed in June 2016.
- We also reviewed two recorded incidents where there had been a delay in accessing the appropriately trained doctor for a Section 47, child protection medical. In one instance a police surgeon was used to mitigate the risk, the trust had liaised with the police.
- We saw on the incident report system in February 2016, two incidents had occurred because of unsafe levels of paediatric registrar staffing for the workload. Following lessons learned relating to the shortfalls within the junior doctor's allocation, the twilight registrar post initiated last winter was discontinued. This improved staff cover as it meant the paediatric registrar no longer had the extra duty of covering the twilight shift.

## Major incident awareness and training

- Major incident and business continuity planning was in place as part of the wider trust continuity planning.



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- Training records showed 100% of staff had received major incident training. Staff confirmed they had received training and were aware of their role in the event of a major incident.

## Are services for children and young people effective?

Good



At the 2015 inspection we rated effective as 'Requires improvement'. In 2016 this rating had improved to 'Good' because:

- Policies were based on national and local guidelines.
- Consent to care and treatment was obtained in line with legislation and guidance.
- Multidisciplinary working took place and staff worked well as a cohesive team.

However:

- We were not assured that staff had the knowledge and competencies to meet the needs of children and young people with mental health needs in their care.

### Evidence-based care and treatment

• The trust monitored and identified whether they followed appropriate guidance relevant to the services they provided.

• We found that policies were based on national and local guidelines and accessible on the trust intranet site. All guidelines we inspected were in date and had been ratified at the Clinical Effectiveness, Policies and Practice Development meetings.

• We also saw the paediatric ward used appropriate guidelines in the management of patients under 18 years of age, with anorexia nervosa. The guidelines were jointly written by the Royal College of Psychiatrists and the Royal College of Physicians and used for patients with severe anorexia being admitted to general medical units.

### Pain relief

- The service used the neonatal and paediatric pain guidelines.
- The trust's pain team contacted the paediatric surgery ward and the paediatric HDU each day. This was to

review patients that were receiving analgesia with a nurse, document their assessment, and advice on their plan of treatment, whilst referencing the neonatal and paediatric pain guidelines.

- Discussion with staff and review of the records showed that pain management was considered by members of staff. The majority of staff was compliant with their training.
- At the time of our inspection, a pain link nurse-training day was being organised alongside the pain team. This was to address any future training requirements.
- The children's ward and units had access to play specialists and a range of distraction tools when required to provide an alternative means to lessen the impact of pain, discomfort or distress.

### Nutrition and hydration

- Initiatives, such as the UNICEF Baby Friendly Initiative were in operation. The UK Baby Friendly Initiative was based on a global accreditation programme developed by UNICEF and the World Health Organisation (WHO). It was designed to support breastfeeding and parent/infant relationships, by working with public services to improve standards of care.
- Care plans we reviewed assessed the nutritional needs of patients. Records contained appropriately completed fluid balance charts.
- A dietitian visited the ward daily to provide advice on the diet and fluids patients should receive.
- Hot and cold beverages were available in each ward and unit and relative/visitors were encouraged to help themselves.

### Patient outcomes

- From December 2014 until November 2015 the emergency readmission rate (within two days of discharge) for the under one year of age group was 3.6 patients. This was similar to the England average of 3.3.
- Multiple readmission rates for the one year age group in asthma, diabetes and epilepsy were lower and therefore better than the England average.
- The multiple readmission rates in the one to 17 year old age group was higher than the England average for asthma (19.6% compared to 16.5%), about the same as the England average for diabetes (13.6% compared to 13.2%) and lower than the England average for epilepsy (26.1% compared with 28.6%).

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- There were emergency readmissions among patients in the 1-17 year old age group between November 2014 and October 2015. Two in paediatrics compared to the England average of 2.7; 1.6 in paediatric surgery compared to 2 readmissions, the England average and 4.6 in general medicine, compared to the England average of 2.2.
- The National Paediatric Diabetes Audit 2014/2015 identified there were 17.7% compared to the England average of 22.1% patients with controlled diabetes.
- The National Neonatal Audit Programme 2014 (published in November 2015) identified the percentage of babies less than 33 weeks gestation at birth receiving at least some of their own mother's milk at discharge home was 61%. This was similar to the England average of 60%.

## Competent staff

- There were formal processes in place to ensure staff received training, supervision and an annual appraisal. All staff, including bank staff told us that they undertook mandatory training; training to ensure they had competencies to do their job and received an annual appraisal.
- Appraisal statistics included family and women's services. The internal appraisal target to achieve was 85%. In May 2016, the number of nursing and midwifery staff who had received an appraisal was 447 (85.6%). The number of medical staff who had received an appraisal was 70 (86.4%).
- Tailored reflection and support to medical and nursing staff involved in medication incidents was taking place. This was to ensure staff learnt lessons from incidents and were competent to do their job.
- To support lessons learnt from critical incidents, scenario training was taking place.
- We were concerned staff on the ward may not have the knowledge to care for children and young people with actual or suspected mental health needs. At the last inspection this was identified and the trust provided as action plan to deliver some bespoke training from the local CAMHS. The training had not taken place.
- Following this inspection, the trust wrote and provided assurance to CQC that a training needs analysis to review their competencies had taken place. A meeting had also been arranged with CAMHS services in July

2016 to review staff training needs and determine what other level of support and training can be offered to the staff. Training was identified for September 2016 and be delivered by CAMHS.

## Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.
- Staff we spoke with gave positive examples of multidisciplinary working. We saw paediatricians and nursing teams, along with other allied healthcare professionals (dietitians, physiotherapists, pharmacists, play specialists) working together.
- The CAMHS team telephoned the ward each day to receive an update on their patients. They also visited twice a week if they had patients on the ward.
- MDT meetings took place and a brief account was included in the medical notes.

## Seven-day services

- Consultants provided 24 hours on call service for seven days and staff reported they were available for ward rounds at the weekend and each day.
- There was Monday to Friday 24 hours support from pharmacy and outside of these hours, a pharmacist was available on-call.

## Access to information

- Staff told us they had access to information for each patient, which included nursing records and results from any investigations.
- There were processes for informing GPs and health visitors of patient discharges.

## Consent

- The trust had an up to date policy for consent and competency standards; this was accessible to staff through their intranet.
- Staff we spoke with understood the Gillick competency standard surrounding consent for children.
- They explained the consent process completed by surgeons and they encouraged the involvement of young people in decisions relating to their proposed treatment.

# Services for children and young people

- Staff told us that consent was completed on the morning of the operation. Depending on the ability of the child to understand, the doctor would ask the child/ the parent to sign/countersign the consent form.
- We inspected two records where consent was obtained. The consent records were complete, dated and signed.
- Between February and March 2015, a paediatric surgical consent audit took place. Thirty records were audited; 75% relating to paediatric outpatients and 25% to inpatients. The outcome showed 100% of the time the documentation was legible and signatures obtained from parents and health care professionals. This was an improvement of 28% from the previous year's audit.

## Are services for children and young people caring?

Good



In 2015 we rated caring as 'Good' and the 'Good' rating was maintained in 2016 because:

- Staff were passionate about their roles and were dedicated to making sure their patients had the best care possible.
- Staff treated children, young people and their relatives/ carers with kindness, compassion, dignity and respect.
- Families felt informed about the care of their child, and involved in the decisions about care.
- Wherever possible mothers were not separated from their new-born baby and facilities were available for parents to be resident at the hospital with their child.
- Good Friends and Family Test (FFT) results were achieved in 2015/16 for paediatric and the neonatal intensive care unit.

### Compassionate care

- Throughout our inspection, we saw that patients and relatives/carers were treated with dignity, respect and compassion.
- All the staff we spoke with were passionate about their roles and were dedicated to making sure the children and young people had the best care possible.
- We observed staff providing care to children in a sensitive way; the nurses responded to crying babies where parents were absent, quickly comforting them.

- In the Friends and Family Test (FFT) from March 2015 to February 2016, the PAU, NICU and wards scored between 91.4 to 100% as a place people would recommend. In April 2016, PAU scored 94%. Whilst the NICU and the paediatric medical ward both scored 100% as a place people would recommend.

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

- We observed staff explaining to families the care their child was receiving. This was done in a compassionate way allowing the families to ask questions to understand what was happening.
- Families we spoke with felt involved and informed about the care of their child, and they had been involved in the decisions about care.

### Emotional support

- Parents told us they were supported throughout their visits to the service.
- A chaplaincy service was available for children and families and a multi-faith prayer room was available on the ground floor at the trust.
- There were bereavement services available to support families.
- The trust and Hull Stillbirth and Neonatal Death Society (SANDS) held a memorial service twice a year for families who had experienced the bereavement of a baby or child.

## Are services for children and young people responsive?

Good



In 2015 we rated responsive as 'Requires improvement'. In 2016 this rating had improved to 'Good' because:

- We saw children and young people being assessed and treated in a timely way.
- A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- The trust had a system for handling complaints and concerns, with learning from complaints and concerns disseminated to staff.
- Playrooms and a schoolroom were available to meet the learning needs of patients.

# Services for children and young people

- The trust was commissioning an out of area review by an independent mental health provider trust. This was to make sure the service was meeting people's mental health needs.

However:

- There were limited facilities for the segregation of patients when needed, such as for infection control. We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow older children to be cared for by gender.
- There was also a lack of teenager environmental facilities.
- Parents told us they found the facilities to be poor.

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

- The trust was commissioned by the local Clinical Commissioning Groups to provide services for children and young people.
- The trust had plans for the development of the service and dedicated children and young people facilities. This had been identified at the last inspection. However, due to the financial constraints and other priorities the trust had not implemented these. The parents' sitting room facilities on the 13th floor had been improved following receipt of charitable funds.

## **Access and flow**

- We saw children and young people being assessed and treated in a timely way.
- However, on the paediatric surgical ward staff told us that they were asked to take medical outliers (patients that should be on a medical ward). When this happened staff had experienced difficulty accessing the medical staff and this has meant a delay in the discharge of the patient.
- The PAU assessed children and young people between the ages of 0-16 years to decide if they needed to be admitted. They were referred to the unit either by their GP or from Accident and Emergency department. The service was available 24 hours a day.
- The average length of stay for non-elective care of children aged less than one year was zero days, and one day for the age group of one to 17 years of age. Both were in line with the England average.

- March 2015 to February 2016, the England average bed occupancy of neonatal critical care beds was between 70 – 75%. At the trust occupancy was at 100% in April, October 2015 and February 2016, 60% in June, August and December 2015 and between these variables the rest of the year.
- A discharge liaison team was available to ensure babies were discharged from the neonatal unit in a timely way.
- A community team of specialist nurses provided continuing care on discharge from the neonatal unit.
- The children's service had commenced the training of three Advanced Nurse Practitioners (ACPs) to work in the paediatric assessment unit and support the emergency department. This was to assist the trust with its flow of patients through the emergency department as well as reduce the length of stay for children awaiting review.
- To help facilitate ease of access to the service for patients attending the outpatient department, extra clinics had been made available on a Saturday. In addition, we were told that staff sent a text to remind the patient or relative of their appointment.

## **Meeting people's individual needs**

- The trust reported their transition to adult services was well established in some of the chronic illnesses such as cardiology, diabetes and neurology. However, they also reported that the service would further develop transitional arrangements in their 2016/17 Quality Improvement Programme and develop a trust wide transition steering group.
- The service did not have children's nurses who specialised in learning disabilities. Instead, the service accessed specialist support from adult services.
- Staff informed us within their safeguarding training, there was information relating to patients with a learning disability. Additionally, the staff had contact numbers and information leaflets to access specialist groups. For example, 'Downright Special ... building a brighter future for children with Down Syndrome.'
- All children admitted to the general paediatric wards had an initial physical diagnosis. This included the patients who were admitted for a physical medical conditions associated with their mental health illness (for example, eating disorders below safe medical weight, and acute overdose requiring medical intervention).

# Services for children and young people

- The number of children with a mental health condition admitted to a general paediatric ward over the previous 12 months was 87. This included, self-poisoning (68), anorexia, eating disorders (10), alcohol intoxication (five), and other mental health disorders (four).
- The service had a consultant paediatrician with a special interest in mental health and a hospital mental health liaison team. In addition, where children and young people admitted to the service had emotional, behavioural or mental health difficulties they were able to access specialist NHS CAMHS services provided by another NHS trust.
- Staff told us that they had access to interpreter services on the ward for children who may not speak English as a first language. The top three languages were Polish, Russian and Arabic. Interpreter services used by the trust included Language line, and British sign language.
- We observed a range of information leaflets to be available across the service. We saw information leaflets and contact details for support organisations in each patient area. For example, 'Run a head' a family support group for children with additional needs and their families.
- We saw a list of questions staff would ask the patient on admission which were written in several languages.
- Wherever possible mothers were not separated from their newborn baby and facilities were available for parents to be resident at the hospital with their child. For example, on the NICU there were bedrooms with en-suite facilities and a bedroom for parents to stay with their baby in the special care baby area. Where in-patient relative facilities were not available, they were offered a temporary bed or armchair should they wish to stay with their child.
- Staff explained that they tried to nurse male and female children and young people in separate bays from eight years of age upwards. We did not see a specific policy that set out the requirements for same sex accommodation within the children's ward areas. We did not see any specific facilities available to allow older children to be cared for by gender.
- A playroom was available in PAU for children and young people. It was equipped for primary aged children.
- There were no separate facilities for teenagers.
- A schoolroom and teacher was available during term time on the ward. Children who were inpatients for five

days or more could access this service. Nursing staff gave an example of how the teaching staff at the hospital liaised with invigilators for a young person sitting their GCSEs.

- There was a parents' room available on Ward 130. As there was no parent's room on PHDU, they had access to the facilities on the paediatric medical ward.
- Parents told us they found the facilities to be poor, with uncomfortable seating, and cramped conditions.
- There were two 'rooming in' rooms available for parents in the neonatal unit. These contained two single beds, an armchair, a changing area, and space for cots. Staff explained that demand for these rooms was high and that they often had to 'juggle' things around to try to meet demand.
- A shower and toilet for parents was only available in one of the 'rooming in' rooms on the neonatal unit. There was seating available for parents in the neonatal sitting room and a kitchen area to make light snack and drinks.
- Two further sleeping rooms were available for parents on the neonatal unit. Both had double beds and were en-suite. One of these rooms had a wet room, which was suitable for parents with physical disabilities.

## Learning from complaints and concerns

- The trust had a system in place for handling complaints and concerns; staff in the children and young people's service were aware of the procedure to follow.
- The Health Group included women and children's services and the complaints identified in the board reports reflected the two services as a whole. Given this, the trust was unable to show the number of complaints and trends as two separate figures.
- However, the monthly Paediatric Governance meeting minutes for December 2015, January and March 2016 showed that between November 2015 and February 2016 there had been five complaints in this service. The Patient Advice and Liaison Service (PALS) had received 33 comments, suggestions, compliments and requests for advice. Themes mainly related to outpatient appointments.
- The Quality report for March 2016 identified the action taken and lessons learnt from complaints. For example, a child had been discharged home with abnormal 'vital signs' (temperature, pulse and respirations). As a result, the trust wrote a policy which addressed the issues, including discussing concerns with the senior duty doctor, prior to patient discharge.



# Services for children and young people

- Learning from complaints and concerns were disseminated to staff through bulletins, newsletters, emails, updates and meetings.

## Are services for children and young people well-led?

Good



In 2015 we rated well-led as 'Requires improvement'. In 2016 this rating had improved to 'Good' because,

- Staff spoke positively about their managers and the culture of the trust.
- All staff were able to articulate the trust's vision and values.
- The Family and Women's Health Group had a strategic vision for the next three years.
- There were clear lines of responsibility and reporting to board level.

However:

- Not all incidents/near misses we reviewed had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt including safeguarding incidents. However, the trust had since changed its incident review processes and brought the responsibility for child safeguarding within the corporate team.
- There was not an effective system to identify and ensure that child safeguarding policies were reviewed and up to date.

### Vision and strategy for this service

- The trust's vision was 'great staff, great care, great future' and all staff were able to articulate the trust's vision and values.
- We saw the Family and Women's Health Group had a strategic vision for the next three years. It aimed to provide the highest quality of care to patients and service users; be responsive to national and local priorities; committed to safety, clinical effectiveness and the efficient and economic use of resources across all services.

- The strategy also identified the vision was to deliver a five year plan of improvements in quality and safety of the care required to deliver key targets.
- Key objectives had been identified. These included a board approved plan for the relocation of children services which remained outstanding from the previous inspection in May 2015. This has meant there was an inability to give a joined up service due to separation of the paediatric surgical ward from other services; including the paediatric service on the 13th floor. Although the trust supported in principle the reconfiguration of the service, they had not identified when this would take place. This was due to the financial constraints of the organisation and other priorities taking precedent.

### Governance, risk management and quality measurement

- The trust's Family and Women's Health Group oversaw the service specific management and governance arrangements of children's services.
- The trust was aware of specific risks for each Health Group, with each one having an individual risk register. For example, the trust register included the inability to deliver appropriate standards of care to children due to the environmental constraints of the 13th floor. The date the information was added to the register, review date, and the controls in place to mitigate any risks, were recorded.
- The children ophthalmology and dermatology division had identified eight risks including, the lack of junior doctors within the paediatric and neonatal services. The minutes of the meeting of the governance group who met monthly, showed the managers and trust board were aware of their local and strategic risk. They had systems in place for their review to keep patients safe.
- The trust had a Quality Improvement Overview Plan. The purpose of the plan was to define, at a high level; the overall continuing quality improvement journey the service was making and the improvement goals the trust would work towards over the next 8-12 months. It included the CQC requirements, recommendations, and longer-term objectives to improve quality and responsiveness across the organisation. A monthly progress report on the improvement plan was produced



# Services for children and young people

and reported to the Health Group Board and the Operational Quality Committee. Actions from the 2015 inspection were included and monitored within this plan.

- At this inspection, we had concerns that not all incidents/near misses (including safeguarding incidents) had been classified correctly or reviewed and therefore not fully investigated or possible lessons learnt. The trust informed us that since April 2016 a new system had been introduced.
- There was not an effective system to identify and ensure that child safeguarding policies were reviewed and up to date.
- As part of the trust's quality improvement plan, they were strengthening their audits of incidents.
- The new system included the incident investigation officer reviewing the grading of the actual severity of the incident. They would carry out a further analysis/ investigation where required, to make sure the incident had been graded correctly. We were informed the incidents we reviewed, were before the new system was introduced and had not received the manager/ investigation officer review.
- The children, ophthalmology and dermatology division's monthly report March 2016, also showed the risks of the service were monitored, together with incidents, complaints, screening updates and performance.

## Leadership of service

- Services at the trust were divided into four Health Groups, medicine, surgery, family and women's health and clinical support services. The Family and Women's Health Group was further subdivided into two divisions, both of which included aspects of children's services: Women's service division and Children, Ophthalmology and Dermatology division.
- Within the children's and young people's service there were clear lines of leadership and accountability. However, several of the staff were new in post and we were told the trust was restructuring their nurse management roles.
- For each shift, a band seven coordinator who managed the ward/ unit and was supernumerary to the nurse staffing numbers. This allowed them to provide support to the nursing staff and was the first line of contact when staff had staffing concerns.

- Staff confirmed they had good support from the ward manager and coordinators. They told us they were supported and the trust was a good place to work.
- We were told that a previously identified bullying culture was definitely improving with the appointment of the new Chief Executive.

## Culture within the service

- We found there was a culture of openness amongst all the staff. Most staff were enthusiastic and spoke positively about the services they provided to children and young people.
- Most staff told us things had improved and felt they were able to raise concerns and would be listened to and supported by their manager.
- We observed staff working well together and there were positive relationships within the multidisciplinary team.
- We spoke with several staff on PAU and the outpatients department. They told us they had worked at the trust for several years and they had not seen any bullying behaviour. They told us their managers had always been open.
- Staff spoke about duty of candour and understood the need to be open and honest with families when things went wrong.
- The trust was open and transparent with families when things went wrong.

## Public and staff engagement







- Staff on paediatric ward 130 were finalists in the trust 'Golden Hearts Awards' 2016, for the positive culture and team spirit category.
- We saw evidence that the service were seeking patient and relative feedback through family involvement groups and patient and family surveys.
- We heard how the patient representative group worked on projects in schools with pupils who had autism to prepare them for entry into hospital.
- Patients' relatives were involved and instrumental in the creation of a relatives/visitors sitting room, where they could make hot drinks on the paediatric surgical ward.
- The NHS staff survey results 2015 showed they scored 3.74 out of five for overall staff engagement.
- Staff told us their managers had a good relationship with their teams and they had an open door policy should they have concerns.

# Services for children and young people

- Staff told us they were proud of the hospital choir. This was a multidisciplinary team of staff from across the four directorates who had come together to form the trust's choir.
- We saw in the March 2016 newsletter, all staff were invited to take part in a short anonymous questionnaire. It aimed at helping the trust understand how lessons were and shared across the organisation. The Risk team would then use the information to improve learning from incidents across the trust.
- Scenario training took place to support learning lessons from critical incidents. This was delivered both in ward areas and within the clinical skills facility within the hospital. They had also produced a DVD as an educational support tool for staff relating to incidents.
- Children and women's services were chosen as a pilot site for the **National Society for the Prevention of Cruelty to Children** film. It was being produced to help parents care for a crying baby and cope with the stresses of sleeplessness and crying.'
- The service used software that calculated the dose of emergency drugs for individual babies depending on their weight. The software was innovative and improved the safety of prescribing.

## Innovation, improvement and sustainability

# 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 end of life care 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 that also incorporated the Queens 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 (SPCT) 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 six wards at Hull Royal Infirmary where end of life care was being provided, we spoke with two patients and four relatives. We also spoke with 12 members of nursing staff, two doctors and eight porters. We visited the mortuary and bereavement service and spoke with four staff from these teams.

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 overall.

# End of life care

## Summary of findings

At the comprehensive inspection in 2014 we rated this core service as 'Good' overall. In 2016 the rating remained 'Good' overall 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 multi-disciplinary 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 each patient's 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 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'. In 2016 this rating remained 'Good' because:

- Patients were protected from avoidable harm and abuse. Incidents involving end of life care patients were low in numbers. 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

### 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 trust's 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, the mortuary 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.
- Within the mortuary, there was clear separation of clean, transitional and dirty zones. Cleaning schedules were displayed and in addition there was a separate category 3 (infectious diseases and forensic) room. In this room, we saw that each storage fridge had IPC warning signs in place.
- 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% staff from the SPCT were compliant with this training.

### Environment and equipment

- Staff we spoke with told us equipment, such as syringe pumps and specialist mattresses, were readily available for patients. However, some staff referred to the 'bed

# End of life care

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 only one type of device was used at this hospital. A palliative link nurse told us that they were the trainer for the pumps and as such provided training in the use of the pumps for other staff on the wards.
- 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.
- The mortuary also had 96 fridges available, eight of which were bariatric. There were also freezers available for longer-term storage.

## 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.

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 five patients receiving end of life care and found that all non-essential medications were discontinued as appropriate. We found that 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 five patients. We found that documentation completed by members of the SPCT was completed fully and consistently in all records. This included the patients' prognosis, symptom management and patients' physiological, social, spiritual and psychological needs.
- 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.



# End of life care

- In line with policy and national guidance, we found that all, except one, do not attempt cardiopulmonary resuscitation (DNACPR) forms were signed by a senior clinician.

## 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 adults' level one and safeguarding children level two 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. In one set of notes the ceiling of care was not documented however it was documented that the patient was not for escalation above ward level and not for admission to HDU/ICU.
- 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 that helped to keep patients safe.
- The SPCT nurses were available Monday to Friday 08:00 -18:00. Out of hours, staff could contact the local hospice for advice.

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- 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%.

## Other staffing

- The trust employed six chaplains; three were part time and three full time. In addition to this, there were 26 chaplaincy volunteers
- The mortuary was staffed by eight members of staff; six qualified anatomical pathology technologists (APT's), including the mortuary manager and mortuary supervisor, a trainee and a mortuary apprentice.

## 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. A 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 effective as 'Good'. At the 2016 inspection the rating was '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 multi-disciplinary 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,

- 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 policies 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).

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- 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 the care records of 44 patients at the end of life, 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 off-licence 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 to.
- 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

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would provide further evidence of the care patients at the end of 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.
- 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 Queens 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 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.

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- 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.
- The SPCT provided an in reach service to Hull Royal infirmary and visited the hospital each day Monday to Friday.
- 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 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, which 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 eight; do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found all but one of these forms were kept in the front of the patients medical records, which was in line with trust policy.
- Six of the eight forms indicated that the patient lacked capacity. We could not find evidence of a mental capacity assessment in four of the patients' notes;



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however, in four of the records we saw that a best interest decision discussion or meeting had taken place involving the patients' family. In one set of notes we looked at for a patient who lacked capacity, we saw that the patients' son had lasting power of attorney, for health and wellbeing. We saw that this was clearly documented.

- 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.
- 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'. At the 2016 inspection the rating was 'Good' 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.
- One family told us that the staff were 'exceptional' and that they were 'delighted' with the care their family member had received and the support had provided to the family.
- Patients and their families 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 spoke to the relatives of a patient at the end of life who described the care provided as 'exceptional' for both them and their family member. They told us that they were 'delighted' with everything.
- Families and carers told us that staff always responded to any questions they had and always asked 'is there anything we can do for you?' We were told that staff provided tea and coffee at regular intervals without families having to ask.
- We saw ward staff and the SPCT being compassionate and caring to patients and their families. Staff were sensitive to the needs of the patients and their families.
- One family told us that staff had always made sure that their relatives' hair and nails were cared for and that they felt that this was really important to maintain dignity.
- 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 patients' 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.

## 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.
- 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. The



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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.

## 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 a patient's belongings 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



At the 2014 inspection we rated responsive as 'Good'. At the 2016 inspection it was rated as 'Good' because:

- Services were planned and delivered in a way that met 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 where their care was delivered 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 and the SPCT 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.
- Care at the end of life care was also provided in other departments at the hospital including the critical care units and the accident and emergency department that had a dedicated end of life cubicle.
- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families.
- The trust had a 'Preferred Priorities of Care' document which 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

- 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 a patient's symptoms. In addition, 100% of relatives indicated that they were

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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.
- We observed a patient being moved from a main ward area, to an individual cubicle in one of the trusts critical care units, to maintain dignity at end of life. Experienced members of the nursing team transferred the patient. The relatives of this patient were fully involved in the decision to withdraw treatment and had been spoken to by the consultant responsible for the patient's care.
- In all areas we visited, we were told that relatives and carers of patients at the end of life would be offered open visiting.
- Not all wards had relatives' rooms available; however, there was an en-suite facility on one floor of the hospital.
- 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.
- Staff on one ward told us that they would provide relatives with a reclining chair if they wished but that

they did not have any folding guest beds; however, staff from this ward were due to meet with the estates team during the week of our inspection and were hoping to turn a room on the ward in to a family room with sleeping facilities.

- 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.
- During our inspection, we visited a ward with a member of the SPCT. Staff were about to refer two end of life care patients for support and advice. The SPCT nurse saw these patients at the time of the visit to the ward without having received a referral which was exceptionally responsive.
- 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 trust employed 5.35 wte chaplains (six people in total). This 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

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- 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 after the decision was made.
- The mortuary at the hospital was both a hospital and public mortuary. Senior staff told us that they provided care for 3000 hospital patients and 1000 deaths which had occurred outside the hospital, for example in people's homes or as a result of traffic accidents each year.
- 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. 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.
- 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 a 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



At the 2014 inspection we rated well led as 'Good'. In 2016 the rating was 'Good' because:

- All teams were aware of the trust vision and values. We saw these displayed during our inspection. In addition to this, we saw 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.

## 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.

# End of life care

- Robust governance, risk management and quality measurement processes were embedded in the teams and the Health Group. The Health Group had a Quality Governance and an 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,

- At the time of our inspection, the trust did not have 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 trust's vision and values. We saw these displayed in clinical areas. We also saw individual team 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 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 multi-disciplinary 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 and Assurance Committee and also held End of Life Steering Group meetings.
- 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 a lead clinician who was the Medical Director for the Clinical Support Services Health Group. 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.

# End of life care

- 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 were well trained and had 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.
- 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.
- We found that staff from the SPCT listened to concerns expressed by relatives and were proactive in taking suggestions forward to improve the services provided for patients and those close to them.

## 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 contacts 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 had recognised one of the SPCT nurses with a 2014 'Henry Garnett Award'.



# Outpatients and diagnostic imaging

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

Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) are the main hospital sites for the Hull and East Yorkshire hospitals trust and Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the HRI site. 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. In 2015, 5.3% of the trust's total appointments were at these locations, 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; 404,580 (57%) of these were at the HRI site. The highest number of attendances at HRI was in ophthalmology, with 59,604 attendances during this 12-month period.

Services at the trust were split into four Health Groups: medicine, surgery, family and women's health and clinical support services. Outpatient services were provided in each of the four Health Groups. Diagnostic imaging and pathology services were in the Clinical Support Services (CSS) Health Group.

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

- Ophthalmology
- Eye clinic
- Eye hospital
- Fluorescein angiography testing area
- Gynaecology outpatients
- Surgical outpatients
- Plastics outpatients
- Medical outpatients
- Audiology/ear nose and throat
- Neurology

We also visited all of the radiology areas, including nuclear medicine, the appointments and referral centre and histopathology.

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 HRI had three general x-ray rooms, a CT (computerised tomography) scanner room and an ultrasound room on the ground floor of the main building adjacent to the accident and emergency department and fracture clinic. Radiology had three general x-ray rooms on the second floor. There was a PACS (picture archiving and communication system) reporting room on the second floor and a hot reporting room on the ground floor. There was an x-ray room on the first floor of the main building to support the Orthopaedic Outpatient Department (OPD). Rooms on the second floor supported inpatient, Outpatient



# Outpatients and diagnostic imaging

and general practice (GP) patients. The radiology day unit had a shared waiting area with ultrasound and ultrasound had three rooms. The majority of GP radiology work was done at the CHH and community sites.

The MRI (magnetic resonance imaging) department was in a separate building and had three MRI scanners. Nuclear medicine was in the main building but was managed separately, within the clinical support services (CSS) Health Group.

We spoke with 45 members of staff in outpatients, radiology and pathology, including managers, nurses, radiographers, medical staff and administration staff. We also spoke with six patients. 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 including quality and performance information.

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 that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging. In 2016 we rated the services overall as 'Requires improvement' because.

- The trust was 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.
- A cluster of eight serious incidents had been declared in Outpatients, relating to patients that had not had their appointments when they should. This had led to delays in diagnosis and incidents of varying harm to patients, 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 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 diagnostic imaging

- The facilities and premises used to deliver services were of variable quality. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair.
- We found there was 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.
- There was inconsistency in the governance and management oversight in outpatients due to the clinics 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', which was running behind schedule. This project was to improve clinic utilisation, bookings processes and performance against national standards. We were also told that an overarching management post was to be developed.

However,

- 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. Weekly performance meetings reviewed the backlog and the individual Health Groups were taking action.
- At the last inspection, patients undergoing hysteroscopy within gynaecology outpatients were not completing consent forms. We found these patients were now completing consent forms as required.
- Outpatients and radiology had increased their capacity by running clinics out of hours and at the weekends, to cope with the increased demand and make sure patients had their appointments in a timely manner.

- Staff providing care and treatment to people in outpatients and radiology were very caring. Patients gave positive feedback about the care they received, and 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 deficiencies or those who needed an interpreter.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching outpatients risk register which meant there was a lack of cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- 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, 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 declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. 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 HRI 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. 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.
- Some improvements had been made to the vascular dressings room in the surgical department, however these were not completed and the room was still not suitable for the purpose for which it was being used.
- There was variation in practice in the use of surgical safety checklists between outpatient specialties carrying out day surgery.
- 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 outpatient 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 a high proportion of radiographer vacancies in general x-ray.

However,

- The majority of staff we spoke with knew how to report incidents and about learning lessons from incidents.
- 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 50,000 radiology reports. A further four serious incidents regarding specific patients had been reported relating 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 the 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. This was cascaded by email and, in some areas; the manager informed staff directly and/or left information in staff rest areas. The trust produced a monthly bulletin which included information and learning from incidents and near events.
- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 13 incidents reported in surgical outpatients and 18 in medical outpatients. No data was submitted for the other outpatient specialties.
- Staff in outpatient departments used Datix to report incidents. The band 7 sister in surgical outpatients, told us there were not many incidents reported within outpatients; incidents usually involved waiting times or cancelled clinics.
- The sister in surgical outpatients said a significant proportion of incidents reported were around patients becoming agitated and aggressive towards staff if their appointment was delayed. A zero tolerance initiative had been introduced due to a relatively recent 'spike' in these types of incidents; this included posters, leaflets and specific staff teaching sessions. This demonstrated a positive approach by the trust.
- In April 2016, a cluster of eight serious incidents had been declared in Outpatients, relating to patients that

# Outpatients and diagnostic imaging

had been lost to follow up and/or delays in diagnosis. The trust had put in a clinical validation procedure in June 2016 to reduce the likelihood of this happening again.

- We found patients and their relatives had been contacted following the serious incidents and the requirements for the duty of candour had been followed in the majority. 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 Outpatient management team told us outpatients had a duty of candour register. The medical director for the Family and Women's Health Group told us that patients who had suffered harm were always made aware and asked whether they wanted to see the 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.
- The medical director of the Family and Women's Health Group told us there had been a serious incident where the patient had been injected in the wrong eye. They said the procedure had been carried out by a locum.
- No 'never events' had been recorded by 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 outpatient staff the lessons learnt from the never events. Some staff could not tell us about the never events that had occurred at the trust.

## Diagnostic Imaging

- Data submitted by the trust showed that between 1 April 2015 and 31 March 2016, there had been 160

incidents reported in radiology at the HRI site. Eight of these had been categorised as severity level 3 (moderate) or 4 (major) and one was categorised as 5 (catastrophic).

- 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 were 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. However, all the reports were available electronically to anyone with authorised access to the systems and not all reports were routinely printed, the largest group being for ED patients where reports were read electronically.
- 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.
- Overall, seven SIs had been reported relating in radiology; four of which related to the printing issue and these were tracked with the commissioners at the monthly SI panel meeting to identify any more as they arose.
- Further investigation of the seven radiology SIs showed three were categorised as major, three as moderate and one as high. All seven patients involved experienced significant delays in diagnosis and/or treatment, which caused distress.
- Two never events had been declared in radiology since the last inspection, both involved wrong site / side surgery. Both never events occurred at the CHH site. The first occurred in October 2015 and the second in March 2016. There had also been a third never event, in March 2015, which had not been investigated at the time of the previous inspection.

# Outpatients and diagnostic imaging

- The two radiology clinical directors had made presentations to the trust's Quality Committee about the SIs and never events on 23 June 2016, entitled:
  - Learning from recent radiology SI's
  - Never Events in Radiology 2014/15 and 2015/16
- Staff told us that, following the two never events, all patients for interventional procedures had their skin marked, apart from a small number of exceptions. 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.
- Radiology managers told us the radiology safety checklist was currently kept in the patient notes and was not scanned into the radiology information system (RIS). They said when the RIS was replaced, in November 2016, the forms would be scanned in. This meant it was currently difficult to audit the completion of these checklists.
- In nuclear medicine, staff told us incident reports went to the radiation protection supervisor (RPS) immediately. The RPS told us the originator would get feedback about the incident outcome.
- Radiology managers told us they monitored trends of incidents. They said the main incident type reported was extravasation incidents; however, these were lower than the national averages. Extravasation is when fluid leaks into the tissue, usually surrounding an injection site. 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; there had been seven incidents notified in this period.

## Cleanliness, infection control and hygiene

### Outpatients

- The environment in most of the outpatient areas we visited was visibly clean, tidy and uncluttered. Surfaces and flooring were intact which aided effective cleaning. However, in audiology and surgical outpatient clinics we found environmental improvements, such as improved soundproofing (in audiology), were required.
- Cleaning staff followed cleaning schedules. For example, there were comprehensive cleaning checklists in all the ophthalmology clinical treatment rooms. We saw these were all completed as required and up to date.
- 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 the processes for carrying out and recording cleaning of equipment each day were infection control compliant. For example, in audiology, we saw staff used ultra-wave cleaning for ear moulds.
- 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%.

### 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. Staff had access to appropriate personal protective equipment, such as gloves, and cleaning products.
- We saw appropriate handwashing notices in place, waste was segregated appropriately and flooring complied with current guidance for flooring in healthcare facilities.
- However, curtains in the recovery area of the interventional radiology day unit did not have the date when they had last been changed. Staff were unable to tell us when they were last changed or what the system was for replacing curtains. The sister said they thought it was, "About every six months." They said they might be changing to disposable curtains in this area.
- The radiology manager told us there was an electronic cleaning checklist used to record cleaning, however we were not shown evidence of this. We did observe cleaning checklists on each noticeboard in the general x-ray rooms, these were all completed and signed morning and afternoon.
- Mandatory training records showed the majority of radiology staff were up-to-date with infection-control



# Outpatients and diagnostic imaging

training, apart from administration and clerical staff whose percentage compliance was 45%. Medical staff compliance was 94%. This was against the trust target of 85% compliance.

## Environment and equipment

### Outpatients

- The environment of most of the outpatient areas visited was in good state of repair, clean and comfortable.
- The surgical outpatients' preparation room was in the process of being upgraded. At the previous inspection, the preparation room was not in an appropriate condition. During this inspection, steps had been taken to improve the environment of the room but it was only partly completed. Patients were still using the room, mainly for being weighed. At the previous inspection, this room had a sluice hopper and sink; these had been removed. However, wall plastering was exposed and there were many visible screw holes. This meant the room still was not an ideal environment for seeing patients in.
- The plastics outpatient department had three consulting rooms; the general environment of each of the rooms was sufficiently comfortable. However, the main desks in the rooms were dated; they were old tables with scratched and worn wooden tops.
- Staff reported there had been some investment in improving patient environments, after a long period of any requests being denied. For example, water fountains had been installed in outpatient waiting areas.
- In ophthalmology, we visited the ward and the outpatient department within the Eye Hospital; we found all areas in a good state of repair with large, light waiting areas. Equipment within the treatment rooms was appropriate, for example there were reclining chairs, ophthalmology equipment and vision test screens.
- The ophthalmology clinical treatment rooms all contained specific equipment checklists; we saw these were all completed as required and up to date.
- Ophthalmology staff told us equipment was managed and tested by the medical physics department, who kept track of service contracts. Breakdown of equipment was on the ophthalmology risk register.
- In ophthalmology, we reviewed comprehensive equipment management and medical estates records in the outpatient department within the Eye Hospital. We

saw these documented the equipment number, location, manufacturer, model number, service and repair dates, and calibration dates. All records were up-to-date and included separate records for laser equipment and certificates of instrument accuracy.

- When we visited the gynaecology outpatient clinic, we found problems with the endoscopy scope cleaner; staff told us this machine broke down regularly. They said this had been a problem for about six weeks. They said they were only allowed six flexible scopes for each clinic but there were usually eight patients at each clinic. They said flexible scopes were much more comfortable for patients.
- They explained flexible scopes were sent off site and had not come back yet. If flexible scopes were not available, rigid theatre scopes had to be used.

### 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. The radiology manager told us the department had enough CR equipment to maintain the service while refurbishments (retrofits) were being carried out. A new CT scanner had been installed two weeks prior to the inspection.
- Staff in general x-ray told us the department had three DR mobiles and a DR machine in orthopaedics. They told us the department, "Does well with equipment replacement."
- A mobile MRI scanner (in a van) was in use when we inspected. The radiology manager explained this was because one of the department's three MRI scanners was not working.
- 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.
- The nurses in interventional radiology regularly audited the condition of the bed and trolleys; staff told us if these were unsuitable, they were condemned.



# Outpatients and diagnostic imaging

- When we visited the nuclear medicine department in the main building we found the facilities were old and in need of updating. The radiation protection supervisors in this area told us working in this was a problem, as they shared facilities with cardiology.

## Pathology

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

## 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 outpatient and radiology departments visited. We found medicines stored securely and staff recorded fridge temperatures regularly as required. We saw historic written evidence, which demonstrated staff checked medicines fridges on a daily basis and temperatures were all within expected ranges.
- Room temperatures where medicines were stored were not monitored but we found air conditioning units were in use and the rooms felt cool.
- Controlled drugs were stored securely and recorded in the controlled drugs book. We reviewed the controlled drugs records in the outpatient department within the Eye Hospital and found these to be all correct, including historical records.
- Any auxiliary staff administering eye drops in the eye hospital followed the consultant prescription pathway. Some of the specialist nurses in ophthalmology had patient group directives in place for administering medicines, injections or drops.

## Records

### Outpatients

- People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate patient records were not always available.
- We observed patient notes were stored securely and away from areas accessible by patients. All of the patient notes we reviewed in outpatients were paper-based.

- However, staff in outpatient clinics reported to us, and we observed patients' notes were not always available. For example, we found 20-24% of notes were missing for medical retinal clinics in ophthalmology.
- If staff were unable to find a set of notes, this would be escalated and, following a second review by the supervisor, outpatient clinics would start a temporary set of notes for the clinician to record the consultation. These were taken to the clinic with an explanation of why originals could not be found.
- Following the implementation of a new computer system, staff no longer had to print off clinical correspondence, referral letters or results, as these could be viewed electronically. At the end of the consultation, the temporary notes would go back to the medical records department to be reconciled with the originals. If medical records staff were unable to find the originals, then the "temp notes" would be made into an acute set of notes and an explanation would be added to the notes.
- In ophthalmology the intravitreal (injection) and emergency service used 'virtual notes'. Virtual patient records (VPR) help to reduce paper and streamline processes. Staff told us VPRs were used in order to get information back to the GPs in a timely manner. Staff said the system also reduced errors due to incorrect filing.

## Diagnostic Imaging

- The radiology information system (RIS) was due to be replaced in November 2016. This would enable checklists and forms to be scanned into the patients' records.
- Radiology stored and viewed images on the departmental PACS (picture archiving and communication system).
- We found the records in nuclear medicine were well documented and evidenced on the departmental computer system.
- The radiology department had recently implemented an electronic reporting system. The radiology manager told us the majority of users, including GPs, received their results electronically.

## Safeguarding

### Outpatients

# Outpatients and diagnostic imaging

- 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.
- 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 for medical and dental staff were lower in some areas but were still meeting the trust targets. In ophthalmology, medical staff achieved 90.3% compliance in vulnerable adult training.
- The trust did not submit disaggregated mandatory training data for other outpatient areas.
- No safeguarding issues were identified during the inspection and staff were aware of their responsibilities and were able to describe what actions they would take they had concerns.

## Diagnostic Imaging

- We saw there was a children's waiting area outside the fluoroscopy department. We asked the radiology manager about safeguarding training. They told us staff received mandatory training in safeguarding adults and safeguarding children and this training was all up to date. Radiology mandatory training records submitted 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

- Mandatory training records submitted by the trust showed staff in ophthalmology, dermatology, gynaecology, ENT, surgical outpatients and medical outpatients were all up to date.
- Senior nursing staff told us all training was done via the trust's HEY247 electronic system.
- In ophthalmology, staff told us on one morning or afternoon a month there were no clinics booked; this was to enable staff to attend training and development meetings.

- Staff in gynaecology outpatients told us mandatory training was done online and staff could check what training was required using the online system.

## Diagnostic Imaging

- The radiology manager told us they monitored mandatory training of staff on a monthly basis and that all 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. The clinical leads in each area were responsible for managing training.
- In nuclear medicine, the radiation protection supervisor told us mandatory and statutory training was on a three-year cycle. They told the staff training was all up to date and new staff carried out their training during induction. Training records in nuclear medicine were kept on the computer's Y drive in the Department.
- Staff in general x-ray told us they were given time to do training and managers were supportive. They said some training could be done online out of hours.

## Assessing and responding to patient risk

### Plastics Outpatients

- We observed a patient being treated under local anaesthetic in the plastics outpatients' theatres. We were unable to observe the initial checks around the patient and documentation but we observed documentation being completed during the minor operation.
- The team was using a safety checklist but we noted the entire form had been completed before the start of the procedure; this included the final stage of the checklist, which should be completed after the procedure and just before the patient leaves the operating theatre.
- In addition, two members of the surgical nursing team were supposed to sign the checklist depending on their role during the procedure. Each checklist should have the signature of the 'scrub' nurse and circulating nurse. On the checklist we observed, there was only one signature from one nurse, this was not in-line with trust policy.
- During the procedure, swabs and sharps were used, including a blade, hypodermic needle and sutures. We

# Outpatients and diagnostic imaging

observed that staff did not count swabs or sharps prior to or after the procedure. The standard of practice within the outpatient theatre varied to that of the main operating theatres.

## Gynaecology Outpatients

- We spoke with the specialist nurse who led on the colposcopy lists. During the colposcopy procedure, vaginal swabs were used on the majority of patients. The swabs were counted by the specialist nurse performing the procedure but the count was not witnessed by a second person.
- No documentation was used to record the number of swabs used or to confirm, between two people, that all swabs were accounted for after completing the procedure. According to a nurse who was present, not completing a witnessed swab count during colposcopy was in line with national practice.

## Outpatients

- There were systems and processes in place for assessing and responding to patient risk to keep patients safe. For example, in ophthalmology, we saw there were warning lights outside the three laser treatment rooms and the two injection rooms.
- In the ophthalmology recovery room, there was a large reclining chair for patients to use while recovering from procedures. Staff told us some patients might feel dizzy or have blurred vision.
- Nursing staff in the outpatient department within the Eye Hospital told us the recovery room had been used for patients or visitors when they had collapsed in the department. They said the department's emergency doctor would be called first followed by the accident and emergency crash team if required.
- We checked the resuscitation trolleys in all eight outpatient areas visited. We found appropriate equipment was available and daily checks had been fully completed by staff as required. For example, when we inspected the resuscitation trolley in the plastics outpatient clinic, we saw it was suitably set up and daily checks were carried out as per policy; secure tags were placed on the draws of the trolley after each check to prevent people from removing equipment in non-emergency situations.
- We found a variation in practice between outpatient specialties carrying out day surgery. When we asked the medical director of the Family and Women's Health

Group about staff conducting swab counts during surgical procedures, they acknowledged there was variation in practice between outpatient specialties carrying out day surgery. They confirmed ophthalmology carried out swab counts during procedures but some outpatient specialties did not.

- From speaking with staff in different outpatient specialties, some said the reason a swab count was not done was because the surgical incision was non-invasive/very small and a swab could not be lost in such a small cavity. Others confirmed they performed a swab count to ensure no swabs were left in a cavity and/or the theatre environment. A process of counting swabs between two members of staff provides assurance that all swabs are accounted for at the end of each surgical procedure.

## Diagnostic Imaging

- The radiology department had three radiation protection advisers (RPAs) and each modality area had named radiation protection supervisors (RPSs). For example, there were four RPSs in interventional radiology. These gave advice on radiation protection when needed to ensure patient safety and minimise radiation risk. We reviewed the risk assessments for radiation protection.
- The RPAs and Radiation Protection Supervisors (RPS) had received appropriate training in line with IR(ME)R guidance. Staff told us the support given by the RPAs and RPSs was excellent.
- All of the staff in radiology had undertaken IR(ME)R training. Training was carried out by radiation physics staff who 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 spoke with the two radiation protection supervisors (RPS) in nuclear medicine. They told us about the ARSAC (Administration of Radioactive Substances Advisory Committee) licence holder and vetting of referrals. We reviewed the list of people who were competent to vet nuclear medicine referrals. Routine vetting was done following a protocol; anything else was referred to the ARSAC licence holder. We reviewed an example of a referrer's authorisation for vetting and found that it was appropriate.
- WHO safety checklists were being used in both interventional radiology departments. The monthly

# Outpatients and diagnostic imaging

audit of their completion was fed back to the multidisciplinary teams. We observed a checklist being filled out in interventional radiology; this was completed correctly.

- We reviewed an audit on the use of the WHO surgical checklist in interventional radiology from November 2015. The results of the audit for the period undertaken demonstrated 93% compliance. The only negative score was a signature missing in two of the 30 checklists audited. This was identified at HRI and fed back to the staff concerned; thereafter there had been 100% compliance.
- In interventional radiology, all procedures, apart from nerve root blocks, had a WHO checklist and the radiology safety checklist. These were completed by staff in the consenting rooms and were checked in theatre by a second nurse before the procedure was carried out. Once in the theatre the whole team checked the radiology checklist as a surgical pause (huddle). The patient was also spoken to during this check, which was led by the nurse.
- We observed notices on display in patient waiting areas, asking patients whether they could be pregnant.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited.
- We observed a 'Pause and Check' notice in one interventional radiology theatre, from the Royal Society of Radiographers. Staff told us use of the pause and check within the rooms was a new initiative following the two recent never events. They said all of the questions were now asked in the room with the whole team and the patient present.
- Contrast media for use in nuclear medicine were securely locked behind a door with a key pad. Staff told us there was a continuous supply of isotopes and we saw evidence of double-checking injections as per the local protocol.
- Radiology equipment had routine quality assurance tests to check radiation exposure levels. Any trends or increases in exposure were reported to the RPS for investigation.
- We checked the resuscitation trolleys in all of the radiology areas visited, the majority of the records of checks performed were complete. The ultrasound department shared a resuscitation trolley with the radiology day unit.
- However, in the CT scanner room opposite the emergency department, we found staff had not

completed the resuscitation trolley monthly checks for seven out of the previous 12 months. When we asked the radiology manager who was responsible for carrying out these checks they told us it was the radiographers working in that area. However, when they asked the radiographers they said the resuscitation team also used that trolley and that team was responsible for restocking the trolley. This lack of clarity over roles and responsibilities for checking and restocking the trolley in this room meant there was a risk that vital equipment may not be available for a patient when they needed it,

- We observed that the CT scanner room adjacent to the accident and emergency department had the doors wide open onto a public corridor. This meant members of the public could access this room, as it was not kept secure.

## Staffing

### Outpatients

- Staff told us there were not always enough qualified, skilled and experienced staff in outpatients to meet people's needs. Staff in most of the outpatient departments we visited were very busy.
- Information submitted by the trust following the inspection, showed that between 21 March 2016 and 18th of April 2016 the difference between planned and actual hours for registered staff in ophthalmology was 18% less than planned, in maxillofacial it was 29%, in medical outpatients 43% and in general surgery outpatients 10%.
- For unregistered staff in the same period, the difference between planned and actual was 27% less actual hours in ophthalmology, 52% in maxillofacial, 19% in medical outpatients and 22% in general surgery outpatients.
- Senior nursing staff in ophthalmology told us the service was expanding and recruitment was ongoing. At the time of the inspection, there was 60 WTE staff in the Department these were a mixture of skills and grades. They told us staff numbers were due to increase to 68.6 whole time equivalent (WTE) staff. The medical director of the Family and Women's Health Group told us the staff headcount in ophthalmology outpatients has increased from approximately 14 to 75 over the past 10 years.
- Ophthalmology had six WTE band three ophthalmic support workers and 14.09 WTE band two staff. Senior

# Outpatients and diagnostic imaging

nursing staff told us the Eye Hospital had recently recruited to four additional intravitreal nurse practitioner posts. There was a band five clinical liaison officer and a band two assistant clinical liaison officer.

- There were 11.25 WTE qualified nurse practitioners in ophthalmology and they were developing the band six staff to become nurse practitioners. The nurse practitioner role had supplemented medical staff numbers to help address problems meeting the timings required for patients' repeat intravitreal injections.
- They told us two band six nurses would be recruited to work as first assistants in theatres and band two technicians were being advertised for. The department had just recruited three WTE band five staff.
- A new role had been identified in ophthalmology for a data support analyst. Finance to fund this role had recently been approved and recruitment was about to start.
- The sister in ophthalmology told us they felt optimistic about recruitment and staffing in the department. They told us that, on a day-to-day basis, it was difficult to fully staff across the external clinics. This was due to absences including various types of leave and long-term sickness. Sickness in the department was being managed according to the trust policy.
- Ophthalmology did not use any agency staff, gaps in the rotas were covered by their own staff working flexible shifts and additional hours.
- The outpatient department within the Eye Hospital had recently recruited to four additional Intravitreal Nurse Practitioner posts staff told us this would enable 12 additional injection lists to run each week.
- In the gynaecology clinic, we found staffing levels had been reduced; staff were very busy and told us the work was stressful. However, they said staff could claim overtime and all staff did overtime if it was needed.
- Staff in audiology told us they were currently short of staff, due to three staff leaving. One audiologist assistant was due to start in August 2016, and a band five post was being advertised.
- Senior nursing staff in general medical outpatients told us their staffing was up to establishment. They had identified additional money for 16 hours a week for a qualified nurse. The sister felt staffing levels were safe, long-term sickness was covered internally and no agency or bank staff were used.

- At the time of the inspection, surgical outpatients had two band seven sisters. One of the band seven sisters was retiring imminently and a band six nursing post was being advertised to fill the band seven gap.
- Due to the recent (1st June 2016) restructure between plastics (moved to the Family and Women's Health Group) and surgery, staffing was under review. The band seven sister was awaiting a decision around future staffing numbers under the new structure.
- In surgical outpatients, demand for plastics clinics had increased, particularly over the past year. Despite the increased patient throughput and workload, staffing numbers had remained the same; staff were working to full capacity and described the staffing as 'tight'. Clerical support and room space was also 'tight'.
- No agency nurses were used in surgical outpatients, but an auxiliary bank nurse was used each day. Extra sessions relied on the good will of staff; who claimed overtime or lieu time.
- Outpatients had daily safety huddles, these identified staffing levels and work allocation for the day.

## Diagnostic Imaging

- The radiology manager told us radiographers managed by the radiology service also worked in the 'cardiac catheter labs.' However, this service was not managed by radiology.
- The radiology manager told us the trust offered relocation packages for radiographers. There were a significant number of vacancies in radiology at the HRI site at the time of the inspection. For example, in general x-ray there were 9.5 WTE vacancies, out of an establishment of 56 WTE. In CT, there were 3.1 WTE vacancies out of an establishment of 24 WTE, in MRI there were 1.5 vacancies out of an establishment of 19.
- There were no vacancies in interventional radiology or ultrasound at the time of the inspection and no agency staff were used in these areas. Radiology nurse staffing was up to establishment at HRI. Data submitted by the trust following the inspection confirmed what staff had told us.
- The radiology manager said the department had used agency staff but these were not always available.
- The radiation protection supervisors in nuclear medicine told us there were six band five technicians, four band six radiographers and two band seven radiographers covering two sites.



# Outpatients and diagnostic imaging

- Radiology supervisors and managers stayed in their own areas and band five radiographers rotated between sites. Some staff in CT and MRI rotated between the HRI and CHH sites.
- Staff in general x-ray told us there were rotas for staff to work extra hours at night and out of hours. This was due to the current staff shortages, they said staff put in their availability and shifts were always covered.
- The radiology managers told us there was low staff turnover and good staff retention in the department.

## Pathology

- The histopathology laboratory manager told us they had increased the number of advanced practitioners in the department, they now had three band sevens and the business case had been submitted for a fourth. These staff carried out 55% of the macro dissection in the department. A band 8a specialist scientific lead was also being trained to do reporting.

## Medical staffing

## Outpatients

- Senior nursing staff and some outpatient specialties told us there were problems with medical staff recruitment, for example, senior nursing staff in ophthalmology told us medical staff were 'stretched.' However, clinics were rarely cancelled and clinics were moved around to accommodate patients.
- In surgical outpatients, the plastics department had a 10-week consultant rota. A registrar and middle grade doctor supported the consultant. No problems were reported in terms of medical cover for plastics outpatient clinics.

## 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 radiology manager told us there was a national shortage of consultant neuro-radiologists. At the time of the inspection there were two full-time radiology consultants working in neuro-radiology.
- The radiologists had four separate specialist on-call rotas; neuro-radiology was one in five, interventional radiology (non-vascular) was one in four, CT was one in

seven and vascular was one in six. This represented 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 service, mainly reporting results.

## Pathology

- The histopathology laboratory manager told us there were three vacancies for consultant histopathologists, there had been five vacancies a year ago. This meant there were three vacancies out of the establishment of 13 WTE. They said they had taken on a speciality doctor and once they had passed their 'MRC Path' exam, they would become a substantive consultant. The advanced practitioners in the department were supporting the consultants with macro-dissection.

## 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.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- The issues from 2015 around consent in hysteroscopy had been rectified. Consent procedures were observed in ENT and ophthalmology and there was a new consent process in interventional radiology theatres.
- Care and treatment was delivered following national and/or local guidance or best practice.
- Staff were suitably qualified and skilled to carry out their roles effectively. We found competent staff in all areas,



# Outpatients and diagnostic imaging

nurse led clinics and expanding use of extended roles. There was high use of advanced practitioners, including in histopathology, specialist nurses and reporting radiographers.

- Services were moving towards seven-day working, many clinics were working extended days and weekends.

However,

- We found issues with document and version control for procedures in radiology. We found uncontrolled paper copies in circulation. This meant there was a risk staff were not following the current procedure.
- 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

- Patients' needs were assessed and their care and treatment was delivered following national and/or local guidance or best practice.
- However, 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. For example, in gynaecology outpatients, the target wait time for patients with postmenstrual bleed was two weeks. Staff told us these patients needed to be seen urgently and the department was not meeting this target.

### Ophthalmology

- In ophthalmology, there was a triage checklist used by staff that showed patients with urgent symptoms were referred appropriately to clinical or medical staff.
- Staff in the bookings centre told us they followed trust policies and procedures for clinic booking. Staff had desktop guidance for each specialty, which covered access plans, timeframes and clinics.
- Nursing staff in the outpatient department within the Eye Hospital told us they had been auditing their OCT (optical coherence tomography) images since August 2014. They said this audit was ongoing and linked with glaucoma monitoring clinics.

- Audiology staff told us they were meeting the key performance indicators (KPIs) for hearing screening. For example, 90% of patients had a hearing screen completed within four weeks of raising concerns.

### 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.
- 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.
- An x-ray radiographer told us they had carried out an audit of lead markers. They told us they were going to repeat this audit to see whether there had been an improvement.
- Radiation protection supervisors in interventional radiology told us they had started carrying out radiation protection audits in May 2016.
- There was a comprehensive quality assurance programme for all of the ultrasound machines; these were tested weekly, monthly or annually.
- In ultrasound, there was a peer review audit, which checked 5% of all scans; sonographers audited each other's work. There were also radiology discrepancy meetings and monthly audit meetings in ultrasound.

# Outpatients and diagnostic imaging

- 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 the audits.

## Patient outcomes

### Outpatients

- Between December 2015 and March 2016 between 82.3% and 91.4% of cancelled outpatient 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.

### 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

- All of the pathology departments at the trust were accredited. The United Kingdom Accreditation Service had inspected histopathology in September 2015; the laboratory manager told us this was a surveillance visit and compliance was maintained.

### Competent staff

#### Outpatients

- 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 appraisal was done via the trust's HEY247 electronic system. Staff we spoke with all told us their appraisals were up-to-date.

- In ophthalmology, one band two support worker described their four-week induction to us. They told us they had been observed and tested before being signed off as competent to carry out eye tests and administer eye drops to patients.
- In ophthalmology, one band six junior sister spent their time managing the department and training staff in additional skills. Staff told us nurses were given opportunity to develop specific skills. For example, one band six nurse carried out high skill level procedures in glaucoma and a business case had been put forward for her to be upgraded to band seven.
- At the outpatient department within the Eye Hospital, staff told us there were four nurse practitioners with ophthalmic roles; they performed intravitreal injections at the HRI site. There were also nurse led diagnostic clinics such as fluorescein angiography and photodynamic therapy.
- Auxiliary nursing staff at the outpatient department within the Eye Hospital were undergoing training and development. Eleven had achieved NVQ level three, nine were currently working on their care certificate and two were undertaking research training, to support research in the department.

### Diagnostic Imaging

- Records were kept of consultant's 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 consultant's practice, as part of the appraisal and revalidation process.
- Consultants were required to participate in appraisal annually and submit evidence of CPD to the Trust's 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

# Outpatients and diagnostic imaging

used by the radiologists i.e. in the new interventional rooms. Staff we spoke with told us they were trained and competency assessed on all the equipment they needed to use.

- We saw there was a good induction programme for agency staff working in radiology, which covered all departments including nuclear medicine. Cleaning staff working in nuclear medicine were given a certificate following their induction to the department.
- Radiology had a number of extended roles for radiographers for example, one radiographer in MRI specialised in knees. There were also reporting radiographer roles, these included musculoskeletal, abdominal, chest, and CT colonoscopy. Some radiographers did forensic work and the ultrasound service was sonographer led.
- Some radiology nurses working in nuclear medicine had been trained to refer patients attending the prostate clinic for a bone scan. The ARSAC licence holder had signed to allow these staff to make these referrals. We checked the ARSAC licences during the inspection and found these to all be in order.
- A reporting sonographer working in ultrasound told us they had been trained to perform musculoskeletal joint injections.
- 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 the radiation departments, including nuclear medicine. The RPS in nuclear medicine told us staff went through their competency framework during the appraisal.
- There was a radiology nuclear medicine e-learning programme, organised by the RPA.
- 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 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 (MDT)

### Outpatients

- Staff in the majority of outpatient clinics visited told us they worked well with other teams. For example, staff in audiology told us they had good contact with local education facilities.
- However, one of the serious incidents declared in outpatients, showed there were communication problems between different MDT meetings. The patient was on two different pathways of care, with no communication between the two teams.

### Diagnostic Imaging

- We found good examples of internal and external MDT working in radiology.
- The nurses working in ultrasound told us they worked closely with the nurses in the radiology day unit. They said there was good support from the day-care team for staff in the ultrasound area.
- One support worker in radiology had worked closely with the 'Pioneer Team Academy' to create radiology link nurses on all wards. The aim was to improve communication between radiology and nursing staff, improve the patient experience and reduce lost scanning time. Their executive sponsor was the Chief Executive of the trust. They told us the idea had been well received by nursing staff of various bands, and feedback was, "better than I could have hoped for."
- The radiology clinical directors told us the neuro-radiologist who worked remotely for the department from Scotland regularly visited the Department and attended spinal MDT meetings.
- 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

### Pathology

- The laboratory manager in histopathology told us the department had set up a formal working relationship with Sheffield NHS foundation trust. They said they were the first two trusts in the country to do this in histopathology. There was an established neuropathology network between the Hull laboratories and Sheffield NHS trust.
- The laboratory manager told us they were about to start using a digital scanner for MDT meetings. This meant

# Outpatients and diagnostic imaging

microscope slides could be shared and viewed interactively from anywhere, using the Internet. The lead consultant histopathologist told us the digital scanner would speed up reporting.

- The lead consultant in histopathology told us they generally met their MDT agreements, but not the Royal College of pathology key performance indicator recommendations.

## Seven day Services

### Outpatients

- Staff in the majority of outpatient clinics we visited, told us they held evening and weekend clinics to keep up with the backlog. When we met with the outpatient management team, they confirmed this.
- For example, ophthalmology outpatient clinics were open from 8.30am to 6pm Monday to Friday and there were clinics every Saturday.

### 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.
- Radiology worked extended days, usually from 8am to 6pm. For example, the CT on level two in the main building was open from 8am to 6pm for inpatients and outpatients. Out of hours there was a 24-hour service in CT, which was staffed by one CT radiographer in the evening and overnight with support workers in the evenings.
- The MRI department was open 12 hours a day, seven days a week.
- The radiology day unit was open from 8am to 6pm and no patients stayed there overnight. Staff told us urgent patients were 'imaged' there out of hours, but did not stay on the unit.
- The radiology management team told us that 'out of hours' neuro intervention provision was currently on the risk register. This was because they were unable to offer a 24-hour seven-day week service.

### Pathology

- The histopathology laboratory manager told us the department was looking at moving to extended working days.

## 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.
- However, we found there was a high proportion of missing notes in the intravitreal service outpatient clinic we observed during the visit. For example, the 28 June 2016 afternoon list had 10 sets of notes missing out of 49 patients due to attend the clinic. This meant 20% of the notes were missing. On the 27 June 2016 (the previous day), there had been 21 sets of notes missing and 87 patients were on the clinic list. This meant 24% of the notes were missing.
- When we asked staff what was being done about this, they told us lists of missing notes were passed on to the clinical performance meetings. Representatives of patient groups and administration/bookings staff attended these. They said the audit of missing notes had resulted in more staff being employed and a new case note system was introduced in June 2015. Staff said they were starting to see improvements as a result of this.

### Diagnostic Imaging

- Staff in radiology told us the intranet site was easy to use to access the information they required.
- 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.

### Outpatients

# Outpatients and diagnostic imaging

- Staff in ophthalmology outpatients told us patients for laser treatments were consented separately for each procedure; these were usually patients with diabetic retinopathy.
- We visited the gynaecology outpatients department where there was a regular hysteroscopy and colposcopy list. At the previous inspection we found that consent procedures were not being accurately followed for the hysteroscopy list. At this inspection the issues around consent had been rectified. We reviewed the notes of five patients who had attended a recent hysteroscopy list and consent had been completed accurately.
- Staff told us written and verbal consent was obtained from patients for all minor operations and hysteroscopies in the gynaecology clinic. Completed consent forms were kept in patient notes.
- Staff told us consent forms were not used for colposcopies; they said verbal consent was obtained from the patient for these procedures. When we asked the outpatients' management team about consent for colposcopy, they told us they had reviewed the national information available and found that 90% of trusts carrying out colposcopy did not obtain written consent. They accepted that this was a potential clinical risk.
- In the plastics outpatient department, we noted one patient had signed their consent on the day of the procedure; there was only one patient signature. This did not follow the two-stage consent process. Three copies of the consent form were in the patient's notes; the patient had not been given a copy.
- The patient administration manager in the appointments and referral centre told us they sent patients text message reminders about their appointments. However, patients could choose to opt out of this.

## Diagnostic Imaging

- In interventional radiology and fluoroscopy, we observed a patient giving their consent for a procedure. The interventional radiology manager explained that patients were consented when the nurses carried out a nursing pathway assessment.
- A reporting sonographer working in ultrasound told us non-interventional procedures used verbal consent and written consent was used for interventional procedures, such as joint injections.

- A consent audit had been carried out in interventional radiology theatres in March 2016; this showed more than 80% adherence to the trust patient information policy (which covered consent). No actions were required.

## 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 in the MRI department in radiology told us they used neuro-linguistic programming (NLP) for patients that had claustrophobia. They gave an example of a patient who had previously needed intravenous sedation when having an MRI scan, who could have the scan without sedation after the NLP sessions with staff.

However,

- In some of the radiology waiting areas we observed privacy and dignity issues, however, senior staff were aware of these problems.

## Compassionate care

### Outpatients

- We observed positive, friendly interactions between staff and patients in all of the areas visited.
- We spoke with six patients during inspection, they were all happy with the service. One patient commented that the staff were "pleasant" and another described three nurses they had seen in the department as, "All brilliant."



# Outpatients and diagnostic imaging

- 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.
- Senior nursing staff in general medical outpatients told us they identified patients who may need additional care while they were waiting for their appointment by using a laminated card, which was put at the front of the notes. This alerted staff to offer refreshments, toileting, alternative seating and pressure area care. Staff we spoke with felt this had been very successful, although it had not been audited.
- In one of the treatment areas we saw staff documented the time they administered drops to patients on a 'patient board'. We noted that the patients' initials were used, rather than their full name. This respected peoples' privacy.
- All of the outpatient areas we visited had water fountains; some also had refreshment machines and televisions for patients to use.

## Diagnostic Imaging

- We found the staff in radiology were excellent; they were very caring. We observed courteous and respectful interactions between staff and patients in all of the areas we visited.

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

### Outpatients

- 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.
- Staff in ophthalmology outpatients told us patients could choose where they would prefer to wait for their transport home; some preferred to wait in the reception foyer.
- 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. When we asked the patient administration manager about this, they told us that giving patients a choice of appointments was difficult to manage.

### Diagnostic Imaging

- In nuclear medicine, all visitors to the Department were given copies of the local rules and radiation information and advice.
- In fluoroscopy, we observed a patient being prepared for a procedure. Two staff explained procedure to the patient, including the risks and benefits.

### 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.

### Outpatients

- Staff in ophthalmology told us one member of staff was always available to stay with patients if the clinic was running late, after 6pm. Staff told us no patients would be left unattended and waiting for transport, there would always be a member of staff to accompany them.

### Diagnostic Imaging

- We saw there was a counselling room in the interventional radiology department.
- A radiographer in the MRI department in radiology told us they had been trained to use neuro-linguistic programming (NLP) for patients that were claustrophobic about having MRI scans. They related an example of a patient who had previously needed intravenous sedation when having an MRI scan, who could have the scan without sedation after the NLP sessions with staff.

## 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 and diagnostic imaging

- The trust was 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 appointment booking process was variable across services, specialties and sites. There were capacity and demand problems in the majority of outpatient clinics visited.
- The quality of facilities and premises used to deliver services were variable. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair. For example, staff in audiology told us there had been a flood two years ago and that the damage was still not fixed.

However,

- 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 histopathology reporting backlog had improved significantly since the last inspection, from 820 twelve months ago to 120 at the time of this inspection.
- There was a telephone triage in ophthalmology by a qualified nurse, which improved the service for patients as it screened out issues that could be dealt with by nursing staff.
- Gastroenterology held evening clinics for 16-18 year olds between 5pm-9pm. This meant they did not have to miss school.
- We found many examples of nurse led clinics and there was an increasing use of nurse practitioners in ophthalmology.
- Feedback from audiology staff was positive; they said they were meeting targets.
- 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.
- Staff in neurology clinics offered drinks and pressure area care to their patients if they had mobility problems and a long wait, for example patients with multiple sclerosis.

## 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.
- Senior nursing staff in ophthalmology told us follow-up appointments for patients were restricted by the lack of space and lack of doctors to run the clinics. They said a growing elderly population and an increasing demand for services such as macular degeneration exacerbated capacity issues.
- Staff in the booking centre told us outpatients were sent a text reminder one week before their appointments, apart from oncology patients. When we asked the patient administration manager whether the use of text messages had improved the DNA rates, they said they were not aware this had been looked at. However, they said it had increased the cancellation rates but were unsure why.
- The quality of facilities and premises used to deliver services were variable. Some outpatient clinics were short of space, and some clinical areas located in the main building were in need of refurbishment and repair. For example, staff in audiology told us there had been a flood two years ago and that the damage was still not fixed.
- We saw the audiology department's waiting area was located in a corridor near to a mixed specialty reception. We saw there was limited space and the hearing rooms and testing rooms were losing their soundproofing and were visually not appropriate. Curtains had been put up to minimise the glare from the soundproofing, staff told us patients may feel dizzy in this room so they tried not to use it.
- Gastroenterology had introduced a pilot clinic for 16 to 18-year-olds; this ran from 5pm to 9pm and had been

# Outpatients and diagnostic imaging

successful. This reduced the time lost in education, as it was after school. Staff told us they were hoping to expand this across other specialties and thus increase the attendance of young adults at clinics.

- Ophthalmology and dermatology ran virtual clinics; this meant patients did not require a face to face consultation at each appointment.
- There was work ongoing as part of the sustainability and transformation plans (STPs) for the larger geographical area with other health and social care partners to address the capacity and demand issues with ophthalmology.

## Diagnostic Imaging

- We saw the waiting areas in radiology in the main building were too small for the number of patients using them. We observed chairs on the corridors outside the waiting rooms.
- In the main building, there were no dedicated waiting areas for patients on trolleys or beds and the areas were not easily accessible to wheelchair users.

## 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 was meeting the current individualised local standard between April and June 2016. The revised trajectory in April 2016 was 84%; the trust achieved 86% and in May 2016 the trajectory was 84.9% and the trust achieved 87%.
- 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%.
- The DNA rate at Westbourne NHS Centre was over 10% in all but two of the 12 months between September 2014 and August 2015. In August 2015 it reached 20%. We asked staff about the high DNA rates for the neurology follow-up clinic at Westbourne NHS Centre on Wednesday mornings. None of the staff we asked about this could explain the reason for this.
- 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, 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

# Outpatients and diagnostic imaging

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's Health 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 or 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. Staff and managers told us 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, staff told us patients regularly waited for up to two hours in oncology clinics. However, when we visited the audiology department, we saw appointments were running on time.
- The Sister in general medical outpatients told us neurology saw approximately 1,500 patients per week and ran large clinics. Senior nursing staff in general medical outpatients told us they were concerned about the long waiting times for patients in the clinic and when waiting for transport. This included patients with multiple sclerosis and other neurological problems such as motor neurone disease.
- One patient in surgical outpatients told us they were under multiple consultants and they had to travel to different trust locations for the varying outpatient appointments. The patient's appointment was 3pm, running 20 minutes late.
- A second patient told us they had needed to alter their follow-up appointment and the department was accommodating about this. Their appointment was at 3.30pm and they were called in to see the doctor on time.
- Another patient in plastics outpatients told us the clinic they were attending was running 35 minutes late. They said the nurse in the clinic was keeping patients informed.
- 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) and holding lists, which 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.

# Outpatients and diagnostic imaging

- 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.

## Ophthalmology

- Referrals to ophthalmology came from GPs, opticians and accident and emergency. Existing patients could also self-refer.
- Senior nursing staff in ophthalmology told us there were not enough doctors to reduce the waiting list in ophthalmology for follow-up appointments.
- There was a telephone triage service 24 hours a day, seven days a week. This was run by specialist band six nurse during the daytime and doctors on the ward overnight.
- There was a one-stop clinic for patients needing an injection. Staff told us each patient had a full assessment at each appointment in order to monitor any changes
- When we visited ophthalmology, we noted that the medical retinal clinic was running on time on the afternoon we visited; however, staff told us that in the morning that day, it was running between 60 and 90 minutes delayed.
- Staff told us patients appointments were only cancelled 'occasionally'. They said patients would never be cancelled on the day, they would pre-inform the patients.
- The only exception would be laser treatments where treatment would not be safe if case notes were not available.
- Staff told us that if a patient turned up on the wrong day or at the wrong location then they would try to see them if possible.
- In the ophthalmology outpatient clinics, we saw large whiteboards documented any waiting times for appointments. They also informed patients which doctors were on duty. The names of the nurses on duty were also displayed on these boards. The nurse covering that area kept these updated.
- The medical director for the Family and Women's Health Group told us ophthalmology workload had increased by 30%. They said staff were working extended days and Saturdays to cope. They told us there was an ophthalmology business case to increase the footprint of the area available by a third. In addition a business case was being developed to increase the staffing.
- They said patients with wet macular degeneration needed regular injections every four to twelve weeks. They said the department did 9,500 of these injections a year and the waiting time had drifted to between six and eight weeks in 2015. Some patients' vision had deteriorated by the time they were seen, and some had suffered moderate harm. The trust told us they had introduced "Treat and Extend", which meant delays in injection appointments varied between zero and two weeks for urgent treatments. They said ophthalmology services had been opened at the Castle Hill site, because there were a limited number of injection rooms at the HRI site.
- They said patient administration gave real-time feedback monitoring the slippage and the lists were subject to regular scrutiny. However, retinal screening was picking up patients with problems and the department was unable to follow this up with a timely appointment.
- Nursing staff in the outpatient department within the Eye Hospital told us they ran two glaucoma-monitoring clinics each week and had introduced virtual clinics; they said these had reduced the backlog and waiting times.

## Diagnostic Imaging

- 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 better than (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'.
- The radiology management team told us their DNA rates were low and they were keen to implement text message reminders. For example, the DNA rate in ultrasound was 5.6%. They said the DNA rates in paediatric ultrasound were higher and they were investigating the reason for this.
- Information provided by the trust showed that the mobile MRI scanner was used on eight days during March 2016. At the time of the inspection, the mobile MRI scanner was in use full-time in order to reduce breaches in the timeliness of MRI imaging.

# Outpatients and diagnostic imaging

- Staff in ultrasound told us their appointments generally ran to time.
- In interventional radiology, patients could be assessed for day case procedures by telephone.
- If plain films were not reported within six days, these were outsourced. This ensured patients got their results in good time.
- 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.
- 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% annually.

## Pathology

- The histopathology laboratory manager told us the reporting backlog in May 2016 was 773 specimens. On 29 June 2015, 870 cases had not been reported within 28 days and on 30 June 2016, 110 cases had not been reported within 28 days. This showed there had been a significant improvement in the past 12 months. The laboratory manager told us no patients had come to any harm due to delays in reporting results.
- Histopathology had rapid processing for needle core biopsies, the laboratory manager told us these were processed within four hours.
- The histopathology department had a service level agreement with an external company to outsource reporting for routine work. The turnaround time in the tender was for 90% of diagnostic reports to be reported within five days of collection.

## Meeting people's individual needs

### Outpatients

- In ophthalmology, we saw yellow and black signage, which clearly directed patients with any visual impairment to the correct areas(s). A specialist team carried out eye tests for children, there were also

specialist staff caring for and treating patients with dementia, additional needs or communication problems. Staff told us there was always a specialist paediatric qualified nurse on duty.

- We saw there was plenty of room to manoeuvre wheelchairs in the ophthalmology waiting areas. There were four toilets available in the main waiting area, one of which was wheelchair accessible. There were handrails and an emergency alarm in this wheelchair accessible toilet.
- In the ophthalmology orthoptist area, there was a separate waiting area for children with books, toys, small seats and age-appropriate wall prints. This area was separate from the adult waiting areas.
- There were no separate toilets for children in ophthalmology; there were baby-changing facilities in the wheelchair accessible toilet. Audiology was located in a small area but we saw it was able to accommodate patients in wheelchairs.
- However, in surgical outpatients, the doors entering in to the department were not automatic. We observed three people in wheelchairs struggling to open the doors and wheel themselves through at the same time.
- The trust had a dementia strategy but staff training in dementia awareness was not mandatory. Staff in audiology told us they allowed extra appointment time for patients with dementia or learning needs. They said staff in the department had attended dementia awareness training.
- 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.
- 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.
- Staff transferred inpatients from the main block to the MRI department on trolleys or hospital beds; staff wheeled these across the car park. At the time of the inspection, there were works taking place in the car park areas, and staff transferred patients to the MRI department by ambulance on a temporary basis. The



# Outpatients and diagnostic imaging

radiology manager said there were covers available for use by patients on a bed/trolley and there were plans to locate the next MRI scanner to be installed in the main hospital building.

- In ophthalmology, we visited the ward and the outpatient department within the Eye Hospital and found there was no sign at the reception desk asking patients to wait back from the desk to reduce the chance to overhear conversations. Eight patients were queuing to use the reception desk when we visited this small reception area. This meant private conversations between patients and reception staff may be overheard.

## Diagnostic Imaging

- In nuclear medicine, the radiation protection supervisors told us staff training in dementia and equality and diversity was not mandatory.
- A reporting sonographer in ultrasound told us patients with learning difficulties or physical difficulties would have a nurse escort. They confirmed dementia training was not compulsory for staff working in the area.
- In the radiology day unit, we saw there was segregation of male and female patients in separate bays.

## 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 outpatient fracture clinic (15), followed by elective orthopaedics (10) and ophthalmology (10). Cardiology outpatients had eight complaints and plastics outpatients had six complaints.
- 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.

### Diagnostic Imaging

- Radiology had received eight complaints in the same period, two of which related to patient care.

### Pathology

- Pathology at Hull Royal infirmary did not receive any complaints this 12-month period.

## 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 had varied between the four Health Groups and visibility of the leadership was variable. There had been no overarching governance structure or cohesive management oversight in outpatients, but this had recently been addressed and was being developed.
- The trust, for some time, had not been achieving the national indicators for referral to treatment and urgent cancer treatment and current outpatient capacity did not meet the demands on the service. There were appointment backlogs and waiting lists in outpatients, especially in ophthalmology. The trust was working with the local commissioners (CCG and NHSI) to improve this.
- The ongoing backlog position was being monitored and addressed at senior management level; however, staff we spoke with in outpatient clinics were unaware of what was being done to improve the situation. Staff in outpatient clinics were unaware of their own waiting list positions and backlogs.
- 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 2015 inspection, outpatients had declared eight serious incidents and radiology had declared seven. There had also been two never events in radiology. There was a lack of assurance that the lessons learnt from some of the serious incidents in both services and never events in radiology had been embedded to ensure no further incidents occurred.

However:



# Outpatients and diagnostic imaging

- 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 outpatient 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 to achieve the national standards. 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.
- Risks recorded within the Health Groups' risk registers reflected the main concerns. There was no overarching outpatient risk register which did not allow cohesive oversight, and limited evidence of outpatient audits and quality monitoring.
- 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, ophthalmology and pathology.
- 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 KPIs was being monitored.
- Staff knew about the trust vision and told us there had been staff events related to this. However, some staff told us the events had been publicised at too short notice for staff to attend.
- 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

- 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 outpatient management structure, operational policies and processes.
- 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.

## 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

# Outpatients and diagnostic imaging

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. Recent changes were starting to address this including the PandA 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.
- 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. The aims of which were:
  - To quantify, as a priority, by specialty, the number of patients that had passed their outpatient follow up date;
  - To have a standard approach to validating these patients;
  - To develop trajectories for the reduction and elimination of follow up backlogs and;
  - To clinically review these patients to quantify if any had had experienced harm.
- Some action plan target dates were overdue.
- There were trust-wide performance and access (PandA) 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 were significant concerns relating to appointment backlogs and waiting lists in outpatients, especially in ophthalmology, which had not been addressed since the last visit.
- 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.
- Risks identified within the Health Group risk registers reflected the main areas of concern. These specifically included ophthalmology, dermatology and a composite risk relating to specialties within the Medicine Health

Group regarding a number of overdue appointments outstanding in respiratory medicine, endocrinology, diabetes, cardiology, neurology and rheumatology. There was no overarching outpatient risk register.

- 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.

## 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.
- For example, 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

# Outpatients and diagnostic imaging

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, rather than outsourcing it. This should be more cost effective and helps maintain 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.
- Two of the consultant radiologists shared the clinical director role in radiology; one for governance and one for information technology. 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 trust had effectively managed a serious incident that had been declared by Radiology in December 2015 regarding 50,000 radiology reports failing to print. This printing issue had led to a further four serious incidents being declared by the time of the inspection. These incidents had been identified by the trust, action had been taken to change the system and additional safety alerts had been added which if breached were reported to the medical director.
- The 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.

## Pathology

- Pathology Governance Committee Meeting minutes showed that the quality systems were discussed and reviewed in these meetings. Agenda items included audits, risk assessments, and corrective and preventive actions (CAPA).

## Leadership of service

### Outpatients

- There was limited trust-wide overarching operational management of outpatient services and each of the Health Groups offered different levels of management and clinical support. Staff talked of plans to get all outpatient services into one structure, and the appointment of a matron for outpatients. 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.
- Most staff told us their local managers and matrons were supportive but there was limited contact with their senior managers.
- Staff in surgical outpatients had previously had 'time out' days for the nursing team and senior staff. This helped staff get to know each other better. We were told that this 'time out' no longer took place.
- Staff felt the trust board was introducing positive changes. They reported feeling more supported and there was a feeling of mutual trust. Staff were generally enthusiastic, positive and optimistic.
- Senior nursing staff in ophthalmology told us the executive team had not visited the department recently.

# Outpatients and diagnostic imaging

The head of nursing had visited the surgical outpatients unit recently, staff told us this was seen as constructive. However, they commented that senior staff could get to know junior nurses better, and have more visibility.

- Staff in gynaecology outpatients told us the department had recently lost two managers; they said this had been very stressful. Two departments had combined, including the consultant staff.

## 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. We found nuclear medicine was a very well led department.

## 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.
- 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.
- The sister in surgical outpatients told us the culture across the surgical division and the trust as a whole was much more open. They felt the 'fear factor' about being open and honest had now gone.
- The sister in ophthalmology told us they were very confident in their staff, and they had good support from the consultants and business support.
- However, staff in ophthalmology told us they rarely saw the matron for the service. They added that the matron covered multiple services and was contactable if needed.

- Staff in gynaecology outpatients told us they were proud of their department, everyone worked together, and things were improving. They said the department had a very positive culture and there was more stability than in the past.
- Staff in nuclear medicine had a good team and provided a good service. They were very open and honest.
- From our observations in the bookings centre, we found a very close friendly atmosphere where staff were supported by their managers, who were working close by. Staff told us they were encouraged to put forward suggestions for better or different approaches to their work.
- 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. However, some staff told us they would like more training opportunities and one support worker told us they felt morale was still very low in radiology.
- 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.
- The lead consultant in histopathology told us they felt the atmosphere at Hull had changed for the better over the past year. They said there was a supportive management structure.

## Public engagement

### Outpatients

- The friends and family test results for outpatients for the six months between December 2015 and May 2016 showed consistently good results but the response rate was consistently low.
- For example, the average percentage of respondents who would recommend the service was 94.2% and the average response rate was 4.2%. In May 2016, there were 2,304 responses from a total eligible of 48,928; of these respondents 94% would recommend the service and 1% would not.

# Outpatients and diagnostic imaging

## 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 not provided with any evidence to show that the general departments actively sought feedback from patients.

## Staff engagement

### Outpatients

- We found the visibility of managers within services was variable. Some staff saw their manager at least once a week and reported they were very approachable. One member of staff said they would not hesitate to contact their manager if they needed to. However, staff in plastics outpatients reported that they had not seen a matron for “a considerable period.”
- 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 were in the Surgery Health Group. The sister told us they had not been involved in any of the decision-making related to this restructure.
- Student nurses told us they were asked to give feedback about the clinical area they had worked in, but did not always hear anything back. For example, one student nurse completed the ‘you said we did’ evaluation but received no feedback. They said they found this disappointing and didn’t know whether any action had been taken to improve things or not.
- In ophthalmology, the sister told us staff meetings were held, but, “not as often as they would like.” They said information was disseminated to staff by emails, a communication book and staff meetings. We looked at the meeting minutes from 26 April 2016 and saw 40 staff had attended, from a wide range of job roles. The agenda for the meeting included: governance, audits, accessing diagnostics, missing notes and broken equipment.

## Diagnostic Imaging

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

- In nuclear medicine, one of the radiation protection supervisors showed us the trust intranet. This appeared to be a useful resource for staff to use.
- Staff in general x-ray told us there were monthly staff meetings. They said if they were unable to attend the meeting they were emailed the minutes.

## Innovation, improvement and sustainability

### Outpatients

- The sister in ophthalmology told us she had won the Bayer ophthalmology honours UK outstanding ophthalmology nurse award in December 2015.
- Nursing staff in the outpatient department within the Eye Hospital told us the International Glaucoma Association had awarded the Department an innovation award for their glaucoma monitoring work.
- A band five registered nurse working in the outpatient department within the Eye Hospital had been awarded the ‘Golden Heart’ trust award for her work mentoring and supporting staff and students in the department.

### Diagnostic Imaging

- Radiology at the trust was an exemplar site for the BSIR (British Society of Interventional Radiology) IQ programme for interventional radiology
- The ultrasound department was the UK reference site for Toshiba in the fields of elastography and fusion guided imaging.
- The 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.
- A reporting sonographer told us the British Medical Ultrasound Society (BMUS) had taken on at Hull ultrasound audit and it was presented at a national conference. This was an accolade for the ultrasound department.

### Pathology

- A strong multi-disciplinary team managed sudden unexpected death in infants and children (SUDIC) cases at the establishment, working under detailed procedures in a chain of custody manner. The dedication of the team had recently won them an award, recognising their commitment to quality.

## Outpatients and diagnostic imaging

- The laboratory manager in histopathology told us their digital scanner was about to go live. A digital scanner

creates a virtual or digital image of histological slides and provides a digital image for scientific analysis. This digital scanner would enable co-working with histopathology in Sheffield.



# Outstanding practice and areas for improvement

## Outstanding practice

We saw several areas of outstanding practice including:

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

## Areas for improvement

### Action the hospital MUST take to improve

- The trust must ensure that planning and delivering care meets the national standard for A&E; meets the referral-to-treatment time indicators and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- The trust must review the process for categorising incidents, including safeguarding incidents relating to children, to ensure effective investigation and lessons learnt.
- The trust must ensure that staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns.
- The trust must ensure learning from never events is further disseminated and lessons learnt are embedded.
- The trust must ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS)
- escalation procedures; that patients requiring escalation receive timely and appropriate treatment, and; that the escalation procedures are audited for effectiveness.
- The trust must ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services.
- The trust must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.
- The trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range, especially within A&E.
- The trust must ensure that staff sign drug charts after the medication has been dispensed and not before (or before and after if required) to provide assurance that medications have been given to/ taken by the patient.

# Outstanding practice and areas for improvement

- The trust must ensure that records of the management of controlled drugs are accurately maintained and audited within A & E.
- The trust must ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services.
- The trust must ensure that patients' food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.
- The trust must ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.
- The trust must ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol).
- The trust must ensure the effective use and auditing of best practice guidance such as the "Five steps for 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.
- 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 with outpatient and maternity services.
- The trust must 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 to ensure critical care services have sufficient numbers of staff to sustain the requirements of national guidelines (Guidelines for the Provision of Intensive Care Services 2015 and Operational Standards and Competencies for Critical Care Outreach Services 2012).

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

## Action the hospital **SHOULD** take to improve

- The trust should continue to improve the access and flow within the hospital, including reducing the number of patients who are medical outliers on other wards.
- 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, especially within maternity.
- 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.

# Outstanding practice and areas for improvement

- The trust should ensure the facilities and environment used by audiology are appropriate for patients' needs.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p><b>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014: Need for consent.</b></p> <p>How the regulation was not being met: There was no policy or protocol in maternity services for staff to assess a young person's (under 16 years of age) understanding using guidance such as Gillick competencies and therefore ability to consent to a proposed treatment. The trust must:</p> <ol style="list-style-type: none"><li>1. ensure that staff who work with children and young people are knowledgeable about Gillick competence and that a process is in place for gaining consent from children under 16.</li></ol>

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.</b></p> <p>Care and treatment was not always provided in a safe way for patients. The trust must:</p> <ol style="list-style-type: none"><li>1. ensure that planning and delivering care meets the national standard for A &amp; E; meets the referral-to-treatment time indicator and; eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits. Regulation 12(1)</li></ol>

## Requirement notices

2. review the process for categorising incidents, including safeguarding incidents, relating to children, to ensure effective investigation and lessons learnt. Regulation 12(2)(b)
3. ensure that staff complete risk assessments and taken action to mitigate any such risks for patients; in particular, risk assessments for falls and for children with mental health concerns. Regulation 12(2)(a) & (b)
4. ensure learning from never events is further disseminated and lessons learnt are embedded. Regulation 12(2)(b)
5. ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust's National early warning score (NEWS) and Modified Early Obstetric Warning Score (MEOWS) escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness. Regulation 12(2)(b)
6. ensure that staff have the skills, competence and experience to provide safe care and treatment for children with mental health needs and patients requiring critical care services. Regulation 12(2)(c)
7. ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy, especially within A&E. Regulation 12(2)(g)
8. 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)
9. ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range. Regulation 12(2)(g)
10. ensure that records of the management of controlled drugs are accurately maintained and audited within A & E. Regulation 12(2)(g)
11. ensure it continues to work actively with other professionals internally and externally to make sure that care and treatment remains safe for children with mental health needs using the services. Regulation 12(2)(i)

## Requirement notices

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

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

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

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

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

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

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

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

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

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

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance



## Requirement notices

Regulation 17 HSCA (RA) Regulations 2014. Good governance.

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

1. ensure antenatal consultant clinics have the capacity to meet the needs of women. They also must ensure there is enough capacity in the scanning department to implement GAP (Growth assessment protocol). Regulation 17(2)(a)
2. ensure that orthopaedic patients are regularly assessed and monitored by their consultants. Regulation 17(2)(a)
3. ensure the effective use and auditing of best practice guidance such as the “Five steps for safer surgery” checklist within theatres and standardising of procedures across specialties relating to swab counts. Regulation 17(2)(b)
4. review the critical care risk register to ensure that all risks to the service are included and timely action is taken in relation to the controls in place and escalation to the board. Regulation 17(2)(b).
5. ensure 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.
6. ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially with outpatient and maternity services. Regulation 17(2)(c)

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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:

## Requirement notices

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)
2. continue to work towards the national guidelines of 1:28 midwifery staffing ratio and collect data to evidence one to one care in labour. Regulation 18(1)