This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

A list of sites at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
</table>
| Hull Royal Infirmary       | Anlaby Road, Hull, HU3 2JZ | • Accident and Emergency  
• Anaesthetics  
• Antenatal  
• Audiology  
• Bone density  
• Chest Clinic  
• Colorectal  
• Diabetic Medicine  
• Dietetics  
• Endocrinology  
• Gastroenterology  
• General medicine  
• General surgery  
• Geriatric medicine  
• Gynaecology  
• Infectious Diseases  
• Interventional Radiology  
• Neonatology  
• Nephology  
• Neurology  
• Neuro-surgery | Hull |
<table>
<thead>
<tr>
<th>Castle Hill Hospital</th>
<th>Castle Road, Cottingham, HU16 5JQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
</tr>
<tr>
<td>Orthopaedics - Adult &amp; Children</td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td>Plastics Trauma Unit</td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td></td>
</tr>
<tr>
<td>Restorative dentistry</td>
<td></td>
</tr>
<tr>
<td>Retinal Screening</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Stroke Medicine</td>
<td></td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>East Riding Community Hospital</th>
<th>Swinemoor Lane, Beverley, East Yorkshire, HU17 0FA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory medicine</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Upper GI surgery</td>
<td></td>
</tr>
<tr>
<td>Colorectal surgery</td>
<td></td>
</tr>
<tr>
<td>Infectious diseases</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>Medical oncology</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Rehab medicine</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic</td>
<td></td>
</tr>
<tr>
<td>Clinical genetics</td>
<td></td>
</tr>
<tr>
<td>Dietetics</td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td></td>
</tr>
<tr>
<td>Breast surgery</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>Clinical oncology</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Pain management</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td></td>
</tr>
<tr>
<td>Plastic surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cottingham</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Pain management</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Vascular</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Paediatrics</td>
</tr>
<tr>
<td>Diabetic medicine</td>
</tr>
<tr>
<td>Paediatric diabetic medicine</td>
</tr>
<tr>
<td>Endocrinology</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beverley</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
</tr>
<tr>
<td>Pain management</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Vascular</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Paediatrics</td>
</tr>
<tr>
<td>Diabetic medicine</td>
</tr>
<tr>
<td>Paediatric diabetic medicine</td>
</tr>
<tr>
<td>Endocrinology</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Specialties</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>retinal screening</td>
</tr>
<tr>
<td>Midwifery</td>
</tr>
<tr>
<td>Upper GI</td>
</tr>
<tr>
<td>Colorectal</td>
</tr>
<tr>
<td>Audiology</td>
</tr>
<tr>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Neonatology</td>
</tr>
<tr>
<td>Neurosurgery</td>
</tr>
<tr>
<td>Urology</td>
</tr>
<tr>
<td>Rheumatology</td>
</tr>
<tr>
<td>Optometry</td>
</tr>
</tbody>
</table>

(Source: Universal Provider Information Request – Sites)

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 provides services to a catchment 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. The Trust employs just over 7,260 whole time equivalent staff to deliver its services.

The health of people in Kingston upon Hull is generally worse than the England average. Kingston upon Hull is one of the 20% most deprived districts/unitary authorities in England and about 32% (16,200) of children live in low income families. Life expectancy for both men and women is lower than the England average. The rates of alcohol-related harm hospital stays and smoking related deaths are both worse than the average for England.

The health of people in East Riding of Yorkshire is varied compared with the England average. About 14% (7,400) of children live in low income families. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull.

The trust provides a range of planned and acute services to the residents of Hull and East Riding of Yorkshire area as well as specialist and tertiary services to a catchment population of between 1.05 million and 1.25 million extending from Scarborough in North Yorkshire to Grimsby and Scunthorpe in North East and North Lincolnshire respectively. The only major services not provided locally are transplant surgery, major burns and some specialist paediatric services.

The trust provides the following acute core services;
- Urgent and emergency care
- Medical care (including older people’s care)
- Surgery
- Critical care
- Maternity
- Children and young people
- End of life care
- Outpatients

The trust’s management structure is based on four health groups;
- Surgery
- Medicine
- Family and women’s health
- Clinical support
Each of the heath groups is led by a triumvirate, which comprises of a health group operational director, a medical director and a nurse director.

The Trust operates from two main hospital sites;
- Hull Royal Infirmary
- Castle Hill Hospital

Hull Royal Infirmary has over 700 beds. In addition to acute medical and surgical services, Hull Royal Infirmary provides accident and emergency (A&E) services and is the recognised Trauma Centre for the region. The Women and Children’s Hospital located at Hull Royal Infirmary houses the maternity and children’s services, including neonatology with a 26 cot neonatal intensive care unit. The obstetrics department provides maternity services to women of Hull and East Yorkshire. The trust is accredited as an Endometriosis Centre in the North East of England. In addition, Hull Royal Infirmary provides critical care services, with 22 beds available for intensive care and high dependency, close to a nine main theatre complex. There is also an ophthalmology (eye) hospital on site. In April 2015, the majority of the medical beds at Castle Hill hospital moved to the HRI to bring together acute medicine and care of the elderly onto the one site.

Castle Hill Hospital has approximately 370 beds and provides cardiac and elective surgical services. It also has medical research teaching and day surgery facilities (the Daisy Building), an ear, nose and throat (ENT), breast surgery facility and outpatients. It has the regional Queen’s Centre for oncology and haematology. Critical care is provided in two units, which support the cardiology and cardio-thoracic services. There are no accident and emergency services at this hospital.

Services at this Trust are commissioned by two clinical commissioning groups;
- Hull Clinical Commissioning Group
- East Riding of Yorkshire Clinical Commissioning Group

The trust sits within the Humber Coast and Vale Sustainability and Transformation Plan (STP) footprint.

Is this organisation well-led?

Leadership
The senior leadership team at the trust consisted of 12 board members with voting rights and four additional directors:
- Chairman
- Chief Executive
- Executive Chief Nurse
- Chief Medical Officer
- Chief Operating Officer
- Chief Financial Officer
- Director of Workforce
- Director of Strategy and Planning
- Director of Corporate Affairs
- Director of Estates and Facilities
- Six Non-Executive Directors

Of the executive board members at the trust, none were British Minority Ethnic (BME) and 20% were female.
Of the non-executive board members none were BME and 29% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>29%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

At the time of the inspection the Chairman had been in post nearly 12 months. The remainder of the board had been stable since the last inspection in 2016. There was one new non-executive director (NED) due to start in post. We saw evidence that the executive team was cohesive and worked well together.

Staff we spoke with at the core service inspection spoke positively about the quality and capability of the executive team. They described them as approachable and supportive. Leaders in the health groups we spoke with explained how the board sought and listened to their views. Managers and leaders we spoke with at the core service and well led inspections told us they tried to maintain visibility across both sites in clinical areas.

The trust had four health groups; medicine, surgery, clinical support and family and women’s health. Each health group was led by a medical director, operations director and nursing director. The trust had undertaken reviews in some of the health groups, since the previous inspection, to strengthen the leadership at this level in the organisation. The executive team acknowledged there was still work to do to establish effective clinical leadership throughout the organisation, but clinical engagement in the trust was improving. The health group leadership teams had development plans in place and had attended external, appropriate leadership courses relevant to their roles.

We found the trust executive leadership team had an appropriate range of skills, knowledge and experience. The board of directors’ portfolios covered all key areas. Leaders at executive level understood the challenges to quality and sustainability. At previous inspections we found inconsistent evidence about the amount of board development that had been undertaken. At this inspection members of the executive team had all recently participated in board development sessions and a programme of board development had been planned and was underway. On review of the board papers and sub-committee meeting minutes we found limited evidence of challenge from some of the non-executive directors.

The trust’s people strategy for 2016 to 2018 underpinned the overall trust strategy and the executive team understood the importance of improving the leadership capability and capacity of staff. The trust had an internal ‘great leaders’ development programme as well as bespoke programmes of work focussed on leadership. Examples of these included ‘medical leadership’, ‘charge nurse bite size leadership’ and ‘let’s get started’ for all new nurses.

The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had a fit and proper person’s procedure for all non-executive and executive directors. This had been written in 2016 and detailed the requirements in accordance with the regulation. There was an annual report submitted to the board to provide assurance that all board members met FPPR and that annual checks had been carried out. We reviewed five personnel files for executive directors and found these to be compliant with the regulation.
Vision and strategy
The trust had a vision, ‘great staff, great care, great future’ and values of ‘care, honesty and accountability’ which had been developed in consultation with staff. The value statements clearly stated what behaviours were acceptable for staff and which were not. At the core service inspection we saw that the vision and values were embedded and there were visible displays throughout the trust of the vision and values. Staff we spoke with were able to explain what the vision and values meant to them.

The trust had a strategy for 2016-2021, this incorporated key enabling strategies, for example, people, estates and facilities and information management and technology strategies. The trust monitored the implementation of the strategy; each commitment of the strategy had a measure of success, lead director, monitoring committee and key milestones. Progress was reviewed twice a year at the executive management committee and annually at the trust board. At the time of the inspection the trust was in the process of refreshing the strategy which was due to be agreed in June 2018.

The trust strategy had seven objectives which aligned to the three values:

**Care**  
- honest, caring and accountable culture  
- valued, skilled and sufficient staff

**Honesty**  
- high quality care  
- great local services  
- great specialist services

**Accountability**  
- partnership and integrated services  
- Financial sustainability

Sustainability and transformation plans (STP) are part of a national programme where the NHS, local authorities and social care form partnerships to improve health, the quality of social care and efficiency of services in a geographical ‘footprint’. The STP processes will inform part of the overall long-term strategy for the trust in terms of service configuration. Hull and East Yorkshire Hospitals NHS Trust was part of the Humber, Coast and Vale STP; the STP footprint was over a large social geography and was more fragmented than other STP’s nationally.

From our discussions during the inspection and with stakeholders the sustainability and transformation plan was less advanced than others. Further work was required within the local system and across the STP to develop a longer term strategy for service and financial sustainability. The executive team at the trust were actively engaged with the STP and since the beginning of 2018 had committed to working with other trusts and partners to deliver high quality patient care. To reinforce the delivery and development of this members of the trust’s executive team had taken on significant leadership roles in the STP.

Culture
We saw a significant improvement in the culture in the organisation and it was clear the leadership team had worked hard to improve this. All staff we spoke with at the core service and well led inspections and in focus groups described a continued improvement in the culture since our previous inspection and spoke positively about the leadership team. The trust had completed a recognised cultural survey and had seen what appeared to be a two times increase above expectations in culture. Staff we spoke with told us they felt supported, respected and valued. Overwhelmingly staff were positive about and proud to work in the organisation. They were passionate about their services and morale was generally high. The culture at the trust was centred on the needs and experiences of people who use services.

The trust had a freedom to speak up guardian. They attended regional and national networks relevant to their role. The guardian described a good working relationship with the executive team, staff and other support services in the trust, for example, human resources, the patient advice and liaison service the staff advice and liaison service. The trust had a formal policy for raising
concerns at work. Staff also had access to an occupational health service for staff, which provided counselling services, and access to help with physical health needs.

The trust had a guardian for safe working. They supported the regional Health Education England (HEE) network hosted by the deanery and submitted a report to HEE quarterly. The guardian told us they felt valued by the executive team and understood their role in improving staff retention and morale. The guardian for safe working had set up a junior doctor’s forum to align trust issues and junior doctors’ concerns; they were also involved in induction of staff and education.

There was an open and honest culture with a focus on patient safety. The trust had a policy in place relating to the duty of candour requirements. The serious incidents, and complaints investigations we reviewed, confirmed that duty of candour was applied effectively. Staff, the executive team, and NEDs we spoke with told us that quality and safety were their priority regardless of financial or performance pressures. There was an acknowledgement that the quality of patient care or a patient’s experience could vary dependent on the level of demand placed on a service. During the core service inspection, we observed respect between specialities and we saw examples of good team working between staff of different disciplines and grades.

Staff we spoke with were able to articulate the values of the organisation. The executive team were clear of the importance of the trust’s values and explained a zero tolerance approach to staff that did not engage with these. The trust used values based recruitment and ‘HEY24/7’ for appraisals. ‘HEY24/7’ incorporated the trust objectives, vision and values, so managers and staff referred to these during performance and career development conversations. The trust had a team and processes in place to support staff with revalidation. Most managers we spoke with across the trust said they were able to address staff performance where needed and received guidance from the human resources team when required.

**Staff Diversity**
The trust included equality and diversity training as part of the mandatory training programme. All staff also participated in professional and cultural transformation training.

The majority of staff at the trust in non-clinical and clinical (non-medical) roles identified as white. Around half of staff in clinical (medical) roles identified as BME.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Percentage of staff identifying as BME</th>
<th>Percentage of staff identifying as white</th>
<th>Percentage of staff with unknown ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical</td>
<td>2.6</td>
<td>96.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Clinical (non-medical)</td>
<td>5.6</td>
<td>93.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Clinical (medical)</td>
<td>50.9</td>
<td>45.7</td>
<td>3.5</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Diversity)*

**NHS Staff Survey 2017 – results better than average of acute trusts**
The trust had 13 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:
### Key Finding

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>KF20. Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>8% (top 20% of acute trusts)</td>
<td>12%</td>
</tr>
<tr>
<td>KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>89% (top 20% of acute trusts)</td>
<td>85%</td>
</tr>
<tr>
<td>KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>50%</td>
<td>52%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>70%</td>
<td>72%</td>
</tr>
<tr>
<td>KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>KF23. Percentage of staff experiencing physical violence from staff in the last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>25% (top 20% of acute trusts)</td>
<td>28%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.08</td>
<td>4.05</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.78</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.70</td>
<td>3.65</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.35</td>
<td>3.31</td>
</tr>
</tbody>
</table>

### NHS Staff Survey 2017 – results worse than average of acute trusts
The trust had 10 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF7. Percentage of staff able to contribute towards improvements at work</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>KF3. Percentage of staff agreeing that their role makes a difference to patients/service users</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>KF24. Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>64%</td>
<td>66%</td>
</tr>
<tr>
<td>Question</td>
<td>White</td>
<td>BME</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>KF27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>42%</td>
<td>45%</td>
</tr>
<tr>
<td>KF12. Quality of appraisals</td>
<td>3.05</td>
<td>3.11</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.56</td>
<td>3.62</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.69</td>
<td>3.75</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.70</td>
<td>3.72</td>
</tr>
<tr>
<td>KF32. Effective use of patient/service user feedback</td>
<td>3.62 (in worst 20% of acute trusts)</td>
<td>3.71</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017 - http://www.nhsstaffsurveys.com/Page/1067/Latest-Results/Acute-Trusts-A-to-I/)

**Workforce race equality standard (WRES)**

The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Of the four questions above, two questions showed a statistically significant difference in score between White and BME staff. These were:

<table>
<thead>
<tr>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>25%</td>
<td>27%</td>
</tr>
<tr>
<td>BME</td>
<td>21%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>BME</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>BME</td>
<td>81%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>BME</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13%</td>
</tr>
</tbody>
</table>
• KF21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.

• Q17b – In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues? *(Source: NHS Staff Survey 2017 - http://www.nhsstaffsurveys.com/Page/1067/Latest-Results/Acute-Trusts-A-to-I/)*

The trust had a published document for WRES with an action plan in place. The action plan linked to the trust’s equality objectives. The trust acknowledged that, in respect of ethnicity, the board was not representative of the population it served or its workforce. Actions to address this were included in the 2017/18 action plan.

**Friends and family test**

The friends and family test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care from October 2016 to September 2017.


**Sickness absence rates**

The trust’s sickness absence levels from July 2016 to May 2017 were better than the England average.
General Medical Council – national training scheme survey
In the 2016 General Medical Council Survey the trust performed worse than expected for one indicator (Induction) and the same as expected for the remaining 13 indicators.
(Source: General Medical Council National Training Scheme Survey)

Governance

Board Assurance Framework (BAF)
The trust provided their Board Assurance Framework, which details seven strategic objectives within each and accompanying risks. A summary of these is below.

- 1 – Honest, caring and accountable culture
- 2 – Valued, skilled and sufficient staff
- 3 – High quality care
- 4 – Great local services
- 5 – Great specialist services
- 6 – Partnership and integrated services
- 7 – Financial sustainability
(Source: Trust Board Assurance Framework)

At the time of the inspection the board assurance framework held nine risks against seven strategic objectives. All the sub-committees reviewed the BAF which was reviewed quarterly at the trust board. All the executive team we spoke with felt that the BAF was reflective of the risks faced by the organisation.

The trust had clear systems to support good governance; staff we spoke with at the core service and well led inspections were able to consistently articulate the processes that were in place. The four health groups’ governance, processes and structures were aligned with the corporate structures and processes. There was a committee structure in place to manage the board’s business. There were four committees: performance and finance; audit; quality and remuneration. All sub-committees of the board were chaired by a NED and had clear terms of reference. There was also an executive management committee structure.
The trust was developing an internal mental health committee to improve oversight of all aspects of the Mental Health Act and Mental Capacity Act. During our core service inspection we observed effective and integrated working between the acute and mental health trust. The trust was in the process of developing a service level agreement with the mental health trust to facilitate weekly data sharing on Mental Health Act and Mental Capacity Act performance.

The minutes of board committee meetings were reported to the board. The minutes identified matters discussed by the committee, matters for escalation and key decisions made or actions identified. Some of the committee minutes we reviewed made reference to the impact on the board assurance framework.

Specialities within health groups had monthly clinical governance meetings. These meetings reported to the health group governance committee that would escalate concerns to the operational quality committee.

The trust had clear financial governance arrangements; staff demonstrated a consistent understanding of accountabilities, responsibilities and associated processes from board to health group level.

We raised some concerns with the executive team after the core service inspection regarding the safety and security of medical outliers in one clinical area. At the well led inspection we raised additional concerns about the care of medical outlier patients following contact from a whistle-blower. In both cases the trust responded promptly and appropriately to our concerns and staff in the clinical areas were aware of changes that had been made as a result. This gave us some assurance about the flow of information and escalation of risk from ‘ward to board.’

**Management of risk, issues and performance**

We saw improvements in the delivery of safe and high quality services at the trust.

The senior team were able to articulate key risks for the trust that included workforce and the delivery of the constitutional standards. 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 risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. There was evidence that the controls in place were reviewed and updated and that the risk rating was reviewed following the mitigating actions taken. The trust’s corporate risk register included risks that scored 15 and above. The operational quality committee accepted the clinical risks and the non-clinical quality committee accepted the non-clinical risks onto the corporate risk register. The risk register was reviewed at the executive management committee. We did not identify any risks during the inspection that the trust had not identified in their own internal governance processes. The risks detailed were reflective of those highlighted to us by frontline staff and health group leads and broadly correlated with our findings during the inspection. Following our core service inspection we spoke with the executive team about the pace of change after the previous inspection was not at the rate we would have expected in some of the specialities.

The trust had a comprehensive performance management framework in place which was reported through monthly health group performance meetings. These meetings included the quality and safety of services, workforce, performance and finances. The operational quality committee reviewed health group escalation reports and relevant matters were fed into the executive management committee. The integrated performance report was reviewed at the quality committee, the performance and finance committee and the trust board.

The executive team recognised the delivery of the constitutional standards was a challenge for the trust. An additional challenge to this was that the trust identified a tracking access issue in July 2017 where patients may not have received follow up appointments or interventions following the introduction of an electronic patient record in June 2015. The trust declared this as a serious incident and established a validation and clinical harm review process involving an external
healthcare company, commissioners and NHS Improvement (NHSI). It was clear from talking to the executive team that there was clear oversight and scrutiny of both the constitutional standards and the tracking access issue. We reviewed the trust’s January 2018 Integrated Performance Report which gave a clear picture of the current and trend in performance. Through our inspection we had discussions with the chief operating officer, other members of the executive team, stakeholders and local partners we were assured the trust had a robust recovery plan in place and was on target with this. The trust was actively working with stakeholders where system pressures affected the trust’s performance.

The chief nurse had introduced fundamental standards audits to every ward and a number of other clinical areas. This was an internal multidisciplinary audit programme that assessed compliance against nine different standards including patient experience, patient centred care, nutrition, medicines management and staff experience. Wards and clinical areas received scores for each individual standard which determined how frequently re-audits would be completed. Managers would be required to put a local action plan in place to improve the scores and would receive support from senior staff and the chief nurse’s team. The board received the results of the fundamental standards quarterly and the wards and clinical areas displayed their results so staff, patients and the public could view them. Staff we spoke with at the core service inspection recognised this approach encouraged accountability and were proud of the improvements to their results that they could demonstrate.

### Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£526,3m</td>
<td>£561,1m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£8,1m)</td>
<td>£2,7m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£534,3m)</td>
<td>(£558,4m)</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£18,3m)</td>
<td>£0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview)

The NHSI assessment of the 2017/18 and 2018/19 financial plans identified full delivery of the trust’s cost improvement plans as a risk. The trust worked with the NHSI Financial Improvement Programme to help mitigate this risk and identify the level of required schemes.

Staff we spoke with explained a clear system and process for budget setting and management across health groups and corporate teams, with good engagement of health group multidisciplinary teams. There was clinical engagement in financial governance and cash releasing efficiency schemes (CRES) which was assisted by improved financial support arrangements in health groups. The trust had a clear process for the quality impact assessment of any CRES. The health group leadership team and executive team had oversight of the assessments and staff reported appropriate challenge from the senior team.

### Information management

The trust had an integrated reporting system that included quality, safety, activity and performance indicators. Specialities within the health groups had access to their own performance dashboard. Staff we spoke with told us business intelligence provided access to real time information.
At the time of the inspection the trust was in the early stages of developing and implementing electronic systems to support care delivery. In some clinical areas at Castle Hill Hospital staff recorded patient observations electronically. The software calculated early warning scores when patient observations were recorded and scores were displayed on the electronic patient record and an overall ward dashboard. This was viewed by medical, nursing and therapy staff and allowed staff to respond promptly to a change in patient condition. Work needed to be undertaken to the infrastructure at Hull Royal Infirmary before the information technology would support the use of electronic observations. The trust was working with their electronic patient record developer to introduce electronic prescribing.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system.

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. The trust supported these arrangements and policies with training so staff knew how to manage information correctly. However, during our unannounced inspection in February 2018 we found patient records were not stored securely in some outpatient clinics and ward areas which meant that patients’ personal information may not always be protected appropriately.

The trust had completed the information governance toolkit assessment, which described how the trust saw its management and security of information. The trust assessed itself on measures of assurance, including confidentiality and security of records, the quality of information, the secondary use of information, and a measure for the overall performance. The trust received significant assurance from this assessment. The trust’s information governance group reported to the non-clinical quality committee.

The trust had effective arrangements to ensure the quality of data used to manage and report on performance. Data quality formed part of the trust’s internal audit plan and was reviewed externally.

**Engagement**

The executive team had worked to improve public, patient and stakeholder engagement recognising that some relationships had been challenging in the past.

People’s views and experiences were gathered and acted on to shape and improve services and culture. The trust board was presented each month with a patient-related story. Patient representatives were included on key committees, for example, executive management board, major trauma board and the improvement board. The trust had a patient and public council that Healthwatch and Age Concern representatives attended. Health groups had a number of patient support groups within specialties. The trust used social media to communicate with and involve the public.

The trust had introduced volunteers, young volunteers and young health champions to bring their experience into the organisation and to try to progress them on to apprenticeships. Clinical staff mentored young people from a local sixth form academy.

The trust had systems in place to ensure the voice of all patients was heard. There was a dementia strategy to support staff with caring for frail elderly patients. At the time of the inspection the dementia lead nurse post was vacant; however, recruitment to the post was underway. The mental health and learning disabilities strategy 2017-2020 we reviewed was still in draft.
The trust used ‘John’s campaign’ to help encourage the carers of patients living with dementia to become involved in their loved ones care. We were told of an example where the department of medicine for the elderly following complaints from the carers of patients living with dementia had invited the carers to sit on and participate on the dementia programme board.

We reviewed six complaints as part of this inspection and found in all of them there was evidence to demonstrate people were supported to speak out and that the complaint was handled with compassion. There was evidence in the complaints that we reviewed that a thorough investigation had been completed. The trust’s aim was that complaints should be investigated and closed in 40 days. The trust’s patient experience annual report 2016/17 showed that on average 61% of complaints were closed in 40 days. This was worse than the trust’s aspiration of 90%. We reviewed the January 2018 quality report in the trust’s board papers; this showed that in the previous three months the trust did not meet its target of 90% of complaints closed in 40 days. The rates of closure in 40 days were 68.9% in October 2017, 77.4% in November 2017 and 69.4% in December 2017.

The trust participated in national patient surveys, for example the friends and family test, CQC inpatient survey.

In the staff survey results 2017, the overall indicator of staff engagement for the trust was 3.8 which was average when compared with trusts of a similar type. This had improved from 3.5 in the 2014 survey results.

The trust had positive engagement with staff representatives and recognised unions. We met with representatives for staff who described good engagement with the executive team with an open and transparent culture. The BME staff network and had introduced a coaching programme to provide BME staff with opportunities to progress in their careers. The trust had also introduced a LBGT (lesbian, gay, bisexual, and transgender) network. Staff from the trust participated in the Hull Pride parade in 2017.

All staff we spoke with told us the executive team were approachable and visible at both acute hospital sites. Staff we spoke with during the core service inspection and in focus groups were able to give us clear examples of issues raised and actions that had taken place as a result, for example, changes to the availability of food in the restaurant and the development of recovery and critical care services in cardiothoracic services. The executive team were aware that medical engagement remained an issue and they were working to address this. They held two development sessions with 60 medical leaders setting out expectations and identifying a plan to overcome the engagement barriers. Following these sessions an executive and medical staff committee was set up in February 2018.

Staff we spoke with told us about the trust’s annual staff awards ceremony which was funded by the staff lottery. All staff we spoke with were positive about the award schemes and said they helped to make staff feel valued. The trust held an annual fun day for staff and their families. The executive team were clear that celebrating staff’s success was important to them. The NEDs completed a schedule of ward visits with executive staff. They told us that this allowed them to meet staff and take feedback and receive assurance about practices or issues that had been discussed at board level or at sub-committees. NEDs we spoke with felt was an important part of their role.

The trust worked effectively with partners, for example, local acute, mental health and community providers, clinical commissioning groups and was an active part of the sustainability and transformation plan. Prior to the inspection we received positive feedback from the trust’s partners about the relationships and joint working. Staff we spoke with at the inspection felt there was now collaboration between partners and local clinical services working across boundaries.
Learning, continuous improvement and innovation

During the core service inspection staff we spoke with told us there was a culture of learning and improvement and that training and development was encouraged. We saw evidence that the executive team were supportive of clinically driven improvement and innovation, for example the chief financial officer had worked with clinicians when changing to an aligned incentive contract with the commissioners. This allowed the trust to work with system partners to improve services, reduce overhead costs and manage demand in the system. The leadership teams felt they had access to resources to support a range of research activities and that research was an important part of their team’s role.

The trust had an annual quality improvement plan that was overseen by the quality, governance and assurance team. The trust also had service improvement team called HEY Improvement Team. All the team members were trained in improvement methodology, in collaboration with the Improvement Academy and the Yorkshire and Humber Academic Health Sciences Network. This team offered dedicated project management support to clinical teams to deliver quality and service improvement.

There was a trust wide learning programme in place. This involved a range of education and training sessions including human factors, simulation and training from external military agencies. Staff received regular newsletters such as ‘lessons shared’ and ‘quality and safety bulletin’ where learning and information was shared. Following the never events that had occurred in surgery in 2017 members of the executive and health group leadership teams delivered a presentation to staff. This included reflections from staff who had been involved in historical never events. We were told this session was very well attended by staff from both acute hospital sites.

We reviewed four serious incident investigations. All four had evidence of appropriate investigations, focused on learning and were led by an appropriate member of staff. There were action plans in place for each of them with accountable persons and achievable dates.

The trust demonstrated it was prepared to learn from the death of patients, and support families and carers through any investigation process. The trust had responded to the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 CQC report ‘Learning, candour and accountability’. To meet the national guidance on learning from deaths the trust had established with local partners a robust and thorough system to review and investigate all deaths based on codes from the patient administrative system. A separate system had been set up with local partners to review and investigate the deaths of people with a learning disability. The work on learning from deaths was overseen by a mortality committee that ensured the process was independent and used robust investigation methods. Staff were trained in the nationally recommended methodologies of structured judgement review and learning disability review (LeDeR). The reviews and investigations of deaths included the concerns of families and carers who had an opportunity to comment on findings. There was integration between the feedback received from deaths, serious incidents, complaints, PALs and the bereavement services. Staff we spoke with about the learning from deaths work told us the next part of this project was to look at how they could start to identify the themes and trends from the work and use the learning from these.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation and its Pathology - September 2017</td>
<td></td>
</tr>
</tbody>
</table>
The trust provided us with a number of examples of innovation in all four health groups. This included:

- Working with eight local trusts to develop a regional store to modernise medicine supply and maximise the use of automation. This work had been presented nationally to pharmacy and other audiences.
- Acute surgical provision, surgical bed reconfiguration at Castle Hill Hospital and a theatre schedule programme resulting in a reduction in overnight operations and a reduction in length of stay.
- Introduction of the bereavement midwife role to support patients.
- Opening of the midwifery led unit and the HEY baby carousel, an event supporting and educating new parents in preparation for birth.
- Development of an integrated chronic obstructive pulmonary disease service with partner organisations and an accredited centre for the provision of severe asthma specialist services.
- Recognition from NHS England for the significant improvements in the identification and treatment of sepsis.
The medical care service at Hull and East Yorkshire Hospitals NHS Trust provides care and treatment for cardiology, clinical haematology, clinical oncology (previously radiotherapy), general medicine, geriatric medicine, nephrology, rehabilitation, respiratory medicine, and stroke medicine.

A site breakdown can be found below:
- Hull Royal Infirmary: 343 beds are located within 13 wards
(Source: Routine Provider Information Request - Acute-Sites)

The trust had 68,478 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 32,209 (47%), 3,030 (4%) were elective, and the remaining 33,239 (49%) were day case.

Admissions for the top three medical specialties were:
- General medicine: 19,227 admissions, up 2% compared to previous year
- Gastroenterology: 11,708 admissions, up 6% compared to previous year
- Medical oncology: 6,837 admissions, up 11% compared to previous year
(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
Mandatory training was provided on a monthly basis. Ward managers would receive a monthly training matrix that advised which staff had completed and required training. Staff were encouraged to complete training, however due to some pressures on the wards training would sometimes need to be cancelled. There was a variance between wards if staff received time back for completing in their own time. Staff could also look at the online system to see when their training was due. One senior sister told us that staff could not progress through the next gateway for their appraisal if they were not up to date with their training.

The trust set a target of 85% for completion of mandatory training apart from information governance which has a target of 95% for completion.

A breakdown of compliance for mandatory courses from April to October 2017 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of course</td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion (%)</td>
<td>Target (%)</td>
<td>Target met (Yes/No)</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
<td>----------------</td>
<td>------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>246</td>
<td>267</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>243</td>
<td>267</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>227</td>
<td>267</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>202</td>
<td>267</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>200</td>
<td>267</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>195</td>
<td>267</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at the hospital was 82%. The health and safety, and infection control modules met the trust completion target.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>554</td>
<td>579</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>550</td>
<td>579</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>521</td>
<td>579</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>520</td>
<td>579</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>495</td>
<td>579</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>408</td>
<td>579</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the hospital was 88%. The information governance and resuscitation modules were the only mandatory training not to meet the trust completion target.

Only 70% of nursing and midwifery staff had completed the resuscitation module with only 76% medical and dental staff completing this module.

The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

New staff on the wards told us that they received corporate induction training and mandatory training was part of this. Newly qualified staff that had commenced posts recently had training days where they would attend the required courses. Staff told us that they had completed sepsis awareness training and were aware of the pathway and policy.
Safeguarding

Annual reports were completed by the trust for safeguarding children and adults. The amount of referrals and type of abuse were documented; the medicine health group completed the highest amount of referrals. Information submitted by the trust showed that 228 adult safeguarding referrals had completed from November 2016 to October 2017.

Safeguarding policies were in place and staff knew how to access them. The policy detailed the different types of abuse and which issues staff should report. We spoke with staff who told us how to make referrals and discussed circumstances where safeguarding issues were raised.

Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the medical wards.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>239</td>
<td>267</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>223</td>
<td>267</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by medical and dental staff at the hospital was 87%. The training target was met for the safeguarding adults module and was almost met for the safeguarding children and young people module.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>542</td>
<td>579</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>502</td>
<td>579</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing and midwifery staff at the hospital was 90%. The trust target was met for all applicable modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There were safeguarding adult specialist nurses based at the hospital who supported the assistant chief nurse to manage the governance for safeguarding. Safeguarding issues were discussed weekly with the chief nurse with open access to the chief executive.
Safeguarding audits were completed on each ward as part of the trust’s fundamental standards. Information provided by the trust showed that the majority of medical wards received a score of 89% or above. Ten ward areas received a rating of 100%.

**Cleanliness, infection control and hygiene**

All staff completed infection prevention and control training as part of their mandatory training requirements. Information provided by the trust showed that compliance with this training in the medicine health group was 91% for medical staff and 96% for nursing staff in 2017. This was higher than the trust standard of 85%.

Areas we visited had suitable hand washing facilities and wall mounted hand gels. We saw staff washing their hands and using the hand gel. We observed staff to be arms bare below the elbows and using personal protective equipment (PPE), such as gloves and aprons, when required. However on three separate occasions staff members were walking around the ward with gloves and aprons after completing care or treatment. We raised this with the ward manager who would review the staff’s compliance. We also observed two staff members on ward 80 wearing the same gloves moving to different patients. This meant that they were not adhering to infection control policies.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. We saw that doors were closed and signs placed on the door to inform staff and visitors that infection control precautions were necessary. However we did see on ward 80 where patients were isolated in side rooms due to vomiting and flu that there were no door signs to indicate the infection control precautions.

At the time of our inspection several patients had been admitted to ward 5 with influenza. Patients were isolated into side rooms with staff wearing the appropriate PPE including masks to enter the rooms. We saw appropriate hand washing from staff on leaving the room and the rooms had correct signage on the rooms to alert of the infection control precautions. We reviewed clinical equipment and noted the majority of these to be clean and labelled. Staff also used labels to provide assurance to patients that they were clean. There were several chairs in the corridor space on ward 110, none of these had clean labelling on therefore it was unknown if these had been cleaned. One of the chairs was visibly stained; we raised these concerns to the ward manager who assured us that these would be cleaned.

We saw a patient on ward 80 had covers over the cot sides in place for safety reasons. There were visible tears in the cover, which meant that the cover could not be cleaned properly and a risk for infection control. This was highlighted to staff.

We observed that separation of clinical and non-clinical waste was in line with trust policy in ward areas and linen was stored appropriately in the areas we visited.

**Environment and equipment**

Most areas we visited were clean, tidy and well organised. However due to the lack of space in some areas appeared cluttered. For example on the elderly assessment unit the linen trolley was in front of the lift that they would have to move around. On ward 110 all the chairs would have to be moved out of one of the rooms to allow space for the physiotherapists to complete exercises with the patients.

We checked different types of equipment such as infusion pumps, blood pressure monitoring equipment, and electrocardiograms (ECG). All these were in good working order and had been safety tested and checked according to manufacturer’s recommendations.

Staff told us they had access to equipment when they needed it. They expressed they had no problems obtaining pressure-relieving equipment, such as mattresses.
Resuscitation equipment was available in every area; the trolleys were sealed with a tag. We checked the equipment on various wards and found most of them were checked daily. On two wards where gaps were noted, these were minimal where one day may not have been checked.

We found some sterilisation tablets not locked away in a cupboard on EAU, we informed staff and these were removed.

We visited the eye surgical hospital which was also known as ward 35. This was on the same site as Hull Royal Infirmary however was set in its own building adjacent to the main tower block. The ward had 12 in-patient beds; some of these beds were used for medical outlier patients. We found two unsecured fire doors in an area of the ward that was not visible to staff at all times. We were told that recently a member of the public had been found in one of the sluices on a weekend. We escalated these concerns immediately to the trust who assured us that they would action the issues raised. We checked this as part of the announced well-led inspection and found that the trust had addressed the concerns raised.

**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 have required a higher level of care. At our inspection in June 2016 we found that staff did not always escalate patients NEWS scores to be reviewed in line with the trust policy. The policy provided guidance as to when to escalate the score, for example a NEWS score between one and four needed to be escalated to the nurse in charge and a decision made of the escalation. A score between five and six required a review from the medical team within 30 minutes. A score above seven required a review from the medical team within 15 minutes.

On the majority of wards observations were recorded on a paper document except on the neurological wards where electronic observations were used. After our last inspection the trust completed an action plan in relation to this and provided training to all staff, provided scenario based learning and launched an awareness campaign. Audits were completed to identify any improvement and ongoing management. A clinical observation audit was conducted in 2017 which identified that further work required to be completed. For example on ward 5, seven patient’s observation charts were reviewed with a raised NEWS score of one. Only one patient had been escalated to the medical staff in line with trust policy.

We reviewed 26 records looking specifically at the NEWS scoring and management. We found that this varied significantly between individuals and wards. On 12 occasions we saw that the NEWS scored at a level where escalation should have been recorded. It had been recorded on the observation sheet as ‘no’ for escalating. There was little information recorded in the patient’s vital signs care plan which indicated any deviation from the policy where escalation would not be required.

We found that two patients on ward 1 during the night had their observations recorded; the NEWS scores were elevated with recordings between four and six. Neither patient was reviewed by medical staff. In one of the patient’s records it was documented that it had been escalated to the medical staff to review the patient, however there was no entry in the patient’s record until the next morning.

On ward 70, a patient’s NEWS score was six; there was no record of escalation and observations not then recorded for another four hours. The policy identifies that for a NEWS score of six there should be a minimum of one hourly observations.

A NEWS score of six was documented for a patient on ward 9 which identified that the observations needed to be completed one hourly. The next observations were recorded two and a half hours later where the patients NEWS score had increased to eight. At this time the score
was escalated.

On ward 10, a patient’s NEWS score of eight was recorded. The information was escalated to the medical team and a review completed by the outreach team.

We found three records to be calculated incorrectly. These included two records where the NEWS score had been calculated lower by one or two numbers. For example the recording was three instead of two; this did not affect the overall risk level indicated within the policy.

Matrons reviewed between five and ten sets of observations monthly in relation to the NEWS score and action taken. We observed the findings from January 2018 and found the majority of records contained accurate NEWS scores which were recorded at the documented frequency. However no records were submitted for the respiratory and renal wards (wards 5, 50 and 500). The documented evidence that the nurse in charge was not informed in many records reflected the findings during our inspection. On ward 8, none of the NEWS scores from nine patients had documented evidence that the NEWS score had been escalated. On wards 80 and 90, five out of ten records showed no documentation that they were escalated. On ward 1, nine out of ten records showed evidence of escalation.

Nursing staff on ward 5 told us that they used their clinical judgement of when to escalate the NEWS score due to the patient’s scored higher due to the constant use of oxygen for patients and higher respiration rates. However there were no escalation plans documented within the medical notes.

Staff told us they had completed training on the system to allow staff to be aware of when to escalate to medical staff. Non registered staff no longer completed observations and this was the responsibility of the registered nurses to complete and escalate as necessary.

Some nursing staff felt there was a disconnection with medical staff regarding escalating raised NEWS scores. Due to the demands doctors did not always review the patients and nursing staff managed the patients. Staff told us they felt the clinical outreach team responded quickly and reviewed the patients NEWS scores appropriately.

On the stroke wards an electronic NEWS score was recorded. The observations were inputted onto the system which calculated the correct scoring. The recording alarmed when the NEWS score has reached a level where escalation was needed. The system allowed staff to document any deviations from escalated plans.

The trust had a stroke peer review which identified that the current demand on hyper acute stroke unit (HASU) beds was not sufficient and that an increase up to 12 beds was recommended to safeguard against current and future demands. At present the HASU only accommodated up to four patients. Plans were in place to extend the amount of beds to eight which had been agreed to be a sufficient number and agreed by the board. However due to low nurse staffing levels the decision had been made not to increase the bed capacity. Staff told us that on two occasions they had to make another patient bay area into a HASU to accommodate patients that were requiring the level of need.

As a consequence of not increasing HASU capacity, patients could be moved out of HASU onto the stroke ward before the HASU phase of their care was completed. This was identified as a risk on the risk register and mitigation in place for patients to be reviewed by a consultant in order to prioritise them for use of available HASU beds. The trust did not collate numbers of how often this had occurred however senior managers felt it would be reported as an inappropriate discharge incident and recorded within the stroke service. The trust reported that there had been no incidents reported within the last 12 months.
Patients who presented in the emergency department with a possible stroke were reviewed by the stroke co-ordinator. They would then be admitted to the ward following the completion of scans and investigations. The medical staff would review them on the ward and plan their ongoing treatment.

The elderly assessment unit closed at 6pm due to not having any medical cover after this time; as a result elderly patients would be transferred to AMU.

A standard operating procedure was in place to admit patients onto the respiratory support unit based on ward 5. The consultant on call would make the decision out of hours. A plan was completed at board rounds to identify which patients could be moved out of the unit if a further patient needed to be admitted. All patients who required non-invasive ventilation (NIV) were admitted to the respiratory support unit (RSU) or ICU. There had been an increase over the winter months with the amount of patient requiring NIV therefore patients had been admitted to ICU until bed space was available on RSU.

An enhanced care team had been piloted for around four months which allowed staff with enhanced dementia training to provide one to one care to patients. Previously when patients had required one to one assistance it had been provided by security staff who may not have engaged with the patient. By providing staff that had specialist knowledge of the patient’s condition it allowed them to understand the patient’s situation. We were told from staff that had accessed the team they found them very beneficial and effective.

**Nurse staffing**

The majority of medical wards had staff vacancies that the trust were actively recruiting to. The trust had a continuous recruitment process to recruit staff and worked with local universities on recruitment campaigns. Several promotion videos had been created in areas where there remained a high proportion of vacancies to try to encourage people to apply to these specialist areas. The trust had a recruitment drive in place and had recently recruited to several unregistered positions. The senior management were aware of the nurse staffing vacancies and the trust board were updated monthly on areas of concern.

Staffing was reviewed several times a day using the safety briefing system. The system reviewed live data that the ward staff frequently updated regarding the staffing levels and other factors that were required to be taken into account to determine if the ward was safe. The system collated a priority need based on the information record. For example a 25% shortfall in registered nurse hours or less than two nurses on a ward during any shift would result in a ‘red flag’. Once a red flag occurred it required escalation to senior management to provide a plan to reduce the risk.

Each month the amount of red flags was published, the highest area was ward 11 (including HASU) with 94 red flags in December 2017. The number of red flags fluctuated for each ward however the trend showed that the areas which had highest number of red flags had the larger number of nursing vacancies. The trust collated trust wide data into the reasons why wards would be identified as a red flag. In December 2017, 88% was due to patients requiring an increased level of monitoring and supervision such as one to one observation. This included patients who may have been violent or aggressive who required a security staff member to ensure safety was maintained. Shortfall in registered nurses time accounted for 10% of red flags.

The trust reported the percentages of ward’s staff fill rate to the board monthly. The fill rate for registered nurses during the day was lower than the minimum standard of 80% for eight and nine wards out of 13 in December 2017 and January 2018. A rationale was provided to why the figures remained low, this was due to providing staff to the winter ward and an increase in absence levels. The staff fill rate was increased for healthcare assistants in order to fulfil some of the gaps in registered nurses. In January 2018 on ward 11, the staff fill rate was 57% for registered nurses, 165% for healthcare assistants. We reviewed previous months to identify if the
staff fill rate had remained low for a period of time. In August 2017 we found that eight wards out of 13 had lower than 80% fill rates.

On ward 110 and HASU the required number of registered nurses was five within the day to provide care for 24 patients including four patients within HASU. Most days registered nurse staffing would not meet the required level and would be lower at four including the ward manager within the staffing figures. Within HASU the Royal College of Physicians National Clinical Guideline for Stroke requirement is for 2.9 whole time equivalent nurses per bed. Most days there was one registered nurse providing care for up to four patients with assistance from unqualified staff.

On AMU the team were actively recruiting nine registered nurses. The area often ran the unit with seven registered nurses including the co-ordinator instead of the required eight registered nurses. Staff did comment that this had improved as there were times over the summer period where registered nurses numbers had reduced to six per shift.

On the elderly assessment unit there were five whole time equivalent (wte) vacancies due to staff leaving for career progression. There was also six vacancies on ward 9. One registered nurse would provide care for up to 15 patients at times. We were told that new registered nurses to the elderly wards were often newly qualified and would move or progress to other areas. There was no rotation in place for staff to move around to different medical ward environments. Staff on ward 80 had trialled having a different shift pattern of 10am to 5pm to provide further support at different times of the day.

There were vacancies on ward 5 along with staff not at work due to maternity and sickness leave. On the day of inspection the actual level of staffing did not meet the required level; one staff member had been moved to support another ward. The correct staffing levels were evident in the respiratory support unit (RSU) which supported four level two patients on the day of the inspection. Doctors had raised issues regarding the staffing ratios within the unit as the current staffing was 1 nurse to three patients instead of two patients. As a result the staff were taken from the ward area. The ward manager was working toward having two separate staffing rotas to reflect the different staffing levels that were required.

The senior manager discussed that each of the health groups had worked together in order to provide continuity for staffing to ward 10 (winter ward). As a result they felt that the flow had worked better for patients who were admitted to the ward. Staff told us on the ward they felt supported by senior staff on the ward.

The trust was dedicated in supporting unregistered staff to develop in their career with some advancing into nursing positions. Staff had been seconded into nurse associate roles and supported to complete specific courses to meet the requirements needed to undertake such roles as nurse associates and student nurses. As a consequence new staffing models were being reviewed to take into account how the newer roles would fit into the requirements for safer staffing levels.

New staff to the wards were supported and provided with a supernumerary period in order for them to become confident and competent in completing patient care and clinical skills. This allowed staff to perform these skills in a period where they did not have the pressure of being part of the numbers required to meet the safe staffing levels. We spoke with new staff members who told us that they had been supported by their team and provided with the relevant training.

From November 2016 to October 2017, there was a vacancy rate of 15% for nursing staff. The trust did not submit an overall target vacancy rate. There was a vacancy rate of 11% in medicine for all staff groups in the same date range.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From November 2016 to October 2017, there was a turnover rate of 23% for nursing staff which is over the trust target of 9%. There was a turnover rate of 18% in medicine for all staff groups with the turnover rate in the latest month much higher than the rest of the year’s data across all the wards where turnover data was supplied. 
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, there was a sickness rate of 4% for nursing staff which is the same as the trust target. 
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The calculation of bank and agency staff usage as a proportion of the total number of shifts available including those covered by permanent staff due was not possible. This was because the total number of bank, agency and unfilled shifts was higher than the total number of available shifts reported by the trust.

The trust has identified a ward (Ward 70 at Hull Royal Infirmary) in medicine which had one of the highest uses of bank and agency staff at the trust. It attributes this to a high vacancy rate and has the following plans to mitigate this: international recruitment, re-deploy from other areas, a UK recruitment campaign. The nurse director was unaware of any area using 20% or more bank or agency staff. 
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

**Medical staffing**

Three consultants were present on the AMU from Monday to Friday 8am to 8pm working across the three zone areas. After this time two consultants worked across the unit until 10pm. This provided continuity in patient care and improved the patient flow within the department as patients were reviewed in a timely manner. An acute physician in charge (APIC) was in place daily on AMU, all patients who required to be admitted onto the unit had to be reviewed by the APIC. In the four medical records we reviewed in AMU, a consultant had seen the patient a plan of care had been created within 12 hours of admission. General medical consultants were on site from 8am to 8pm seven days a week and on call from home out of hours. Medical staffing was managed overnight and locums were organised to cover any shortages.

We found there were vacancies with medical staffing in some clinical specialities for example, the elderly service. There were four elderly medicine consultant vacancies despite several recruitment campaigns. Four long term agency locums were employed to provide stability and safety across the services. Alternative ways were to be trialled to address the issues, these included; development of speciality doctors, acute clinical physicians and advanced nurse practitioners positions.

Medical staff rotated throughout the stroke wards based at Hull Royal Infirmary and Castle Hill Hospital (ward 35 rehabilitation). Each day a consultant would complete a ward round for the patients in HASU, acute unwell and new patients. Over the weekend, junior doctors provide cover on each ward.

For the winter ward (ward 10) it was agreed that medical cover would be provided by long term locums, each week one consultant would cover the ward to provide some consistency to the patients on the ward.

We were told of occasions where the middle grade medical cover during the night was not at the required level, when this occurred the issue was escalated and staff prioritised where they were needed. This meant that some doctors were required to cover more wards and carry more than one bleep system. The bleep system that was used for out of hours; staff felt was managed appropriately. Medical agency locums are also used to fill gaps in the junior doctor rotas, but we routinely utilise internal/bank staff in the first place.
We reviewed the 24 hour GI bleed rota that the trust submitted for January 2018 to August 2018 which had appropriate cover each day.

New roles were developing in elderly medicine, these included advanced care practitioners and speciality posts.

We observed both medical ward rounds and safety brief meetings. These were thorough and efficient with all information clearly communicated. All staff members had the opportunity to contribute to the meetings.

All the medical staff we spoke to felt support and aware of who was providing supervision. The majority of staff told us they had time to be able to attend specific medical training.

The elderly assessment unit, closed to admission overnight due to ward not having the required medical cover. The risk was identified on the risk register and strategies had been implemented to minimise the risk. These included developing the frailty tool and having the frailty team in the emergency department to prevent admissions. Junior doctors were based on the ward until 10pm with consultants covering until 7pm.

From November 2016 to October 2017, there was a vacancy rate of 11% for medical and dental staff. The trust did not submit an overall target vacancy rate. There was a vacancy rate of 11% in medicine for all staff groups in the same date range.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, there was a sickness rate of 1% for medical and dental staff which is under the trust target of 4%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The calculation of bank and locum staff usage as a proportion of the total number of shifts available including those covered by permanent staff due was not possible. This was because the total number of bank, locum and unfilled shifts was higher than the total number of available shifts reported by the trust.

The trust has identified two services one in medicine which had some of the highest uses of medical bank and agency staff at the trust. These were care of the elderly (wards H8, H80, H9, H90 and EAU) at Hull Royal Infirmary. It attributed the care of the elderly figure to a high vacancy rate and planned to mitigate this by recruiting more doctors.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

In August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.

### Staffing skill mix for the 297 whole time equivalent staff working in medicine at Hull and East Yorkshire Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>29%</td>
<td>23%</td>
</tr>
</tbody>
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Records

Care plans were divided into care bundles, which related to certain risks such as falls, nutrition, pressure care and venous thromboembolism. The care bundles were generic assessment with an area for individualised care to be added for each patient. Intentional rounding documentation was in place for each patient and we saw these documented within the records. This was a document where staff completed regular checks with patients at set intervals carrying out scheduled tasks or observations. These included reviewing pain, altering the patient’s position and checking whether they required any further assistance such as drinks or food.

We looked at 80 records consisting of medical and nursing notes reviewing specific information within the records. All nursing records consisted of the intentional rounding; these were completed consistently across different wards.

At our inspection in June 2016 we noted that nutritional assessments were partly completed. This included the use of the food charts where the amount of food consumed was recorded during the day and then given a red, amber and green (RAG) rating system rating to identify their overall malnutrition risk. At this inspection we reviewed 40 food charts to identify if improvements had been made. We found that 20 food charts were completed to identify what the patient had eaten and had been rag rated to identify their overall risk. The other 20 records had been completed to identify the food consumed but had not been rag rated to identify the malnutrition risk. There was no pattern into which wards fully completed the food charts, for example when reviewing two food charts for the same patient one was completed fully and the other was not.

The trust completed an action plan after our last inspection in relation to this and identified they wanted to increase compliance within the wards and review the audit process in place on the wards. The action plan showed that they would monitor nutrition and hydration through care plans in place on the wards. Each month the matrons reviewed ten patients to identify if the food charts had been accurately completed, with the RAG rating included.

We saw in one patient’s records that the patient had triggered for a referral to a dietitian due to their low appetite, however it was not clearly documented in the notes if a referral had been made. We discussed this with the nurse in charge who showed us that an electronic referral had been completed.

At our inspection in June 2016 we noted that falls risk assessments were not always completed. The falls assessment consisted of a booklet which contained reviews of the patient’s ability to mobilise and the use of bed rails. A comprehensive multifactorial assessment could then be completed by answering yes to any of the three questions raised or the patient being over 65 years. We reviewed 29 falls risk assessments and found 17 to be completed and contained the multifactorial assessment completed if required. Out of the twelve that were not completed, 10 were aged over 65 where the multifactorial assessment should have automatically been completed. The trust completed an action plan after our last inspection in relation to this and identified they would review the applications of falls assessment for over 65s. They also identified they would complete audits and incorporate the multifactorial assessment tool into moving and handling training.

We saw several sheets within the notes did not have identification labels or information on. This meant that if the notes became dislodged there would be no indication to which patient they belonged to. Information provided by the trust showed that documentation audits had been
completed on wards, a common theme was that patients name or identifier was not completed. Action plans and recommendations were attached to the audit in how to improve compliance.

Several staff felt that records were not fully completed due to low staffing levels and more time was spent providing care to patients rather than recording it. Staff told us they were aware that there were gaps in recording information such as completion of fluid and food charts.

The majority of record trolleys we observed were locked, however one occasion on ward 110 the notes trolley was left open and unattended.

**Medicines**

Medicines were stored securely with access restricted to authorised staff members. The rooms were tidy and well organised. Policies and procedures were available on the trust intranet and links were available to guidelines and reference sources.

We reviewed 25 medication charts and found most of them had been fully completed including allergies and VTE assessment. This had an improvement significantly since our last inspection in June 2016. We saw one medication chart required to be rewritten and staff had added extra columns on.

At our inspection in June 2016 we found that controlled drug checks were not completed daily on most wards. At this inspection daily checks for controlled drugs had been completed each day and on all wards we visited. This had improved significantly since the last inspection. Controlled drugs were audited every week by registered nurses on the ward and every six months by the pharmacist. Any actions and learning was fed back to the ward manager and a report issued to the medicines safety group.

On one ward, staff had identified an issue with the record for patient’s own controlled drug medicine. The issue had been investigated and resolved, however the reason was not always clearly documented and they had not been recorded as an incident so that lessons could be learnt.

At our inspection in June 2016 we found on several wards fridge temperatures checks had not been performed and there were many examples where the fridge had been recorded as out of range and no corrective action had been taken. At this inspection we found that there was a system in place to record daily temperatures and these were completed regularly with no gaps. This had improved significantly since the last inspection. On ward 80 there were a small number of occasions where the temperature was outside normal range with no action. We reported this finding to the chief pharmacist and the time of the inspection.

We saw on three occasions on wards 1, 100 and 110 registered nurses completed documentation and signed to say the patient was having the medication prior to giving it to the patient. The patient may have refused the medicine when presented by the nurse and the signature on the chart would not show this. The form would then have to be changed to reflect any refusal and why. On one occasion on ward 100 the medicine trolley was left open whilst the nurse gave the patient their medicines. The medicine trolley could not be seen by the registered nurse whilst she attended to the patient. This meant that there could have been access to the trolley without their knowledge.

The medication round we observed on AMU, registered nurses signed the medication chart after they had administered the medication to the patient.

Medicines reconciliation was completed by ward based pharmacists and pharmacy technicians. The trust had set a target of 70% for medicines reconciliation within 24 hours of admission. This target was not achieved. The trust had set a target of 83% for medicine’s reconciliation at any one time, this target was achieved. This had improved significantly since the last inspection in June 2016. The pharmacy department was currently piloting a new daily report which identified patients
who have been admitted for over 20 hours without medicine reconciliation. These patients would then prioritised by a dedicated pharmacy team.

The trust had a self-administration policy and staff were able to describe how they would use this policy. However we found two patients on ward 5 that were self – administering medicines without having a risk assessment in place in line with policy.

Three people on two wards were receiving their medicines via a feeding tube, however these medicines were prescribed orally on the medicine administration record and no assessment had been made that ensure the medicines were appropriate for this method of administration. This was brought to the attention of ward staff during the inspection and action had been taken when we revisited the wards later in the day.

Arrangements were in place to ensure that medicine incidents were reported, recorded and investigated through the trust governance arrangements. Staff we spoke with knew how to report incidents involving medicines. Significant incidents were discussed at the safe medication practice committee and appropriate actions taken in response to concerns.

To reduce delays in discharge some wards were piloting a system of pharmacists transcribing medicines onto the discharge letter. We also saw that patients’ ‘take home’ medicines were dispensed by pharmacy staff on some of the wards, which helped to reduce waiting times for discharge medicines.

Antibiotic prescribing audits were completed monthly looking at indication, appropriateness and review/stop dates.

**Incidents**

Staff knew how to report incidents using the electronic reporting system and told us they were encouraged to do so. However, staff we spoke with told us they did not routinely report any staffing concerns.

We saw that staff reported incidents due to falls and pressure ulcers and that these were investigated. Some ward managers reported that they learned from incidents and how they had improved documentation.

An alert had recently been received in regards to oxygen; on ward 5 one staff member had the responsibility of ensuring that all staff were aware of the alert. We spoke with the staff member who confirmed that they had started to speak to staff, and requested they sign to say they were aware of the information.

Staff told us they either received feedback about incidents via email, team meetings, verbally or through monthly lessons learnt bulletin. Staff could give us examples of changes that had occurred as a result of an incident.

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 the need to be open and honest with patients and their families.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never event.
The trust reported no incidents which took place from November 2016 to October 2017 and were classified as never events for medicine.
(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017))

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England and took place from November 2016 to October 2017.

Of these, the most common types of incident reported were:
- Pressure ulcer meeting SI criteria with six (35% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with five (29% of total incidents)
- Treatment delay meeting SI criteria with four (24% of total incidents)
- Medication incident meeting SI criteria with one (6% of total incidents)
- Slips/trips/falls meeting SI criteria with one (6% of total incidents)

Site specific information can be found below:
- Hull Royal Infirmary: 17 incidents; Pressure ulcers and suboptimal care of deteriorating patient are the most prevalent types of incident reported and combined make up two thirds of the trusts SIs in medicine
(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

We looked at examples of serious incident investigations and found they had been investigated thoroughly. Staff, patients and relatives had been involved with the process. The reports were open and honest. Any learning from the incident was documented and the incident shared at meetings to review the content of the report.

**Safety thermometer**

The safety thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

The trust completed a monthly safety thermometer newsletter which provided trust wide compliance with the patient harms. Staff could access this on the trust website.

Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 31 new pressure ulcers, 15 falls with harm and 31 new catheter urinary tract infections from November 2016 to November 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Hull and East Yorkshire Hospitals NHS Trust**
There was a fluctuating but general trend in reduced incidence of pressure ulcers in more recent months. (Source: Safety thermometer - Safety Thermometer)

During our inspection, we saw safety thermometer information displayed at the entrance to each ward, which showed how many falls and pressure ulcers there had been during the previous month.

There had been 15 pressure ulcers reported in January 2018, the majority (eight) were graded as category two pressure ulcers. Falls were monitored each month and reported to the board through the safer staffing monthly report. In January 2018 there had been 25 falls across the wards, 19 were classed as minor falls. Staff told us they used slipper socks, sensors and posters informing patients to ask for help, to try to reduce the number of falls.

Is the service effective?

Evidence-based care and treatment

Care and treatment was provided based on national guidance and was evidence based. Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE).

Staff told us they had access to policies, procedures and care plans on the trust intranet. The policies we reviewed all had identified authors with review dates in place. Policies were reviewed and discussed at the quality governance and assurance committee meetings. Any overdue policies were reviewed and added to an action tracker to monitor progress and identify problems. We were told that the intranet contained sections with a variety of different resources. For example, there was a section on falls that provided staff with knowledge and information, how to prevent falls and included the trust’s documentation.

The trust participated in national audits such as lung cancer audit, heart failure, myocardial ischaemia national audit project and sentinel stroke national audit programme (SSNAP). We saw the trust completed reviews of the findings and provided action plans to either maintain or improve the results. The trust developed speciality governance dedicated SSNAP meetings.

At our last inspection in June 2016 the trust completed audits that reviewed fundamental standards on each ward. These consisted of nine key areas:

1. Staff experience
2. Patient environment
3. Infection control
4. Safeguarding
5. Medicines management
6. Tissue viability
7. Patient centred care
8. Nutrition and hydration
9. Patient experience

The trust continued to complete the fundamental standards and display the information at the front of each ward. Specific guidelines were used to ensure consistency across all the areas; following the assessment process a rating was given for the overall score which then calculate the review time period.

Results from the fundamental standards were documented with the trust’s board meetings and we saw improvement for individual wards from our last inspection in June 2016. The results from the fundamental standards had improved for many wards and the majority of wards were in the correct timeframe for their reviews. The only exception to this was the reviews for infection control which some wards were awaiting their review from October 2017 to December 2017.

**Nutrition and hydration**

Patients we spoke with told us they were able to choose their meals for the day from a menu that was given to them every morning. Patient’s requests for specific diets were observed and managed in order to be able to meet their individual needs. One patient told us that their own individual preferences were received and they had a good relationship with the staff serving drinks and meals.

Drinks were regularly provided to patients and they told us that staff would make them hot drinks any time they asked for one. We saw that most patients had food and drinks in reach on their table. Patients in the discharge lounge had access to food and drink whilst waiting for the transport or medication.

Some wards had nutritional apprentices; their role was to record the patient’s weight and assist with feeding and complete the food chart. Milkshake rounds had been introduced onto wards to increase patient nutrition.

Patients who required assistance with feeding and nutrition were highlighted using the ‘red tray’, this allowed staff to be allocated at meal times to assist with feeding. Boards were visible in the kitchen that highlighted patients that required assistance. On ward 110 and 11 some staff felt that patients who required frequent support in managing their fluid intake struggled due to low staffing levels. Some family members attended the ward to support with this.

Ward 80 were trialling the use of coloured plates for the elderly patients, to identify if this improved patient’s nutrition. A number of studies had shown the benefits of patients living with dementia using coloured plates to increase their food intake. There was a memory café based on ward 8 which patients and family members could use.

Each ward was audited in regards to the nutrition fundamental standard, this reviewed compliance to the trust’s nutrition and hydration policy. Out of the nine standards the trust reviewed on an ongoing basis, the nutrition standard had the highest number of wards under 80%. Three wards out of 13 receiving a score of below 80%. We discussed this score with some of the ward managers where the rating was low who told us support and guidance had been provided. The rationale for the lower score was due to the incomplete food charts where food charts had not rag rated at the end of the day to identify if the patient was at risk of malnutrition.
Since September 2017 eight wards have had their nutritional fundamental standards reassessed. Five showed some improvement such as AMU increased from 68% to 100% and ward 8 increased from 78% to 87%. However two reduced significantly; ward 80 reduced from 83% to 56% and ward 110 from 86% to 68%.

During our inspection we observed a fundamental standards nutritional assessment taking place. The dietitian was undertaking a nutrition assessment as part of the process on ward 1. We saw the dietitian speak to patients and ask a range of questions. They reviewed five sets of notes to identify if the food charts had been completed correctly. The ward were provided with feedback and informed they had 96% for the result.

**Pain relief**
We were told that staff responded quickly to when patients needed pain relief. One patient told us that staff attended to them within minutes of asking for pain relief. The patient said that pain relief was not prescribed on the medication sheet and they reacted quickly to ensure that they received adequate pain relief. Another patient was given medication that did not manage their pain; this was reviewed and changed to another analgesia that was effective. Patient group directions (PGD) could be used on the discharge lounge for various different pain medicines. This allowed patients to receive adequate pain relief prior to their discharge home.

**Patient outcomes**
From September 2016 to August 2017, patients at Hull Royal Infirmary had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England averages.

**Elective Admissions - Hull Royal Infirmary**

![Graph]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions
- Patients in nephrology had a slightly higher than expected risk of readmission for elective admissions
- Patients in neurology had a higher than expected risk of readmission for elective admissions

**Non-Elective Admissions - Hull Royal Infirmary**

![Graph]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top*
- Patients in general medicine and geriatric medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a similar too expected risk of readmission for non-elective admissions

**Sentinel Stroke National Audit Programme (SSNAP)**

Hull Royal Infirmary takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April to June 2017. This is an improvement on the previous 2 audits where Hull Royal Infirmary received a grade C.

Speech and language therapy has had consistently poor performance in both patient centred performance and team centred performance with an improvement in most recent quarter (improved to a grade D after 4 quarters of receiving a grade E). Occupational therapy has performed consistently well with an A grade achieved in the latest 4 quarters for both patient centred and team centred performance.

### Team centred Performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec-Mar 17</th>
<th>Apr-Jul 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
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<tr>
<td>Domain 4: Specialist assessments</td>
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<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A↑↑↑↑</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>C↓</td>
<td>A↑↑↑↑</td>
<td>A</td>
<td>A</td>
<td>B↑</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
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<td>E↓</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
</tr>
<tr>
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<td>C</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
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<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B↑</td>
<td>E</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
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<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Team-centred Total Key Indicator Level</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
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</tr>
</tbody>
</table>

### Patient centred Performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
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<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A↑↑↑↑</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>D↑</td>
<td>A↑↑↑↑</td>
<td>A</td>
<td>B</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>D↑</td>
<td>E↓</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>D↑</td>
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<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
</tr>
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<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
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<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
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</tbody>
</table>
Heart Failure Audit

In-hospital Care Scores
Results for Hull and East Yorkshire Hospitals NHS Trust in the 2016 Heart Failure Audit varied hugely across the sites for two of the metrics (cardiology inpatients and input from consultant cardiologist) with Castle Hill Hospital performing much better than England and Wales average and Hull Royal Infirmary performing much worse. Castle Hill Hospital performed better than the England and Wales average for all of the four of the standards relating to in-hospital care. Hull Royal Infirmary performed better than the England and Wales average for one of the four standards, similarly to one of the four standards and worse than two of the four standards relating to in-hospital care.

Discharge Scores
Hull Royal Infirmary performed worse overall, scoring lower than the England and Wales average for six out of the nine standards and similar to England and Wales average for one of the nine standards.
Both hospitals performed worse than the England and Wales average for the referral to heart failure (HF) nurse follow up and the referral to HF nurse follow up (LVSD only). Both performed better in the referral to cardiology follow up.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 142 inpatients with diabetes at Hull and East Yorkshire Hospitals NHS Trust. This was equal to 18% of the beds audited which places them in quartile 3. 76% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 1.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 0% of nSTEMI patients were admitted to a cardiac unit or ward at Hull Royal Infirmary and 82% were seen by a cardiologist or member of the team compared to England averages of 96% and 56%.

The proportion of nSTEMI patients who were referred for or had angiography at Hull Royal Infirmary was not reported as there were fewer than 20 eligible patients for this metric; the
England average is 83%.
(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 13%, which does not meet the audit minimum standard of 90%. The 2015 figure was 84%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 32%, this is significantly better than the national level. The 2015 figure was 22%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 63%; this is not significantly different from the national level. The 2015 figure was 57%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 66%; this is not significantly different from the national level. The 2015 figure was 71%.

The one year relative survival rate for the trust in 2016 is 35% which is significantly worse than the national level.
(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017
The crude proportion of patients who had a vision assessment (if applicable) was 13%: this did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 11%: this did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 42%: this did not meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 8%: this did not meet the national aspirational standard of 100%.

The Hull Royal Infirmary did not have a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings as of the National audit of Inpatient Falls 2015.
(Source: Royal College of Physicians)

The Trust does have a multi-disciplinary Falls Prevention Committee in place which monitors falls prevention and falls data. The Falls Prevention Committee delivers its meetings in line with its agreed work plan which covers: serious incidents and reviewing the decision/findings; reviewing of incident data to ensure relevant investigations are undertaken, rated appropriately, and actions are addressed and lessons are learnt; and also undertakes reviewing of risks.

Competent staff
We spoke with the ward manager on ward 11 and HASU. Previously not all registered staff were competent to working in HASU. The ward manager had committed to ensuring that all staff would be competent within this area within one year. All registered staff had now undergone training to be competent in providing care in HASU.

Staff on ward 5 provided support to patients who required non-invasive ventilation (NIV); this was obtained through training and annual updates. Specific training was completed and we saw
evidence of this in staff files and workbooks.

Preceptorship packages were in place for new staff and they were supernumerary for the first four to six weeks. In AMU we were told that staff were supernumerary for a period of six weeks and within that time frame began to take on more responsibility under the supervision of other staff.

We spoke with a new registered nurse who had worked on the ward as a third year student nurse. They told us that they had been supported and had completed various training packages.

Staff had been encouraged to undertake further courses to develop their skills and knowledge. Staff told us they had completed competency based training, mentorship training and academic degrees.

We spoke with a band 4 trainee associate nurse who told us they had competencies to complete. They had received training in NEWS, sepsis and observations. They felt well supported by the practice development matron, who ran the programme, and their manager. They had been provided with a mentor and an associate mentor.

Ward managers could access the trust dashboard which provided information about appraisal figures. Staff could log on to the system to complete the joint objectives together with their manager. Staff told us that they had appraisals.

From April to October 2017, 76% of staff within medicine at the trust had received an appraisal. The figure for medical and dental staff was 83% and the figure for nursing and midwifery staff was 70% compared to a trust target of 90% for medical and dental staff and 85% for other staff groups. However, the information given was only for 6 months, the trust still have 6 months for appraisals to be completed. Two staff groups met the trust target appraisal rate these were allied health professionals and healthcare scientists.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>49</td>
<td>53</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>66</td>
<td>78</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff – Hospital</td>
<td>71</td>
<td>86</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>20</td>
<td>26</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>161</td>
<td>210</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>116</td>
<td>152</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>252</td>
<td>362</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>16</td>
<td>24</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
**Multidisciplinary working**

We saw examples of good multidisciplinary team (MDT) working. For example on ward 11 action plans for patient’s ongoing care were discussed between the patient’s consultant, physiotherapists, occupational therapists, medical and nursing staff. We observed ward round and all staff contributed; medical staff participated with the consultant when reviewing the care. A mental health worker was present on one of the wards visiting a patient and joined in with the ward round. A joint plan of care was created to reflect the patient’s mental health needs alongside their acute clinical needs.

Safety huddles took place on wards every day which discussed staffing, safe patient care including falls.

Board rounds were completed several times a day with a variety of different staff members. Each patient was reviewed with their ongoing plan of care. In AMU zone rounds took place several times a day in order to review the patient’s ongoing care. These also included staff from the emergency department to discuss patients that required to be transferred to AMU.

We spoke with several physiotherapists; staff were located into teams and covered various wards to ensure there was a continuity of care. This enabled staff to build a rapport with the patient and develop support and independence.

Most of the wards had discharge assistants; their role was to support staff in discharging patients. They would involve other services, such as social workers and find out why the discharges were delayed. In AMU they were trying to extend the hours that they worked to see if this would work. The discharge assistants communicated with the social workers daily to update and review the plans required for the patients. Discharge assistants liaised with community practitioners, such as community heart failure nurses and the respiratory team, which ensured that discharges were a lot quicker.

Various different disciplines had been allocated to the trust’s escalation winter ward (ward 10), this allowed staff to work together in order to encourage the patient’s independence and reduce the patient’s stay within hospital.

**Seven-day services**

One staff member told us how they had contacted the out of hours mental health liaison team to discuss a patients ongoing mental health condition. The team responded and visited the patient the next day to support the ward staff and identified they would visit every day. The mental health worker also liaised with other family members who were at home due to the patient’s admission. This allowed the patient to concentrate on improving their acute condition.

The ambulatory care unit was accessible seven days a week to review patients that had been referred by their GP or attended the emergency department. Patients with chest pain could be reviewed in a timely way without waiting in other departments. A specific referral and patient criteria was in place for ambulant patients to attend the department.

The trust provided a thrombectomy service Monday to Friday; however they wanted to increase the service to include weekends. Patients were required to spend a period of time in HASU after the procedure therefore this could not commence until the increase in HASU patient beds was in place.

The critical care outreach team covered both hospital sites, providing 24 hours cover every day. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them through an increased NEWS score. The team supported patients who were on both respiratory support unit and ICU that required NIV.
The pharmacy department was open seven days a week, 365 days a year. An on-call pharmacist was also available when the department was closed. The pharmacy intranet site contained guidance for ward staff and for managers on how to access medicines and pharmacy advice when the department was closed.

**Health promotion**
There was information available on the wards for patients to take with them that assisted in maintaining their own health. We observed that leaflets were available for patients covering certain conditions and lifestyle choices such as: alcohol consumption, smoking cessation, falls prevention and how to increase your appetite. Leaflets were provided to patients on how to manage their nutritional needs.

We saw that services were available to support people prior to discharge. On the elderly assessment unit, patients could undertake assessments in order to ensure that they would be safe at home.

Advice leaflets were given to patients on discharge, which informed them of possible complications following a procedure. This would allow patients to safely manage their condition at home and to seek advice if appropriate.

We observed that during our inspection there were banners for staff and visitors outlining when they had particular symptoms they should stay at home to limit the spread of infections such as flu.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
The knowledge and understanding of mental capacity and deprivation of liberty safeguards (DoLS) varied between staff. Some staff articulated when a DoLS would require to be completed and others were not sure. We spoke with staff regarding their understanding of DOLS; they did not recognise the use of bed rails or bed tables as a restraint. Two medical staff told us that patients would have an observation period before completing the DoLS paperwork.

A patient had been admitted who had a DoLS in place in their nursing home; however no application had been made for the patient whilst in hospital.

We observed a patient living with dementia wandering around the ward requesting to go home. This patient did not have a DoLS in place.

We did see on ward 11 that DoLS applications were discussed for patients as part of the board round. After the meeting we saw a staff member complete a DoLS application. DOLS paperwork on ward 9 was often completed by the nurse in charge; however registered nurses had also completed training in how to complete the paperwork.

The trust had a policy covering the use of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for patients who lacked capacity.

There was some confusion for nursing staff as to who would complete the paperwork for mental capacity, some were unsure if it was completed by medical staff or social workers. Capacity assessments were completed by the medical team. Nursing staff told us that they had to remind the medical team to review the patient’s capacity as there has been occasions where the patient has regained mental capacity but the paperwork had remained in place stating they did not have capacity.

We reviewed records and found that the mental capacity was not always recorded. For example one patient’s had been admitted with a stroke which had left them unable to speak and they did not have the mental capacity to make decisions regarding their care. This was not recorded in the
medical notes. Another patient required a procedure in order for them to receive enteral nutrition, the medical notes identified that discussion had taken place with the family. There was no mental capacity assessment found within the records.

Patients told us that staff asked for consent prior to completing any care and procedures. We saw that one patient was reluctant to have a procedure and the doctor discussed that it would not be completed until the patient fully understood and consented to the treatment.

We saw that patients who had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were completed in line with national best practice. They had been completed to identify who discussions had taken place with.

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) training had been completed by 89% of medical and dental staff within medicine and 94% for nursing and midwifery staff in medicine. Both staffing groups met the trust target of 85%.

Deprivation of Liberty Safeguards (DoLS) training had been completed by 89% of medical and dental staff within medicine and 94% for nursing and midwifery staff in medicine. Both staffing groups met the trust target of 85%.

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>238</td>
<td>267</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>238</td>
<td>267</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
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<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>545</td>
<td>579</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>547</td>
<td>579</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Is the service caring?

Compassionate care
During our inspection we saw that patients were treated with privacy and dignity. We overheard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff were always polite, kind, respectful and professional in their approach.

We spoke with 18 patients, relatives and carers. The majority of people were happy with the care received, stating; ‘nothing is too much trouble’; ‘I have been treated well’. However a small number of people felt that staff shortages had impacted on the care they had received such as having to wait a period of time for personal care or toileting. Staff were apologetic if they were delayed in attending to patients.

We spoke with several patients on the elderly assessment unit who told us that one specific non-registered staff member provided them with excellent care. They felt that the staff member was always very caring and would go out of their way to help them.

Staff were supportive to patient’s needs; one relative told us how important it was to the patient for their food to be cut into smaller sizes. Staff supported with this to enable the patient to eat independently. We observed staff mobilising a patients safely and providing them with reassurance and support.

One patient told us how staff had made arrangement for someone to attend to the patient’s pet due to their admission to hospital. The patient felt they could then concentrate on their required stay in hospital.

The Friends and Family Test response rate for medicine at the trust was 23% which was worse than the England average of 25% from November 2016 to October 2017.

The average of all participating medical ward’s annual recommendation score was 92%. The majority of the wards scored over 90% for recommendation rates.

Friends and family Test – Response rate from 01/11/2016 to 31/10/2017 by site.

![Graph showing Friends and Family Test response rate from 01/11/2016 to 31/10/2017 by site.](image)
Emotional support

Patients, families and carers told us that they felt they received good emotional support from staff.

We heard good examples of staff providing additional emotional support to patients. These included patients feeling reassured undergoing investigations and staff taking time to listen and support patients. One patient told us that one nurse took time in finding out their individual preference with personal care and ensuring that was met.

Staff provided emotional support to patients to minimise their distress. Patients reported that if they became upset staff were quick to respond and give reassurance.

On ward 5 we saw a staff member walking around the ward supporting and encouraging a patient to mobilise. A patient on ward 80 who was confused was supported by a staff member to be guided back to their bed area.

A family member was struggling to manage the patient at home and this was having an impact on the relative mental health and well-being and ability to be a carer. We saw evidence of supporting the family member and referring them to psychology to support their own needs.

A chaplaincy service was available to provide pastoral, religious and spiritual support for patients and relatives. We were told that chaplains and volunteers would visit the wards on request or as part of their routine visits.

Understanding and involvement of patients and those close to them

Patients told us that staff explained their care and treatment to them in a way they could understand. They felt they were involved with their decision making and could make informed decisions. Staff were open and honest with their discussions with the patient’s and relatives.

Family members could discuss more details with both nursing and medical staff on the telephone; they were given specific codes in order to receive more information. Relatives on ward 90 told us that staff talked through the options available and they felt they had everything to make difficult decisions. Staff were flexible regarding visiting out of the agreed ward times to discuss with medical staff patient’s ongoing care.
Staff respected patient’s wishes if they did not comply with treatment. With one patient we saw that a best interests meeting was held with the patient to discuss the options available and an acceptance that the patient had the capacity to make the decision they wanted.

We saw evidence in patient’s records that decisions had been discussed with both patients and relatives. Patients confirmed that they felt doctors and nurses communicated well together.

We observed patients admitted onto AMU, staff discussed the reason for admission and their level of understanding. Medical staff were observed to involve patients and acknowledge they understood the information.

Is the service responsive?

Service delivery to meet the needs of local people
The trust worked closely with the local commissioning groups (CCGs) stakeholders, patients and staff to plan and deliver services to meet the needs of local people. These included meetings with local authority to review patient pathways to prevent admissions and reduce patient’s length of stay.

A new service had been commissioned to help support families through the decision to place a family member in residential or nursing care home. They would then be matched with homes that most suited their needs. Families and the patient are then supported to visit the care home and move within a few days.

British Red Cross provided an assisted discharge service to support discharging patients. The service was operating seven days a week between 10am and 6pm to allow patients to return home earlier.

Meeting people’s individual needs
The service took account of people’s individual needs. A learning disability nurse specialist offered support for those patients with particular needs. However, staff we spoke with were unaware if these patients were flagged on the electronic system. Services had picture charts that they could use to help them communicate with patients.

A trust wide dementia and delirium screening tool was used for all patients on admission. Staff contacted the mental health team if they required support. The service used the butterfly scheme for patients with dementia, which allowed delivery of person centred care for patients with dementia or delirium whilst in hospital. Patients with dementia were identified on the electronic patient system. Staff told us that the dementia care bundle paperwork had only recently been introduced and were being piloted on certain wards. We found that the nine dementia care plans / butterfly schemes had not been completed on wards where the pilot had been commenced.

The ‘reach to me booklet’ was used to provide an understanding of the patients normal routine and understanding. This required to be imbedded into the records. Audits had shown the butterfly scheme and reach to me had improved.

On the elderly wards there was lots of old memorabilia such as pictures and bus stops. One family member told us that they walked up and down the corridor with their relative and discussed all the various items displayed. They felt that this had a calming and positive effect on their relative.

During our inspection work was underway on ward 80 to create a cinema, this would show old films and allow patient to sit and watch the films. The ward were developing to become more dementia friendly, this included moving signs to be at eye level and easily seen. Pictures and other old memorabilia were being introduced.
Physiotherapists provided information about staying active. Prior to Christmas patients participated in exercise classes.

Various initiatives were in place on ward 90 such as befriending dogs and the Royal Ballet had attended. Royal British Legion members would visit the wards and talk to patients. The elderly wards had linked with the children’s wards for the children to draw pictures for the patients.

Staff told us they could access interpreter services if needed for those families where English was not their first language. This included access to British Sign Language interpreters.

The computer devices held translating services and applications to translate into other languages. Staff who could also speak in the patient’s first language could be accessed. We were told that for consent issues translating services were used. However for general questions, families were sometimes asked.

**Access and flow**

Previously medical patients who had been assessed as appropriate to be moved to a non-medical ward due to bed pressures had been transferred to Castle Hill Hospital. No patients were now transferred to Castle Hill Hospital, however may be moved to a non-medical ward prior to discharge. A referral criteria was in place to ensure the correct patients were moved, patients with cognitive impairment or risk of falling were expected not to be moved. However we visited ward 35 (eye hospital) to review the medical outlier patients and found three met this criteria. This had been highlighted as a risk at the quality governance and assurance committee meeting in November 2017 with inappropriate patients being sent. We were told that these incidents were reported onto the incident report system. Seven non-medical patients were on the ward, we reviewed the records, medical reviews had not occurred every day. Only two of the patients received medical reviews the previous day.

Patients were cohorted on specific wards on the Hull Royal Infirmary site. A designated consultant reviewed the medical outlying patients and general reviews were provided by the medical team on the ward. We reviewed five sets of records of patients who were medical outliers on non-medical wards. We saw that all patients had been reviewed the consultant within the last 24 hours.

The frailty intervention team (FIT) had been implemented for around one year and this involved consultants and advanced nurse practitioners reviewing patients, urgent referral to memory and falls clinics and reviewing X-rays. Patients who tended to attend the hospital on frequent occasions were also referred to this service to try to reduce the number of admissions.

Daily meetings were held at the hospital with other agencies such as local authority and community services to review patients that had been assessed as medically fit for discharge. Patients with complex needs were also added to the meetings to prepare for discharge prior to their assessment to prevent a longer hospital stay. Throughout the day senior managers meet with matrons from each business divisions to review the discharge plans for each identified patient to prevent delayed discharges.

**Hull Royal Infirmary**

From October 2016 to September 2017 the average length of stay for medical elective patients at Hull Royal Infirmary was 5.3 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 5.5 days, which is lower than England average of 6.6 days.
Elective Average Length of Stay - Hull Royal Infirmary

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for elective specialties:
- Average length of stay for elective patients in gastroenterology and respiratory medicine is higher than the England averages.
- Average length of stay for elective patients in nephrology is lower than the England average.

Non-Elective Average Length of Stay - Hull Royal Infirmary

Note: Top three specialties for specific trust based on count of activity.

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in general medicine, geriatric medicine and respiratory medicine is lower than the England averages.

The discharge assistant’s role was to support the patient’s discharge and reduce the patient’s admission. They monitor how long patients have been waiting for scans and referrals to services such as social services and therapists. If the timescale reached waiting periods of more than 24 hours the discharge planner raised an alert which then allowed the patient to be prioritised. Discharge assistants ensured that patient discharges were well organised. Discharges had become a lot quicker since the introduction of this role.

We were told that changes in AMU with the creation of three zone areas and consultants in each area had a positive impact on the patient’s flow and experience. Staff told us that they felt that there had been a marked improvement in the patient flow from the unit to other areas of the hospital or discharge. We requested data to corroborate these findings however the trust were unable to quantify the improvements.

A rapid access clinic was in the process of being trialled. This involved a referral from a GP who felt that the patient may need to be admitted to hospital. The patient would be seen by a consultant who would review the medical condition to identify if a hospital admission was necessary or a plan of care that could be managed within the home environment with support from additional services.

Physiotherapists and occupational therapist completed clinics to reduce the number of hospital admissions.
Once patients were assessed as ready for the discharge, they were transferred to the discharge lounge. This allowed other patients to be admitted into the vacant bed spaces on the wards.

The trust reported that from October 2016 to October 2017, 75% of individuals did not move wards during their admission and 25% moved once or more, one of these moves being for a patient ‘at end of life’. This had improved since our last inspection in June 2016 where 40% of patients had no moves and 60% moved once or more.

Site specific information can be found below:
- Hull Royal Infirmary: 77% of individuals did not move wards during their admission, and 23% moved once or more.
  *(Source: Routine Provider Information Request (RPIR) P51 – Bed moves)*

Between November 2016 and October 2017, referral to treatment rates for admitted pathways were fairly consistent but worse than the England averages. In the most recent month October 2017, referral to treatment rates at the trust showed that 75% of patients were treated within 18 weeks versus the England average of 90%.

*(Source: NHS England)*

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>95.1%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

*(Source: NHS England)*

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>96.2%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>92.1%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.2%</td>
<td>91.9%</td>
</tr>
</tbody>
</table>

**Learning from complaints and concerns**

From November 2016 to November 2017 there were 125 complaints about medical care. The trust took an average of 33 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 40 days or 60 days if the complaint is classed as complex. As of November 2017, there were 25 complaints still open and yet to be completed. The majority of complaints were regarding access to treatment or drugs or patient care including nutrition.
- Hull Royal Infirmary: There were 109 complaints, which took an average of 32 days to investigate and close. 22 complaints remained open at the time of the trust’s submission.
  *(Source: Routine Provider Information Request (RPIR) P61 Complaints)*
On ward 11, the ward manager told us that they were visible at patient’s visiting times to discuss patient care with relatives and carers. The number of complaints had reduced as people could speak to staff before they felt the issues escalated and required to be investigated formally.

The ward manager on ward 80 told us that a common theme of the complaints received was communication and telephones on the ward not being answered. As a result the telephone was diverted after a specific number of rings to ensure that the call was answered.

Staff we spoke with told us they would try to resolve any complaints or concerns at ward level if they could to try and prevent the situation escalating. This also ensured that patients and family felt listened to and responded. Complaints were discussed at team meetings. We saw that complaints were also discussed at the quality governance and assurance committee meetings and lessons learnt documented.

Is the service well-led?

Leadership
The medicine health group managed the medical wards at Hull Royal Infirmary. Emergency medicine was included within the health group which allowed senior staff to manage patient flow throughout the hospital.

The senior management team consisted of medical director, an operations director and a director of nursing. The triumvirate met daily to review ongoing issues. They were aware of the challenges they faced and were proactive in looking at new models of care to address current and future challenges.

Matrons provided support to clinical areas and would visit wards daily to review the staffing and identify any issues that required to be escalated. Matrons provided feedback at safety briefs in regards to these concerns. We were told that staff found the matrons supportive.

Ward managers were in place in all areas, with some recently new to the area. We spoke with some that had identified areas they needed to improve and set some plans in place to achieve these. These included reducing the number of falls and pressure ulcers on the elderly wards.

A change of management and leadership had taken place on ward 70 to support staff in improving the care provided. External reviews had been completed by the CCG which confirmed there had been vast improvements on the ward. The staff were motivated in continuing to improve and maintain the improvement.

We spoke with staff who said that ward managers were approachable, supportive and listened. In one area it was highlighted that the same members of staff were moved to support other wards. The ward manager listened to their concerns, assured staff and created a system to ensure that the same staff were not moved all the time and this was rotated.

It had been agreed due to winter pressures and demands on services that ward managers would work within the numbers to ensure patients were cared for appropriately by the correct amount of staff. This reduced their capacity in being able to spend time completing their managerial work as they only had one day per week in this role.

Most teams had ward meetings on a regular basis. In some teams this had been identified within their individual appraisal that they were expected to attend a number of times in the year. Staff were encouraged to add items to discuss within the meetings.
Vision and strategy
The senior management team for medicine services were clear on their ongoing vision for the departments. The medicine team were aware that the bed base for patients needed to be increased and proposals were in place to expand speciality areas.

Each division had developed between two to five year plans. This then fed into the health groups summary strategies. Business case proposal had been submitted for various areas within medicine, these included; respiratory and stroke services.

The trust said that they were on a journey and felt they were moving forward towards meeting their goals along with implementing further changes. The trust were changing their status in April 2018 to become a teaching hospital trust.

Staff we spoke with were aware of the trust values. New staff to the trust told us that the trust’s vision and strategy was discussed in the corporate induction along with the trust values.

Culture
We found a positive culture with staff being open, honest, and willing to share information with us on inspection. Staff were loyal to the organisation but were prepared to challenge leaders if they thought patient safety was compromised.

The majority of staff we spoke with told us that morale was good and that they all worked well as a team and supported each other. Staff told us they pulled together to overcome challenges. For example a staff member was supported following a clinical event and given time out of the ward area. There was a good mix of staff new to the trust and others who had worked at the hospital for a number of years.

It was apparent that senior leaders and managers were proud of their staff and praised them in their work. They felt that staff had gone above and beyond to provide the care to patients when extreme pressures had been placed on the hospital. The senior management team told us that all the health groups worked well together over the winter period when patient capacity and demand was very high.

On ward 1 they had recently began to award an employee of the month. Staff from the ward voted for who they wanted to win and they received a gift from the ward manager. The previous month one of the domestic members of staff won due to their commitment to the ward and communication with the patients.

Staff success was celebrated through trust events such as golden heart awards and moments of magic. Nominations from both staff and patients allowed patients achievements to be recognised and rewarded.

Medical staff felt supported by consultants and were provided with protected teaching one day a week. We were told that they would be released to attend the training.

The staff survey results had increased for the trust and senior staff completed surveys to review how staff feel and identify what they need to look at and review.

Governance
The medicine health group had a clear governance structure. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality governance and assurance committee minutes and found comprehensive discussion around current risks and performance. Information was discussed at these meetings from the different speciality groups. We found that some of the concerns that we had at our inspection had
been identified by the trust and actions were in place to improve compliance. These included the documentation of risk assessments.

We reviewed morbidity and mortality where deaths were discussed in detail to identify if the correct actions were taken. An in-depth analysis of the situation was discussed and the rationale presented for why decisions were made. A mortality review was completed on each patient which identified if the reviewer felt there was any concerns regarding the care received. We spoke with the operational lead for mortality who told us they monitored for any mortality trends and fed this back to the speciality teams.

Each ward had completed the fundamental standards of care audits and there had been improvement within the results. The number of score below 80% inadequate ratings had reduced and moved toward requires improvement or good ratings. The findings were discussed in various minutes we reviewed and was presented at the trust board meetings to provide an overview.

Ward managers were given an area of patient care to audit and review each month. Previous audits have included auditing controlled drug compliance, uniform compliance. The audits were completed and the findings submitted into an action plan which was cascaded to staff.

Matrons provided a handbook monthly to review the care given on wards. They reviewed patient’s records and medicine charts to identify if they had been completed. Patients were asked a series of questions regarding their experience, opinions and observation. Staff members were observed completing clinical observations such as recording blood pressure and temperature. Staff were asked a range of questions reviewing their knowledge on National Early Warning Score (NEWS) and other information.

**Management of risk, issues and performance**

There was a departmental risk register, which measured the impact and likelihood of the risk and documented the controls and mitigations in place to manage the risk. This fed in to the corporate risk register so that the board were sighted on local risks. We saw that the risk register was discussed and reviewed in the quality governance and assurance committee meetings. Staff contributed to the risk information and new risks were added at the request of staff.

Bed flow meetings were in place several times a day. Safety briefs took place three to four times a day depending on the demand on the hospital. At these meetings staffing was reviewed and patients factors such as the requirement for one to one supportive care. We attended a briefing and found that measures were put in place to identify the wards where red flags had been identified as areas where staffing was not adequate. The trust had a minimum standard whereby no ward was left with fewer than two registered nurses on shift. The red flag areas were reviewed first and vacancies were filled through agency or the movement of staff from other areas.

A further meeting was in place at the evening, where staffing and bed status were reviewed. Two site matrons covered the medical areas overnight, one monitored the flow in the emergency department and one managed the medical ward areas. Part of their role was to visit each area at least twice during the night to provide support and assurances to the staff.

A winter ward (ward 10) opened in January 2018 to accommodate the rise in patients that were required to be admitted to the hospital. In order to manage the ward, staff from health groups had provided staff members to stay on the ward for the duration of the ward remaining open. Nine registered nurses were based on the ward with the addition of bank and agency staff in order to ensure staffing levels were at the correct level. This provided continuity to the ward. A ward manager was moved to the ward to also provide consistency and stable leadership. Operation wintergreen was generated due to the demand and strain put on the hospital through the winter period. It allowed a plan of action to be put in place to manage the demand to the services. This included a senior person reviewing patients in order to make a clinical decision in their care. Pharmacy and therapy staff were increased to provide more cover and non-clinical staff
provided support and assistance. Speciality consultants attended AMU daily to review patients that were required and would attend the department as needed. Staff told us they worked well together and were kept informed.

The trust had recruited staff from international areas and had supported them with accommodation and other training and assessments. Staff were working as healthcare assistants until they had completed their objective structure clinical examination (OSCE). This was an exam that required to be passed in order to register with the Nursing Midwifery Council (NMC) and practice as a registered nurse.

**Information management**

Live information management systems allowed senior management to monitor and review the capacity and demand within the hospital. The system allowed staff to be aware of where bed availability was and this was updated by staff on the ward. In turn this then provided staff at the safety brief meeting a true reflection of the current issues. The system allowed the senior managers to review and plan where the risks were to nurse staffing and manage these safely and effectively. A record of the decision made were made during the meetings and logged onto the system to provide an audit trail.

The IT systems could be viewed by other health groups in order for them to understand the pressures on departments. Staff could view the system to see which patients were waiting in ED to be admitted to the ward and prepare and plan where they would go.

Several different organisations had visited the trust to review the information systems and how to use them to monitor patient care and improve quality.

Computers were readily available on each ward and we saw that the majority of times the computer was locked when not in use.

**Engagement**

Staff were kept up to date with what was happening in the trust with emails and a monthly newsletter. Staff told us that they could access all the information they needed via the trust intranet.

We saw that ward managers on ward 11 had ‘sister’s surgery’ twice a week. This allowed patient’s relative and carers each week to have a specific allocated time to discuss any concerns, the patient’s ongoing care and condition.

The trust’s website outlined opportunities to contact the trust and express opinions. It also supplied information on the services and hospital. The trust utilised social media as an engagement tool with the public and a list of social media accounts was listed on the website.

**Learning, continuous improvement and innovation**

The trust were committed in supporting their non-registered staff in order to apply for nurse associate and apprenticeship roles. This included completing further education in core subjects within their working day. We spoke with some of the nurse associates who were very positive about their career progression and support from the trust.

On level five of the hospital a rotation for staff was to be introduced to move around the renal, respiratory wards and respiratory support unit. This was to support and encourage staff to develop their knowledge and skills as well as increase the interest and competency of staff.

The home non-invasive ventilation (NIV) service worked closely with staff on ward 5 and attended the ward weekly to identify if any patients required NIV at home. This had increased staff’s
knowledge and awareness of the service and allowed patients to be supported in hospital earlier and in turn reduce readmissions. A service was available for patients who required to have intravenous (IV) antibiotics for their medical condition on a regular basis. This allowed the patient to be taught to self-administer their own medication to prevent them being admitted to hospital.

The trust were working with local colleges to promote people to join the trust. Part of their role ensured that they could work towards qualification such as NVQs in healthcare.

Surgery

Facts and data about this service

The trust has 16 surgical wards and 33 operating theatres across two sites. The trust covers 11 surgical specialities:

- Trauma & orthopaedics
- Neurosurgery
- Colorectal surgery
- General surgery
- Gastroenterology
- Urology
- Upper gastro-intestinal surgery
- Breast surgery
- Vascular surgery
- Cardiothoracic surgery
- Ophthalmology

The health group has 381 surgical inpatient beds. 
(Source: Routine Provider Information Request (RPIR) – Acute-Sites)

The trust had 55,614 surgical admissions from October 2016 to September 2017. Of these admissions:

- 13,001 (23.4%) were emergency admissions
- 29,854 (53.7%) were day cases
- 12,759 (22.9%) were elective admissions

(Source: Hospital Episode Statistics)

Surgical services have eight surgical wards on the Hull Royal Infirmary site. The hospital has nine operating theatres in the main tower block, three ophthalmology (eye surgery) and two day surgery theatres.

Is the service safe?

Mandatory training

At the 2016 inspection, the trust target for mandatory training compliance was 85% compliance; training data we reviewed showed an overall training compliance rate for the surgery health group of 85.1%.

Staff we spoke with said they were up to date with mandatory training. Staff also said that training link staff on their wards sent reminders when training was due and reminders when training had expired.

A breakdown of compliance for mandatory courses from April to October 2017 for medical and
dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>380</td>
<td>418</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>361</td>
<td>418</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>360</td>
<td>418</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>308</td>
<td>418</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>299</td>
<td>418</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>295</td>
<td>418</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at the hospital was 80%. This had decreased slightly from the 2016 inspection. Of the six mandatory training courses delivered by the trust to medical and dental staff, only two met the completion rate target of 85%. The trust did not meet its completion target for the information governance training it delivered. The completion rate for this course was similar to other courses at 86% but the trust target for this course is higher than other targets at 95%.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing and midwifery staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>811</td>
<td>860</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>809</td>
<td>860</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>779</td>
<td>860</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>754</td>
<td>860</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>727</td>
<td>860</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>627</td>
<td>859</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the hospital was 87%. This had improved from the 2016 inspection. Of the six mandatory training courses delivered by the trust to nursing and midwifery staff, the completion rate target was met in four cases. The lowest completion rate attained by the trust was 73% for resuscitation training. The trust also did not meet the target for information governance training. While the completion rate for this course is similar to other courses at 91%, the trust target for this course is higher than the other targets, at 95%.
The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

At the 2016 inspection, the training target level for safeguarding adults training was 85%. The training level was 84.6% compliance for all staff within the health group.

At this inspection, the training levels were met by nursing staff for both safeguarding adults and safeguarding children and young people. Medical staff met the target for safeguarding adults but were slightly below the compliance rate for children and young people.

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for medical and dental in surgery is detailed below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>361</td>
<td>418</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>353</td>
<td>418</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Of the two safeguarding courses delivered by the trust to medical/dental staff, one (safeguarding adults) met the target with 86%. The course that did not meet the target (safeguarding children and young people) had a completion rate of 84% which was 1% below the target.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for nursing and midwifery staff in surgery is detailed below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>787</td>
<td>860</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>737</td>
<td>860</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met the target of 85% completion rates for both of the safeguarding training courses delivered to nursing/midwifery staff.
(Source: Trust Provider Information Request P18)

At this inspection, staff we spoke with said that they completed adult and children’s safeguarding as part of their mandatory training. They also said the trust safeguarding team were accessible and supportive when staff needed advice about safeguarding concerns.

The service had systems in place for the identification and management of adults and children at risk of abuse.
The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and which issues staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and how to raise them. The safeguarding policy included information on the PREVENT strategy, which is a government anti-radicalisation directive.

Staff we spoke with were able to detail the actions they had taken in relation to safeguarding concerns. One gave an example of their involvement when a patient had sustained hospital acquired deep pressure damage; another said about their actions following the recognition of possible physical abuse of a patient by a family member.

**Cleanliness, infection control and hygiene**

At our inspection in 2016, we found significant improvements in compliance with infection prevention and control audits and compliance with theatre engineering performance measures and annual servicing.

At this inspection, we found wards and departments we visited visibly clean and tidy, and we saw ward cleanliness scores displayed in public corridors. We reviewed patient led assessments of the care environment (PLACE) reports for the trust and noted 97.9% compliance between March 2017 and June 2017, marginally below the 98% England average.

The trust had an infection prevention and control (IPC) policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices.

Records we reviewed and conversations with staff confirmed that staff received and completed training in infection control.

We saw information displayed on the wards and departments visited on the number of days since last hospital acquired clostridium difficile (*C. difficile*) infection and Methicillin-resistant Staphylococcus aureus (MRSA) isolate.

The trust reported one case of hospital acquired MRSA from October 2016 to September 2017. The trust reported 44 cases of *C. difficile* in the same reporting period. This was lower that the trajectory of 53 cases, the agreed threshold for 2017/2018.

The trust had a policy to screen surgical patients for Methicillin-resistant Staphylococcus aureus (MRSA) and some patients for Methicillin-sensitive Staphylococcus aureus (MRSA) as per best practice guidance.

During the inspection, we observed that staff were compliant with hand hygiene policies including ‘bare below the elbows’ and personal protective equipment practices. Staff we spoke with were aware of their responsibilities in relation to infection prevention and control, for example, bare below the elbows and decontamination of their hands before and after patient contact, or contact with the patient environment.

Handwashing advice was clearly displayed and facilities for hand hygiene were available in the foyer area of the hospital and at the entrance to all wards. Hand hygiene compliance data was displayed on the wards and departments we visited. Staff used both at the point of use and personal issue alcohol gel.
We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for use. We observed staff performing cleaning and disinfection of reusable equipment between patients, which followed the trust policy. We saw that staff used a specific label to identify that equipment was clean and ready for use. We reviewed 25 pieces of reusable clinical equipment and found these to be clean and labelled.

Staff we spoke with said they had access to appropriate personal protective equipment (PPE). We observed staff, using sterile gloves and appropriate aseptic techniques when instilling local anaesthetic for patients.

We saw appropriate processes for clinical waste in the eye hospital, including colour coded waste bags for clinical and non-clinical waste. Staff were able to dispose of waste at the point of use. Sharps bins were used by staff to dispose of used disposable instruments, such as sharps, needles, and glass ampules. Sharps bins in most of the areas visited were secure, dated and signed, and stored off the floor in all areas we visited. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste. However, within the eye hospital two out of four sharps receptacles reviewed were three quarters full and did not have temporary closures in place, one of these was on an unattended trolley in the corridor.

Rooms were available for patients requiring isolation, and patients requiring isolation were isolated appropriately.

As the hospital was mainly for emergency surgery, staff did not carry out surgical site surveillance on this site. However, it was carried out on the Castle Hill Hospital site.

Infection prevention and control training was delivered to staff working in the health group, IPC training compliance rates from April to October 2017 showed 86% for nursing and medical staff had received training, above the compliance target of 85%.

Infection prevention and control audit results for November 2017 showed that all areas scored over 80% compliance. On some areas we visited the infection prevention and control data was out of date, despite more recent data being available.

Environment and equipment
At the 2016 inspection, we told the trust they must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.

At this inspection, we saw that improved processes had been implemented for checking resuscitation equipment and all equipment we reviewed was clean, tidy, and ready for use and staff had checked the equipment as per the trust’s policy. Trolleys we inspected were all locked were all appropriately stocked, all equipment was in date and there was evidence over stock rotation.

At the 2016 inspection, we asked the trust to review access and security arrangements for theatres and recovery areas. At this inspection this work this had been completed and access to theatres was now restricted.

The environment within the eye hospital, did not allow a clean to dirty flow. During the inspection, we saw used instruments taken along the same corridor where clean instruments had been prepared and stored on trolleys for subsequent cases. Multiple pre-operative instrument trolleys were stored in a publicly accessible corridor. This was not in line with the national recommendations for safe peri-operative care (AfPP) 2016. This meant there was the potential for clean and dirty instruments to cross and become contaminated and clean instruments to be
tampered with. We discussed this with a member of staff at the time of our inspection and were told that this was standard practice as the eye cases were very quick so staff prepared the trolleys for the theatre list in advance. This was not recorded on the risk register.

Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of good stock rotation.

We looked at 65 pieces of equipment and found 55 to have been electrically safety tested within the review date and serviced in line with manufacturers’ guidelines. In the eye surgery department we saw one thermometer with no evidence of testing and a slit lamp that had a label that indicated it had not been serviced since February 2016.

We also saw that some equipment in the theatre (main and eye) was not managed appropriately for example we saw that reusable laryngoscope blades had been removed from packaging therefore there would be no traceability of this piece of equipment. We raised these concerns with staff at the time of the inspection.

We reviewed the trolley used for difficult airway access within theatres and noted from visual observation it was not easy to identify equipment in each drawer, as per best practice requirements. There were also four face masks stored on this trolley with no packaging available and no evidence of decontamination or traceability.

**Assessing and responding to patient risk**

At the 2016 inspection, we told the trust to ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust’s national early warning score (NEWS) and escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.

During this inspection, the trust used the national early warning score (NEWS) tool; surgical areas used a paper based system to record the early warning score. Nursing staff manually escalated any patients of concern to medical staff. Nursing staff we spoke with were able to articulate the deteriorating patient and were able to describe when they would escalate to senior staff for further review. The clinical trigger response chart was not located on the NEWS chart however staff we spoke with knew where to access this information. Staff we spoke with also said that, out of hours, they could contact the outreach team for support if they recognised a patient deterioration.

At the time of the inspection, only registered nurses were able to monitor and record NEWS scores, this was in agreement with commissioners following a number of serious incidents related to the deteriorating patient. The trust had recently updated the NEWS policy and had revised the levels of escalation.

On ward 120, the ward manager had created a checklist for staff to use during the ward ‘huddles’. This document ensured that staff covered all aspects which could affect patient safety, for example, National Early Warning Score (NEWS) reporting, patient acuity, equipment checks, patients at risk of falls, IPC concerns, patients at risk of pressure damage, patients with a do not attempt cardiopulmonary resuscitation, any safeguarding concerns, patient flow, patients who require assistance with nutrition or hydration. We reviewed one of the huddles and noted that discussion was held including the patient NEWS score confirmation of escalation, where appropriate, had occurred.

We reviewed four sets of patient notes in these we saw appropriate evidence of escalation of deteriorating patients. The matrons reviewed compliance with clinical observations in relation to NEWS as part of the matron audits, results from January 2018 showed that on the majority of
occasions records reviewed showed compliance with the audit criteria, and appropriate escalation of deteriorating patients.

We asked to review internal compliance data of the checks by the trust, this showed that the trust had reviewed ten sets of records on each ward in January 2018, within surgical areas 362 records had been reviewed and 320 (90%) had frequency of observations stated. Late observations were only recorded on 16% of occasions and staff calculated NEWS score incorrectly on 5% of occasions.

Staff we spoke with confirmed registered nurses completed NEWS and sepsis training. A sepsis care plan was available to support staff. This training and further support was provided by the critical care outreach team.

Post the 2016 inspection; the senior management team informed us that they were implementing e-observations including electronic NEWS scores on ward 12, during this inspection we did not see e-observations being used on this area.

At the 2016 inspection, we also said the trust must ensure the effective use and auditing of best practice guidance such as the ‘five steps to safer surgery’ checklist within theatres and standardising of procedures across specialties relating to swab counts.

At this inspection, the hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. During the inspection, we did not observe consistency with five steps to safer surgery including the World Health organisation (WHO) surgical safety checklist.

From our observations it was apparent the five steps to safer surgery checklist, was not embedded as a routine part of the surgical pathway. For example, we observed effective use of the WHO checklist in the main theatre suite at the hospital, on one occasion, but in the eye Hospital modified WHO checklist were not used for patients undergoing ophthalmic procedures. We observed that the surgeon performed no checks of the lens pre-implantation. We raised this as a concern with staff we spoke with who explained that a new WHO checklist had been trialled in another speciality, this had been implemented six weeks ago; however staff did not feel this was appropriate for use in ophthalmic surgery and a process to create a checklist adapted for use in the speciality was underway. It was also confirmed that there was not a standard operating procedure (SOP) for lens checking. Staff we spoke with explained that this would be introduced in this service in the near future.

Managers we spoke with also confirmed that training had not been completed with all staff and was due completion in the next few weeks.

We saw that consumables such as needles, scalpel blades and swabs were recorded on a whiteboard in the eye hospital theatre. A verbal and visual check was completed by the scrub and circulating practitioners however there was no instrument count undertaken.

Patient safety briefings were carried out pre-operatively this included discussion around the order of patients on the list, the addition of any emergency cases and the instrument and equipment requirements.

We reviewed eight sets of surgical notes containing surgical safety checklists. On the majority of occasions the checklists were complete, however during the inspection we saw variable levels of engagement from the clinical team, this did not provide assurance that this was an effective process.
We asked to review internal compliance data of the checks by the trust, as the trust had only recently relaunched the checklist, they were unable to supply these, but we were able to review the associated implementation and action plans. The trust had also reported three never events all associated with wrong site surgery or wrong prosthesis being implemented. We could therefore not be assured that the checklist was being used correctly consistently.

The trust had relaunched the safer surgery checklist six weeks prior to the inspection. There was an action plan including national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs), this was comprehensive and the health group was on track with implementation and training, however staff we spoke with at the eye hospital did not appear familiar with the NatSSIPs or the LocSSIPs.

At the 2016 inspection, we told the trust they must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff.

During this inspection, we saw improvements in the documentation of elective reviews and staff we spoke with did not highlight any issues with the current processes.

We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling and venous thromboembolism (VTE) compliance in all sets of patient records we found that these were completed. Where necessary we saw that patients identified as high risk had been referred to further services such as tissue viability teams or dieticians or provided with additional equipment such as pressure relieving devices as required.

The trust electronic patient management system held a virtual hip fracture ward that was reviewed and updated each day with actions to ensure patients were appropriately managed.

Staff we spoke with said a fire evacuation practice had been completed in the eye hospital in December 2017.

**Nurse staffing**

At the 2016 inspection, we said that the trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels on surgical wards.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 15% for nursing staff in surgery. The trust did not provide an overall target for vacancies.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 14% for nursing staff in surgery. This was worse than the overall trust target for turnover of 9%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 4% for nursing staff in surgery. This was the same as the overall trust target for sickness of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust reported three of the five areas with highest bank and agency staff use to be in surgery. These were: trauma (general theatres), orthopaedic and trauma (ward 120), and neurosurgery (ward 4) all at Hull Royal Infirmary. The trust attributed this to a high vacancy rate and had the following plans to mitigate this: international recruitment, re-deploy from other areas, a UK
recruitment campaign. The nurse director was unaware of any area using 20% or more bank or agency staff.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Staffing fill rates were reported on the hard truths dashboard. We reviewed the information supplied for December 2017 and saw the majority of registered nurse (RN) fill rates were consistently above 80% day and night shifts. Two areas ward 4 and ward 12 had scored below 80%, 68% and 72% respectively for registered nurse day shifts.

On the days of the inspection, we saw that some wards were not meeting the planned staffing levels. For example, nurse staffing boards we reviewed showed that 71% of wards (five out of seven wards visited) had not met the planned staffing levels. Data we saw displayed on wards 7 and 12 had one less than the planned numbers of RN’s on duty for days and/or night shifts. The planned staffing for the eye hospital ward was two registered nurses (RN) and one health care assistant (HCA). Staff we spoke with said the retention of the HCA’s was very difficult as these staff were frequently moved to work elsewhere in the hospital.

The trust used safecare to monitor patient’s acuity and plan staffing levels, staff escalated issues through the site management meetings four times a day, these meetings were used to establish patient flow issues, staffing issues and the capacity and demand on each site. Staff we spoke with said there was effective discussion at the meetings which helped them to ensure ward staffing levels remained safe.

Senior staff we spoke with said that nursing staff retention was improving. Overseas nurses were being supported well and this had led to them recommending the trust, as a place to work, to friends.

Staff we spoke with did highlight that they were asked to move wards and work in other areas they also said that staff being moved had resulted in more pressure in their area of work but they recognised that sometimes staff had to be moved to another ward to maintain patient safety. Senior nurses we spoke with were able to use the tool to show to staff how often they were being moved and how often staff were being moved to support their areas, they felt that this helped to show that it wasn’t always one area providing staff to others and a shared approach was used.

On the majority of occasions staffing levels in theatres were in line with the national recommendations for safe peri-operative care (AfPP) 2016.

**Medical staffing**

At the 2016 inspection, we said that the trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels on surgical wards.

The trust reported actual whole time equivalent (wte) and headcount staffing figures from March to October 2017 but these were not provided at core service level or site level.
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 11% for medical and dental staff in surgery.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 17% for medical and dental staff in surgery. This was worse than the overall trust target for turnover of 9%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust
reported a sickness rate of 1% for medical and dental staff in surgery. This was better than the overall trust target for sickness of 4%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust reported two of the five areas with highest bank and locum staff use to be in surgery. These were: orthopaedic and trauma (wards H12, H120, and MTC) covering both sites, and general surgery (wards H6 and H60,) also covering both sites. It attributed this to a high vacancy rate and planned to mitigate this by recruiting more trust doctors.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same. The following chart shows this in greater details:

**Staffing skill mix for the whole time equivalent staff working at Hull and East Yorkshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

At this inspection, for all surgical specialties a consultant was present on site 8am till 6pm Monday to Friday. Acute general surgery and trauma and orthopaedics had consultant presence at the weekends.

On orthopaedic wards junior staff were available throughout the day and consultants carried out daily ward rounds and a weekly grand round.
On call cover was provided by junior doctors working in three different teams. Foundation level doctors were supported by middle grade doctors. Staff we spoke with acknowledged some gaps in the medical rotas; this was highlighted on the health group risk register.

Junior medical staff we spoke with said they felt supported working in the trust and felt able to raise concerns as required.

Formal medical handovers took place twice a day during shift changes; we did not observe these during inspection.
**Records**

Paper records were available for each patient that attended the wards and departments; the trust used an electronic patient management system to record key information about the patients hospital stay and anticipated risks.

Electronic whiteboards were available on all wards we visited, these provided staff with easy access to key information, such as discharge dates and review by other members of disciplinary team physiotherapists, dietitians etc.

We reviewed twelve sets of records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. We did observe that during the inspection notes were not always stored in an organised manner and the majority of the notes we reviewed had loose entries, this potentially could lead to patient’s records going missing or being filed in the incorrect records.

Patient records were all stored in areas that were secure or observed and we did not see any patients notes left unattended.

We saw that patient records held individualised plans of care for example sepsis, pressure area prevention and falls care plans.

We did not see the recording of weight on three out three records we reviewed; not recording the weight of the patient can lead to risks for the patient such as inappropriate medicine doses being prescribed.

Quality assurance audits were carried out on record keeping on a monthly basis; five sets of records were independently audited by the matron each week.

**Medicines**

At the 2016 inspection, we said the trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.

At this inspection, we saw that staff recorded medicines refrigerator temperatures daily. We also saw actions recorded if the temperatures were not within expected ranges.

Pharmacy services were available at Hull Royal Infirmary and Castle Hill Hospital seven days a week, 365 days per year. On call arrangements were in place if the department was closed.

We checked that controlled drugs were stored safely and securely on areas visited and found these had been checked in line with policy and there were no discrepancies. Controlled drugs were audited by the nurse in charge of the ward on a weekly basis and biannually by a pharmacist. Learning from this audit was feedback to the ward manager and medicines safety group.

Medicines reconciliation was completed by ward based pharmacists and pharmacy technicians. The trust did not achieve the target for medicine reconciliation within 24 hours of admission; however the trust did achieve the medicine reconciliation at any one time target.

The trust pharmacy department were piloting a new daily report which identified patients admitted for over 20 hours and had not received medicine reconciliation. These patients were then prioritised by a dedicated pharmacy team.

We reviewed five medicine administration charts and noted medicines were prescribed and administered within national guidance. We saw that medicine administration records had an order to support staff in the event of patient needed emergency oxygen. Where appropriate we saw this completed on the charts we reviewed.
In the eye hospital, we found eye drops stored in unlocked patient accessible rooms. We were told that all surgeons used the same eye drops pre-operatively and that these were given under a patient group directive (PGD) by nursing staff pre-operatively. Post-operative eye drops were prescribed by the relevant consultant, a supply of these as take home medicines, were always available for staff to supply to patients.

Antibiotic prescribing audits were completed monthly looking at indication, appropriateness and review/stop dates.

Medical gases we reviewed were all stored appropriately in designated holders.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The trust reported three incidents which took place from November 2016 to October 2017 and were classified as never events for surgery. All three never events took place at Castle Hill Hospital since August 2017. *(Source: Strategic Executive Information System (STEIS))*

At the 2016 inspection, we said the trust must ensure learning from never events is further disseminated and lessons learnt are embedded.

Staff we spoke with in theatres said that the trust intranet displayed information about serious incidents and never events. In addition, staff were sent bulletins via email and lessons learned were also detailed in the trust newsletter. Information regarding the recent never events framework changes had also been shared with staff through the lessons shared bulletins.

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England and took place from November 2016 to October 2017.

Of these, the most common types of incident reported were:

- Surgical/invasive procedure incident meeting SI criteria with six (43% of total incidents)
- Treatment delay meeting SI criteria with five (36% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (7% of total incidents)
- Pressure ulcer meeting SI criteria with one (7% of total incidents)
- Slips/trips/falls meeting SI criteria with one (7% of total incidents)

*(Source: Strategic Executive Information System (STEIS))*

The service had systems in place for reporting, monitoring, and learning from incidents. The trust had an incidents and near miss policy, dated January 2017. This provided staff with information about reporting, escalation, and investigation processes.

Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. In addition, once reported the reporting system sent an alert to other relevant professionals, for example when pressure damage was reported the tissue viability team received notification.

The trust had declared a further two serious incidents with in the health group in November 2017 and three in December 2017, these were in the process of being investigated.
One ward manager had created a checklist for the daily safety huddles on the ward, which included staff feeding back about incidents and also highlighting if any incidents had been reported since the last huddle.

Staff we spoke with described positive reporting cultures within the health group and said they were supported to report incidents.

Ward staff we spoke with said that any learning from incidents was shared at team meetings. We saw examples of changes in discharge procedures from theatres post an incident occurring. Lessons learned briefings were also produced by the trust; again, we were told that these were shared with staff at ward level through team meetings. We were assured that serious incidents and never events in other health groups were shared, as staff were able to tell us about these.

Ward managers said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed three serious incident reports; we found theses to include contributing factors, identification of lessons learned and recommendations to prevent recurrence of this incident. Duty of candour requirements was detailed in all the reports we reviewed.

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.

All grades of staff we spoke with were aware of the duty of candour and were able to provide examples of when they would use this.

In the November 2017, operational quality committee and health group board minutes we saw 100% compliance with duty of candour requirements.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 18 new pressure ulcers, eight falls with harm and seven new catheter urinary tract infections from November 2016 to November 2017 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Hull and East Yorkshire Hospitals NHS Trust**

![Graph of pressure ulcers](image-url)
During the inspection, we saw patient safety display boards on the wards we visited, which showed when the most recent patient harm had occurred. For example, we saw that patients on the ward at the eye hospital had not suffered any hospital acquired unavoidable pressure damage.

Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed showed that the trust was currently failing to achieve the VTE assessment indicator with performance of 90.6% November 2017. This was worse than the trust target of 95%. This had been reported at the quality committee and the committee had agreed actions to improve performance.

**Is the service effective?**

**Evidence-based care and treatment**

During the inspection, we reviewed some of the trust’s clinical protocols and patient pathways used for patients on surgical wards; these included the trust hip fracture and neurosurgical pathways.

We saw patients’ treatment was based on national guidance, such as the National Institute for Health and Care Excellence (NICE), The Royal College of anaesthetists and the Royal College of Surgeons.

Policies were stored on the intranet and staff we spoke with were able to access them.

Wards and departments we visited participated in local audit programmes called fundamental standards audits; these audits included nine fundamental standards. These audits had been developed to monitor patient care across a number of core elements including; staff and patient experience, patient environment, IPC, safeguarding, medicines management and nutrition and hydration. We saw the results of these audits displayed on ward corridors. Staff used observations of care, discussion with patients and staff to provide assurance on the care delivered. Senior staff rated the assessment and this indicated the frequency of the review required. Following the review ward managers were expected to produce an action plan to improve performance and these action plans were approved by the senior matron for the area. Elements of the audit included infection prevention and control, safeguarding, medicines management and patient experience. Out of the 63 displays reviewed, nine displays showed out of date information, most commonly patient experience and IPC.
The health group had a local audit programme and these were discussed during audit meetings. Clinical audit compliance was measured by the health group and we saw that 19 clinical audits had overdue actions; the health group had arranged a meeting to discuss further.

**Nutrition and hydration**

At the 2016 inspection, we said the trust must ensure that patients’ food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

At this inspection, on the majority of occasion’s food and fluid charts were completed, however we did not see that staff always totalled daily intake and output.

Senior staff carried out audits on nutrition and hydration, one of the surgical areas on this site had scored red (less than 80%) for compliance with nutrition and hydration in November 2017. Within the eye hospital we saw staff following the results had developed a display board about the importance of nutrition and hydration to support patients and raise staff awareness. On ward 120 we saw that a patient had remained nil by mouth for five days due to there being no dietitians available seven days per week. However, the patient had been given subcutaneous fluid therapy to prevent dehydration. Staff we spoke with said that staffing difficulties within dietetics had led to some delays.

Protected mealtimes were promoted on the wards we visited. Red trays and water jug lids were used to identify patients who needed assistance with food and fluids. We saw that staff supported patients who needed assistance during our visit.

Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed showed patients had adhered to fasting times prior to surgery went ahead.

Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient notes we reviewed, showed appropriate levels of completion. Staff re-assessed patient nutritional status during the admission at regular intervals.

The majority of the patients we spoke with said that the food was very good and said that water was replenished twice a day but that could ask for more and staff would bring it for them. One patient said they thought the patients were ‘spoiled’ by the staff as staff supplemented this patient’s diet with alternative snack foods.

**Pain relief**

During this inspection, we saw patients being offered pain relief, patients we spoke with said that staff offered them pain relief on a regular basis and said that staff checked that pain relief administered had been effective.

We observed staff using pain scoring tools to assess patients’ pain levels; staff recorded this information on the paper records.

Some surgical patients received intravenous patient controlled pain relief post-operatively. This was in line with national best practice guidance from the British Pain Society.

Nursing staff we spoke with said that the trust pain team were available for support with patient’s pain. We were told that this team was very responsive. Patients we spoke with said that staff responded quickly when they needed pain relief; they also said that if pain relief was not effective, they quickly asked a doctor to review their pain relief.
Patients we spoke with on all wards said they received pain relief as soon as they needed it. One said that staff always checked their identity before giving pain relief.

Patient outcomes

Relative risk of readmission

Hull Royal Infirmary

From September 2016 to August 2017 patients at Hull Royal Infirmary had a better than expected risk of readmission for elective admissions and non-elective admissions when compared to the England averages.

Elective Admissions - Hull Royal Infirmary

![Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in ophthalmology at Hull Royal Infirmary had a better than expected risk of readmission for elective admissions when compared to the England average.
- Patients in vascular surgery and neurosurgery at Hull Royal Infirmary had a worse than expected risk of readmission for elective admissions when compared to the England averages.

Non-Elective Admissions - Hull Royal Infirmary

![Non-Elective Admissions Graph]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in colorectal surgery and upper gastrointestinal surgery at Hull Royal Infirmary had a better than expected risk of readmission for non-elective admissions when compared to the England average.
- Patients in trauma & orthopaedics patients at Hull Royal Infirmary had a worse than expected risk of readmission for non-elective admissions when compared to the England average.

Hip Fracture Audit

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 8% which was within the expected range. The 2016 figure was 8%.
The proportion of patients having surgery on the day of or day after admission was 52%, which was worse than the national standard of 85%. The 2016 figure was 57%.

The perioperative medical assessment rate was 81%, which failed to meet the national standard of 100%. The 2016 figure was also 81%.

The proportion of patients not developing pressure ulcers was 96%, which falls in the middle 50% of trusts. The 2016 figure was 99%.

The length of stay was 15 days, which falls in the top 25% of trusts. The 2016 figure was 17.3 days.

(Source: National Hip Fracture Database 2017)

At this inspection, we reviewed action plans; the action plan did not capture all issues of concern within the audit and did not address areas of action that the trust had taken. For example the recent theatre reconfiguration plan that had resulted in 40 additional theatre slots each month. This had also created an identified theatre for urgent cases, which were non-life threatening but where patients needed to be operated on the same day. This was still to have a consistent effect on the proportion of patients having surgery on the day of or day after admission. The senior management team was aware of the issues and the need to improve, but did not have a clearly documented plan on how this was to be achieved. Non-compliance with the best practice recommendations for the hip fracture surgery was highlighted on the risk register.

Staff we spoke with within orthopaedics said that they identified patients who were admitted for surgery following a fall on other wards. They had reviewed a sample of notes to determine any actions that they could implement locally to improve audit results. It was frequently found that the patient had not had a capacity assessment completed on the original ward. As this was one of the markers for the audit ward staff we spoke with said they felt powerless to affect this criterion, from our discussions with them it was unclear whether they had highlighted this concern.

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 86% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 89%.

The risk-adjusted 90-day post-operative mortality rate was 1% which was better than expected. The 2015 figure was 4%.

The risk-adjusted 2-year post-operative mortality rate was 29% which is worse than expected. The 2015 figure was 19%.

The risk-adjusted 30-day unplanned readmission rate was 9% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 41% which was better than expected. The 2015 figure was 45%.

(Source: National Bowel Cancer Audit)

At this inspection, we reviewed action plans which included mortality reviews and low levels of anaesthetic risk scoring, this was marked as completed.

The service had implemented a consultant surgeon on call system that ensured that an upper gastrointestinal surgeon and a colorectal surgeon were on call either during the day or at night each day; this meant that patients had access to an appropriate specialist surgeon within 12 hours of admission. We observed an operation, which had resulted in a patient avoiding a stoma due to this initiative.
National Vascular Registry
In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 4% for abdominal aortic aneurysms which was within the expected range. The 2016 figure was 4%.
Within carotid endarterectomy, the median time from symptom to surgery was 17 days which was worse than the national aspirational standard of 14 days. The 2016 figure was 19 days.
The 30-day risk-adjusted mortality and stroke rate was within the expected range at 0.9%. The 2016 figure was 2.5%.  
( Source: National Vascular Registry)
At this inspection, we reviewed action plans which included a review of the vascular pathways this had been completed.

Oesophago-Gastric Cancer National Audit
In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10%.
The 90-day post-operative mortality rate was 9%, which was within the expected range. The 2015 rate was 9.5%.
The proportion of patients treated with curative intent in the strategic clinical network was 34%, which is significantly lower than the national aggregate.
This metric is defined at strategic clinical network level (the network can represent several cancer units and specialist centres); the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results
(Source: National Oesophago-Gastric Cancer Audit 2016)
Despite requesting information from the trust we were not supplied with an action plan for this audit.

National Emergency Laparotomy Audit
In the 2016 National Emergency Laparotomy Audit (NELA), Hull Royal Infirmary achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 102 cases.
Hull Royal Infirmary achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 65 cases.
Hull Royal Infirmary achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 56 cases.
Hull Royal Infirmary achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 46 cases.
The risk-adjusted 30-day mortality for Hull Royal Infirmary was within expectations, based on 102 cases.
(Source: National Emergency Laparotomy Audit)
Despite request we were not supplied with action plans for this audit.
At this inspection, we spoke with staff from the service about the trusts performance in the National Emergency Laparotomy Audit (NELA) which was worse than the national average. We
were told that historically there was poor participation and case attainment in the audit; however, the trust had appointed an audit clerk to aid data entry and a consultant as a champion for NELA. A new audit form had been developed and this was currently awaiting governance sign off. It was hoped that this would improve the data submission and improve compliance. In addition, following the audit results a decision was made to admit all patients undergoing an emergency laparotomy to an intensive care bed post-operatively, the senior management team said they had seen a reduction in mortality as a result of this initiative. They were confident that the recent developments would show improved audit scores.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

![Graph showing patient reported outcomes measures](image)

In 2016/17:

- Performance for groin hernias according to both the EQ VAS index and EQ-5D index was about the same as the England average.
- Performance for varicose veins was better than the England average.
- Performance for hip replacements was worse than the England average according to EQ VAS index, but similar to the England average according to EQ-5D index and the Oxford Hip Score.
- Performance for knee replacements according to EQ VAS index was worse than the England average. However, performance for knee replacements according to both the EQ-5D index and the Oxford Knee Score was generally the same as the England average.

(Source: NHS Digital)

Despite requesting information from the trust we were not supplied with an action plan for this audit.

At the 2016 inspection, we reviewed the trust's trauma unit peer review report and identified a number of issues of concern within the report at this inspection we requested an update on actions and noted that the hospital now had a major trauma consultant rota with week day cover and a daily multidisciplinary ward round had been implemented.
**Competent staff**
From April 2017 to October 2017, 78% of staff within surgery at the trust had received an appraisal. The figure for medical and dental staff was 76% which was worse than the trust target of 90%, while the figure for nursing and midwifery staff was 77% compared which was worse than the trust target of 85%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>14</td>
<td>13</td>
<td>108%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>63</td>
<td>73</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>52</td>
<td>63</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>212</td>
<td>274</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>412</td>
<td>534</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>127</td>
<td>167</td>
<td>76%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>98</td>
<td>133</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>5</td>
<td>8</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At the 2016 inspection, we saw that the health group had an appraisal target of 85% with 87.7% of nursing staff having an up to date appraisal, appraisal data was not available for medical staff.

During this inspection we saw a decrease in the appraisal rates reported for nursing staff, however staff we spoke with said that they had receive an appraisal within the previous 12 months.

Senior staff we spoke with said that registered nurses were being given the opportunity to complete education modules in anaesthetics to improve their skills and to help address the gaps in operating department practitioners (ODP's).

Student nurses we spoke with said that they had been well supported by their mentor and that they had enjoyed their placement at the hospital.

The trust employed nurses with extended skills to support patients. For example in the eye hospital; an advanced practitioner was employed to performed general anaesthesia and local anaesthetic nerve blocks, when an anaesthetist was present in another theatre. Staff had complete additional competency based training qualifications to allow them to undertake these roles.

Staff were offered extended practice training to enable them to carryout additional roles such as role specific training and nurse prescribing.

Registered nursing staff we spoke with said that systems were in place to alert them to their registration and revalidation dates, staff we spoke with said that they had been supported through
revalidation by the trust.

Medical staff we spoke with said that they received time for training, education and portfolio development.

**Multidisciplinary working**
There were established multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses and radiologists.

Staff held daily multidisciplinary huddles on the wards we visited.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

Physiotherapy staff were integrated in to some of the areas we visited for example neurosurgery and orthopaedics.

**Seven-day services**
At the time of the inspection, junior medical staff were available seven days a week with support from senior doctors and consultants. Surgical consultants provided a seven-day service. Nursing staff said that medical staff were accessible and supportive when they needed advice.

Staff working on the neurosurgical and major trauma ward said that they had access to physiotherapy and occupational therapists seven days per week.

The trusts pharmacy and diagnostic imaging departments provided a seven-day service.

The trusts dietetic department offered a Monday to Friday service.

**Health promotion**
Health promotion information was available on wards we visited. This included display boards and information leaflets for patients on smoking cessation, healthy eating, wound care and infection prevention and control.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**
A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>354</td>
<td>418</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>352</td>
<td>418</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for nursing staff in surgery is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>803</td>
<td>859</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>802</td>
<td>859</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

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.

Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards.

We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

In the eye hospital, we accompanied a member of staff collecting a patient for theatre, from the day ward; we saw that the member of staff checked the patients care records for evidence of written consent prior to transferring the patient to the theatre area. We saw that patient identification and allergy status was sought verbally and checked against a red (allergy risk) identification wristband worn by the patients. The operative site was marked and also confirmed verbally with the patient.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient’s capacity.

Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for patients who lacked capacity.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person’s best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLS). DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards. One staff member spoke with us about ensuring the least restrictive option is always used. We saw where a patient was deemed to lack capacity this was supported by a documented assessment and best interest decision-making.

Staff we spoke with could describe the process used when patient mittens were used, for example, when a patient was confused and attempting to remove intravenous therapy lines, this
included ensuring a best interest decision-making process is used and a restraint care plan is included within the records.

Staff we spoke with said that they had access to mental health referral pathways and would use these if they had concerns about any patients.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of care records in line with national best practice. We saw one example of there being no documentation relating to the discussion with a family about a DNACPR order, in the medical notes.

One member of staff we spoke with said that the trust were implementing the ‘ReSPECT’ documentation. ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

Is the service caring?

Compassionate care
The friends and family test response rate for surgery at the Hull and East Yorkshire Hospitals NHS Trust was 22%. This was worse than the England average of 29%.

Hull Royal Infirmary achieved a response rate of 25%.
(Source: NHS England Friends and Family Test)

We spoke with ten patients and three relatives on the surgical wards at this hospital. One patient said that all staff had been good and that ‘they could not have asked for more’ from all staff including the cleaners. This patient also said that staff always checked on them without using their call bell ‘even when they were really busy’.

On ward 120, we observed staff caring for patients and found that they were compassionate and reassuring. A patient on ward 12 said that the nursing staff were very understanding and pleasant. Another patient said that the staff were ‘absolutely perfect’.

A patient on ward 7 said staff were nice and ‘nothing is too much trouble’. This patient said that all the staff would ‘sort any problem’ they had, ‘even the cleaners’. Another said that ward 7 was the ‘best ward in the hospital’.

We spoke with two patients in the eye hospital; both patients said that staff were kind, caring, helpful and attentive. In the eye hospital, we saw staff behaving in a caring manner towards patients. Staff introduced themselves, reassured patients and explained the care and treatment they were undertaking.

A patient on ward 60 said that they had been in this hospital on several occasions and that this was the best ward they had been in. They said that the staff were very understanding and that doctors spoke to them respectfully and treated them like all the other patients. They said that staff took the time to get to know them. They said ‘it did not matter how busy they were staff always found time to chat with them’. We were told that the staff had a great bedside manner. We were told that it was not just the doctors and nurses ‘that are great’ it was the cleaners too.

During the inspection, patients reviewed had access to call bells and drinks at hand. Staff working in neurosurgery described accessing large call bells for patients through the occupational therapy
team. A patient we spoke with said that staff always checked that they had their call bell to hand and that they always respond quickly when they called. Another said that it had been nice to be on ward 60 where the staff were really caring regardless of how busy they were and how tired they got. During the inspection, we did not hear call bells ringing for long periods of time.

Staff we spoke with in theatres said that patient care was paramount.

Wards and department we visited displayed their friends and family results. We saw 100% of patients would recommend the eye surgery department in June 2017. This was from 315 responses.

We observed staff closing curtains/doors whilst observing personal care.

**Emotional support**
We saw that ward managers were visible on wards and relatives and patients were able to speak with them.

We heard a conversation between a member of staff and a recently bereaved family on ward 120. We saw that this member of staff explained things to the family in an open, honest and caring manner.

A patient we spoke with said that they had been supported emotionally many times. They said without asking staff recognised when they needed to talk and they made themselves available. Another patient said that staff always remembered and called them by their name. The patient said they thought this was very nice.

A patient on ward 12 said that staff always made time to ‘pass the time of day’, that they always checked on them at night and asked if they wanted a cup of tea.

A multi-faith chaplaincy service was available for patients.

Clinical nurse specialists including vascular nurse specialists were available within surgery and attended wards to provide additional support and advice to patients.

**Understanding and involvement of patients and those close to them**
A range of information leaflets and advice posters were available on wards we visited these included discharge information, specialist services and general advice about nutrition and hydration.

A patient we spoke with on ward 60 said that staff explained everything to them. They said ‘If all wards were like this, the world would be a better place’.

A patient we spoke with said that staff were always respectful and took their wishes in to consideration before providing any care or treatment.

Patients said that nurses always took time to explain things; one said this was after the doctors had been. This patient said the nurses deserved a medal. They also said that staff had explained everything to their family and kept them involved in their care.

A patient on ward 7 said doctors explained everything and encouraged them to ask questions. Another said that they often relayed messages from family members who rang to check on their welfare.

Patients we spoke with 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 aware of their discharge arrangements and actions required prior to discharge.

We saw that ward managers were available on wards we visited and patients were able to speak to them if needed.

Is the service responsive?

Service delivery to meet the needs of local people
The surgery health group provided elective (planned) and non-elective (acute) surgical treatments for patients.
The health group worked closely with local commissioners to plan and deliver services.

At the eye hospital, we saw that there was a reception desk at the entrance and a lift that signposted the eye surgery department however on entering the lift there were two buttons for two floors but no indication which floor the department was situated on.

Meeting people’s individual needs
During the inspection, NHS England had relaxed the requirements around mixed sex accommodation for all NHS providers to ease winter pressures. During the inspection we did see male and female patients located next to each other in high observation areas. The trust said this was in agreement with commissioners. We also saw staff moving female patients into bays opposite males. These bays were directly adjacent with glass doors, this meant that patients could see and had to pass by patients of the opposite sex to get to toilet facilities which is not in line with the requirements for mixed sex accommodation.

The trust had an enhanced care team who were available to support staff when caring for patients who needed one to one care to maintain their safety. Staff we spoke with were aware of the process to access additional support.

We reviewed the notes for a patient living with dementia and saw that this patient had a comprehensive ‘this is me’ document in place.

Staff we spoke with said that visiting times were flexible for families and carers of patients who were receiving care at the end of their life, or for example, when patients living with dementia were more settled when family were present. The wards used a butterfly symbol to identify and support patients living with dementia or delirium.

The orthopaedic ward we visited had additional provision for patients living which dementia and patients had access to dementia friendly aids such as red toilet seats, white plates with red edged, red trays and red lids on jugs. Staff also used a pathway for patients living with dementia; this was written in collaboration with carers and family members.

Most areas visited had living with dementia information boards and leaflets available. Staff on ward 60 had prepared a butterfly box (containing old images of the city, ration books and other items) to provide distraction for patients.

The trust employed a learning disabilities lead nurse, and staff we spoke with knew how to access this service and provided examples of when they had attended the ward. We also saw posters on most areas visited which showed contact information. Orthopaedic wards we visited also had access to a living with dementia link nurse, who had extended training and knowledge.
In the eye hospital, we saw that signs on the toilet doors had braille signage to assist patients however, the facilities were not designed to support patients living with dementia as all of the fitments, including grab rails and the walls were painted white.

Patients we spoke with said that staff always respected their privacy and dignity. One patient said that staff considered how they would feel as a patient. Another said that staff respected their wishes for example female patients not having intimate care performed by male staff.

Trust data from the patient led assessment of the care environment (PLACE) assessments from March 2017 to June 2017 showed privacy, dignity and well-being (78.7%) and assessment of environment for dementia care as (70.7%) these were both below the national average of 83.7% and 76.1% respectively.

One patient we spoke with said that staff had been accommodating and had let their next of kin visit outside visiting times as they could not attend at the usual visiting times due to their shift pattern.

One patient we spoke with said that staff did not always respond in a timely manner when they needed to be assisted on or off the toilet. Another said that if staff were unable to respond quickly, they always gave an explanation and came back as soon as they could.

A patient on ward 7 said staff respond quickly ‘even when they are really busy’ with emergencies.

Patients who had been treated for any cranial or spinal surgery were given the contact details of the neurosurgical nurse practitioners so that they had direct means of contact if they had any questions or concerns following their discharge.

The pre-assessment team or the admitting ward reviewed patients’ needs on admission, in regards to hearing difficulties.

Translation services were available for people whose first language was not English. Staff we spoke with said that this service was very responsive and if consent was being gained, they would often visit the hospital and interpret face-to-face.

Patients with particular health needs were identified at staff briefings for example; those with learning disabilities, mental health conditions and living with dementia.

Specialised equipment for bariatric patients was available on some wards visited such as wheelchairs, commodes and chairs. Other equipment was stored on the other site and staff knew how to request and arrange transportation. Ward 120 was unable to accommodate bariatric patients due to the design of the ward.

Relevant information for patients was displayed on the walls and corridors of wards we visited, such as audit performance, health promotion and condition specific information.

The wards and departments were accessible for patients with limited mobility and people who use a wheelchair.

**Access and flow**

At the 2016 inspection, we said the trust must ensure that planning and delivering care meets the national standards for the referral to treatment times. This was because the trust did not meet national performance indicators for surgery.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for admitted
pathways for surgery was consistently worse than the England average, fluctuating between 60% and 67%.

The most recent data from October 2017 shows 62% of this group of patients were treated within 18 weeks versus the England average of 69%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were better than the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>81%</td>
<td>74%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>67%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Seven specialties were worse than the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>Urology</td>
<td>76%</td>
<td>77%</td>
</tr>
<tr>
<td>Cardiotoracic Surgery</td>
<td>66%</td>
<td>84%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>53%</td>
<td>73%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>44%</td>
<td>62%</td>
</tr>
<tr>
<td>ENT</td>
<td>33%</td>
<td>65%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

At this inspection, the senior management team were aware of the issues and were working to deliver a trust action plan to improve overall performance.

Elective theatre lists were available six days a week with an emergency list available seven days a week.

Average length of stay

Hull Royal Infirmary

From October 2016 to September 2017, the average length of stay for all elective patients at Hull Royal Infirmary was 3.4 days, which was similar to the England average of 3.3 days. The average length of stay for all non-elective patients at Hull Royal Infirmary was 4.8 days, which was better than the England average of 5 days.
Elective Average Length of Stay - Hull Royal Infirmary

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017:
- The average length of stay for neurology and vascular surgery elective patients was worse than the England averages of 4.4 days in both areas.
- The average length of stay for ophthalmology elective patients at Hull Royal Infirmary was 1.3 days, which was similar to the England average of 1.4 days.

Non-Elective Average Length of Stay - Hull Royal Infirmary

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017:
- The average length of stay for plastic surgery and trauma & orthopaedics non-elective patients at Hull Royal Infirmary was lower than the England averages.
- The average length of stay for upper gastrointestinal surgery non-elective patients at Hull Royal Infirmary was 4.7 days, which was worse than the England average of 4.2 days.

(Source: NHS England)

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The latest information for Q2 2017/18 showed this trust had cancelled 203 surgeries. Of the 203 patients whose surgeries were cancelled, one was not treated within 28 days.
Percentage of patients whose operation was cancelled and were not treated within 28 days - Hull and East Yorkshire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust showed an upward trend to a peak in Q4 2016/17 and has since declined. The number of patients whose operations were cancelled and not treated within 28 days was better than the England average.

Cancelled operations as a percentage of elective admissions - Hull and East Yorkshire Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust was generally worse than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.
(Source: NHS England)

We saw that the surgical admissions care pathway included ward moves on the front page for staff to complete.

During the inspection, we saw that a number of surgical wards had medical patients (outliers) located on them, the trust had recently been through a period of increased demand and had postponed some elective surgery to accommodate additional emergency patients.

Learning from complaints and concerns
The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

From November 2016 to November 2017, there were 156 complaints about surgical care. The trust took an average of 37 days to investigate and close complaints, this was in line with their complaints policy, which stated that complaints should be investigated and closed within 40 days. As of November 2017, there were 16 complaints still open and yet to be completed. Themes included dissatisfaction with surgery results and problems in other areas of health following surgery.

- Hull Royal Infirmary: There were 94 complaints, which took an average of 35 days to investigate and close. Ten complaints remained open at the time of the trust’s submission.
(Source: Routine Provider Information Request (RPIR) P61 – Complaints)
We saw information displayed in ward areas about how to raise a concern.

Staff we spoke with could describe how they would respond if a complaint or concern was raised. This included offering an initial, sincere apology and then advising that they would escalate the concern to the nurse in charge and offering the trusts’ Patient Advice and Liaison Service (PALS) details.

Themes and trends of complaints were shared within the health group via ward huddles, team meetings and individual conversations.

Is the service well-led?

**Leadership**

In 2016, we saw that the senior leadership team were new in post and required further time to develop and become fully effective in their roles. Since the last inspection, the senior team had remained stable. There was a clear leadership structure; all wards had a substantive ward manager position that was supported by matrons.

Staff we spoke with said that the health group leadership team were supportive and visible on the wards and departments.

Most ward managers we spoke with described positive, supportive relationships with the senior leadership team and matrons. However, some staff we spoke with said they found the ‘site team’ less supportive and approachable. This member of staff gave an example of an inappropriate admission being sent to the ward to prevent an emergency department breach. Another said when they had requested support they did not always feel supported or listened to.

We found the ward managers on the wards we visited knowledgeable and professional. They appeared visible and approachable for the staff they supported.

Junior medical staff we spoke with said they felt supported by senior colleagues.

A health care assistant we spoke with said that the ward sister on the ward they worked on was ‘fantastic’, they also said they were supportive and approachable for any issues that happened on the ward. This member of staff told her that the leadership team on the ward supported staff ideas and listened when changes to practice were suggested.

Staff we spoke with described being able to access leadership training programmes and talent training to improve leadership styles.

**Vision and strategy**

The health group’s values, vision and strategy were visible on posters in the corridors we visited. Staff we spoke with were aware of the trust vision and values.

The health group’s operational strategy was in line with the overall trust strategy.

All staff we spoke with were aware of the trust values and that this was discussed with them on induction.

A nurse practitioner we spoke with said that in the past, the trust vision and values had been paid ‘lip service’ however they said that more recently they felt the values had become more embedded.
Culture
We spoke with six members of staff within the theatre suite at this hospital and all staff gave positive feedback about team working.

Staff we spoke with said they felt valued. A health care assistant on ward 40 said that they felt that supported and valued, they said their team was supportive and there was a positive culture on the ward, staff all worked together especially when the ward was very busy.

We spoke with a member of staff who had worked at the trust for many years and they said that the culture in the trust was very different to how it had been many years ago. They described the culture as being more team focused and supportive. They also described the chief executive and director of nursing being much more visible.

A patient we spoke with said the student nurses who had cared for them were ‘very enthusiastic’; they said that felt this was due to attitude of the staff on ward 60.

The senior management team were aware of cultural issues that could hamper compliance with the surgical safety checklist and were focusing on this to improve compliance, this included human factors training.

Governance
The surgery health group had a clear governance structure. The governance structures within the health group provided assurance of oversight of performance against safety measures, from board to ward. We reviewed a report from the health group escalating issues to the operational quality committee and board, this detailed issues for escalation, issues for upward reporting, risks, themes actions and learning. This report also highlighted good news from the health group.

We noted that the health group governance meeting had not been quorate in October and November 2017. Ward managers we spoke with said they attended a quality and safety meeting where governance was discussed, including the health group risk register, complaints and any serious incidents. A business meeting was also held to discuss finance and operational issues.

Following the never events that had occurred in surgery in 2017 members of the executive and health group leadership teams delivered a presentation to staff. This included reflections from staff who had been involved in historical never events. There was also a trust wide learning programme in place which involved a range of education and training sessions including human factors, simulation and training from external military agencies.

Morbidity and mortality meetings were held within the health group, patient deaths were discussed in depth to identify if any learning available and review whether the correct actions had been taken. A mortality review was completed on each patient which identified whether there was any concerns regarding the care received. Mortality trends were monitored centrally and fed this back to the specialty teams.

The chief nurse had set up an additional panel where the fundamental standards audits were discussed, at this panel the group reviewed performance, identified themes and trends and provided board level assurance of the quality of care delivered. The chief nurse presented the finding to the board on a regular basis.

Management of risk, issues and performance
The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services. Each surgical speciality had individual business plans which included intelligence, command, threats and actions.
The health group had risk registers in place. These highlighted current risks and documented mitigating actions to reduce the risk. Risks were discussed at governance meetings and we saw escalation of the risks to other committees.

We spoke with senior staff within the health group about their highest risks, they identified staffing, implementation of the WHO checklist and finance which included cost of complex orthopaedic surgery as key risks, however not all of these risks were identified on the health group risk register.

The trust had relaunched the safer surgery checklist six weeks prior to the inspection, they had a very detailed programme commencing in July 2017 running through to August 2018, however there was little evidence of action that had been taken following the 2016 inspection, prior to the programme commencing.

Staff we spoke with on some surgical wards explained how the beds on the wards had been reconfigured during ‘operation wintergreen’ the trust winter pressures procedure. They said that it had been difficult at times to manage the change in patients’ needs but that the relevant medical consultants had been visible and supportive during the operation. Some said they had found the process to be a learning experience.

The health group held a surgical safety brief each day at 7:45am, this meeting was attended by the nurse in charge from each ward, any safety concerns were identified at this meeting to the ‘zoning representative’ (who was one of the ward managers on a rotational basis). This included any concerns about staffing, patient acuity and risk, bed availability and delayed discharges. Following this the zoning representative then attended a central briefing meeting at 9:30am, 2pm and 4pm to report the initial and any subsequent concerns that arose for the health group’s wards.

Consultants we spoke with said that they had a half day each month with no clinical work schedule which allowed them to attend departmental, mortality and morbidity and audit meetings.

**Information management**

Information provided by the trust, showed that 89.5% (November 2017) of staff within the health group had completed information governance training. This was worse than the trust’s target level for training of 95%. We did not have any concerns about the security of patients’ records during this inspection.

Computers were available on surgical wards; staff were able to access policies and clinical guidelines via the trust intranet. During the inspection, all computers were locked securely when not in use.

**Engagement**

Staff we spoke with said that the senior management team and some of the executive team were visible on the wards.

The national NHS staff survey showed the trust scored 3.77, average for staff engagement when compared with other trusts of a similar type.

Staff were informed of changes in the trust by electronic communication and a monthly newsletter.

Patient feedback was gained during the fundamental standards audits when staff gained patient feedback and tested whether evidence was available that this feedback had changed practice. Within the health group all scores were above 90% September 2017.

The trust’s website outlined opportunities to contact the trust and express opinions. It also supplied information on the services and hospital. The trust utilised social media as an engagement tool with the public and a list of social media accounts was listed on the website.
Patient representatives were included on committees, for example the major trauma board. The health group had a number of patient support groups within specialties.

The trust had introduced volunteers, young volunteers and young health champions to bring their experience into the organisation and to try to progress them on to apprenticeships. Clinical staff mentored young people from a local sixth form academy.

Colorectal surgeons had developed an improved colorectal/upper GI rota; this development had been supported by the senior management team.

**Learning, continuous improvement and innovation**

The service had implemented a consultant surgeon on call system that ensured that an upper gastrointestinal surgeon and a colorectal surgeon were on call either during the day or at night each day; this meant that patients had access to an appropriate specialist surgeon within 12 hours of admission. We observed an operation that had resulted in a patient avoiding a stoma due to this initiative.

The trust had appointed an audit clerk to aid data entry and a consultant as a champion following poor performance in the National Emergency Laparotomy Audit (NELA). A new audit form had been developed and this was currently awaiting governance sign off. It was hoped that this would improve the data submission and improve compliance. In addition, following the audit results a decision was made to admit all patients undergoing an emergency laparotomy to an intensive care bed post-operatively.

**Maternity**

**Facts and data about this service**

The Hull and East Yorkshire Hospital Trust has 73 maternity beds. These beds are located within three wards at Hull Royal Infirmary;
- H31 Maple Ward has 23 beds including four recovery beds.
- H33 Rowan Ward has 34 beds including five transitional care beds.
- Labour Ward has 16 beds including four recovery beds.

The trust also has three beds and one triage room at the Fatima Allam Birth Centre.
*(Source: Trust Provider Information Request – Acute sites)*
- Maple Ward provided antenatal care.
- Rowan Ward provided postnatal care.
- Labour Ward provided 16 beds in total, including a midwifery led unit and a four bedded recovery area for women following an elective caesarean section. One of the obstetric led delivery rooms had a birthing pool and all three midwifery led rooms had birthing pools. There was direct access to two obstetric theatres from the Labour Ward.

From July 2016 to June 2017, there were 5,237 deliveries at the trust.
A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

**Number of babies delivered at Hull and East Yorkshire Hospitals NHS Trust – Comparison with other trusts in England.**

The table below shows a profile of all deliveries from June 2016 to June 2017. In all four types of delivery, the trust is similar to the England average.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caesarean sections¹</td>
<td>1,475</td>
<td>28.2%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>496</td>
<td>9.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,252</td>
<td>62.1%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>14</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,237</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non assisted) deliveries

(n=608,950)
**Standardised caesarean section rates**

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12.1%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>737</td>
<td>130.1 (z=2.4)</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>738</td>
<td>93.6 (z=-0.5)</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>1,475</td>
<td>28.2%</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

(Source: Hospital Episodes Statistics (HES) June 2016 to July 2017 – Provided by CQC Outliers team)

Delivery trends by quarter for the last two years can be seen in the graph below.

**Number of deliveries at Hull and East Yorkshire Hospitals NHS Trust, by quarter.**

![Delivery trends graph](image)

*SOURCE: HES - Deliveries (July 2016 - June 2017)*

The number of deliveries over the past two years have remained steady, with quarterly figures fluctuating between a low of 1,253 which was recorded in 2016/17 Q1 and a high of 1,391, as recorded in 2016/17 Q2.

**Is the service safe?**

**Mandatory training**

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training. Staff described how they could access training on the trust’s Learning Management System (LMS) in e-learning and classroom based sessions.

Maternity staff completed skills training and emergency drills regarding the management of a deteriorating patient as part of a regular monthly programme for education and safety, organised for the whole team by designated education midwives.
The data below shows that staff in the maternity service met their target for mandatory training in all modules apart from information governance. The trust provided mandatory training information for a 12 month period. The information below is only for a partial year and the trust still have six months to complete training to meet their internal target.

A breakdown of compliance for mandatory courses from April to October 2017 for nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>171</td>
<td>190</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>171</td>
<td>190</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>169</td>
<td>190</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>169</td>
<td>190</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>167</td>
<td>190</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>162</td>
<td>190</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14)

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing and midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children and Young People</td>
<td>167</td>
<td>190</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults</td>
<td>165</td>
<td>190</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust exceeded the target for both safeguarding courses delivered to nursing and midwifery staff.

(Source: Trust Provider Information Request P18)

The trust had systems and processes in place to protect children and adults from neglect or abuse. The service had a named midwife responsible for safeguarding women and children who worked alongside staff. Staff we spoke with had been trained in safeguarding so that safeguarding was everyone’s business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.
We saw that the trust had up to date safeguarding policies for adults and children.

In the period November 2016 to October 2017 the service made 7 safeguarding referrals. 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).

Additional information provided by the trust showed 73.6% of midwifery staff had completed safeguarding level three training, safeguarding training information was not provided separately for medical staff in obstetrics.

The service had a specialist midwife for children who worked closely with the central trust safeguarding children team. Around 29% of maternity services overall attendance was made up of children (17 and under).

In the last 12 months there was a serious case review regarding the maternity service. Actions taken included: working with children’s social care to improve the quality of safeguarding children referrals; all midwives attending threshold of need training; introduction of a new model of safeguarding supervision; raising awareness of learning disability and mental capacity within the service; and development of a pathway to identify frequent attenders to the antenatal clinic.

In terms of female genital mutilation, women were asked at antenatal booking about it and any answer was shared with the GP and health visitors. The trust had a policy to guide staff on issues relating to female genital mutilation. Staff could report using an online notification tool. Where a woman had had female genital mutilation the midwife would complete a notification in relation to the birth of the baby.

Any children at risk of child sexual exploitation were dealt with through the trust's safeguarding children processes.

The trust had a vulnerabilities midwife who was key in supporting women who meet the criteria for this service and had complex physical or psychological health needs. They based this service around “care of the complex woman with complex social factors perinatal guidelines (toolkit)”. Examples of vulnerable women included, sex workers, women involved in abuse of drugs or alcohol, women living with learning disabilities and women living with HIV.

Staff told us the specialist vulnerabilities midwife was involved in development of birth plans and worked closely with the mental health perinatal team provided by another local NHS foundation trust.

Staff we spoke with were aware of the trust’s abduction policy, which detailed actions to be taken in the event of a baby being taken. The system for preventing abduction of an infant was on the service’s risk register at our last inspection in 2016 because it required replacement. The service had been looking at introducing security tagging and had visited other trusts to look at how this could be implemented. However, at this inspection there had been no new system implemented. Mitigating actions had been put in place, such as, pressure alarmed mattresses. We observed staff and visitors were all compliant with ward security and allowed nobody to follow unauthorised through security doors. This was observed in every area we visited.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.

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
using personal protective equipment when required, and they adhered to ‘bare below the elbow’
guidance. Staff encouraged visitors to use hand gel when they entered clinical areas.

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.
Staff cleaned equipment after use and used assurance stickers to indicate it was clean and ready
for use.

Cleaning rotas were displayed in the antenatal day unit and all delivery rooms on the Labour
Ward. We looked at cleaning checklists in three delivery rooms including the birthing pool and saw
these were completed.

All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% in
January 2018.

We saw 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 offered flu vaccinations and staff told us ten midwives had undertaken bespoke flu
and pertussis vaccination training in order to promote vaccinations for pregnant women.

Women were screened for Methicillin resistant staphylococcus aureus (MRSA) before undergoing
elective caesarean sections as part of the pre-operative assessment.

Environment and equipment
We visited the antenatal day unit and found it to be crowded at several times during the day.
Staff we spoke with told us they had developed a plan to increase capacity but this was new and
had not yet been implemented.

There were two dedicated obstetric theatres located just off the labour suite, this enabled easy
access.

We found that the environment was accessible using a buzzer system, with good signage. 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 television (CCTV) cameras were installed at the entrances to the
Labour Ward, Rowan ward and Maple ward.

Staff we spoke with reported having enough equipment that was ready and safe to be used.
Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in
labour. The trust had a medical devices and equipment policy which set out how checks on
equipment were done, how faults or damage were reported and what monitoring was in place.

Planned preventative maintenance was reviewed monthly between estates and team leaders to
identify any gaps. Repairs needed earlier could be logged on the estates electronic reporting tool
and emergency repairs had a 24/7 on-call service. All the equipment we saw had visible
evidence of electrical testing indicating safety checks and when it was next due for servicing.

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.
At our last inspection we found the labour ward did not have a formal handover room. Staff had used an empty delivery room leading to staff having to stand. At this inspection we observed handovers taking place in the labour ward hub where there was space for the whole team to attend and discuss patient care in a comfortable and confidential environment.

The labour ward had a separate 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 close to the nurses station were used for women with higher risk scores and other rooms were used for women at lower risk. The midwifery led unit utilised the rooms furthest away, with their own midwife coordination centre.

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 midwifery led unit had an additional three rooms with birthing pools with safety nets stored in rooms and we were told these staff completed the same emergency drills as core labour ward staff.

Resuscitation trolleys were located on the main corridors in each of the areas we visited. We checked the resuscitation trolleys in all the clinical areas and found daily checks had been completed in line with best practice in all clinical areas.

**Assessing and responding to patient risk**

Within the maternity service 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 labour ward, Rowan and Maple ward were assessed using the MEOWS score. We reviewed six sets observation charts and found that observations were recorded and scores calculated correctly.

We reviewed MEOWS charts at our previous inspection in 2016 and had found they were not completed clearly. However, at this inspection there was sufficient and regular information recorded for staff to assess patients’ conditions and staff understood escalation protocols and interventions.

The Trust sepsis pathway complied with NG51 NICE guidelines. There were two trust-wide sepsis nurses and a clinical lead. The sepsis pathway was embedded in maternity care and staff used red flags to identify sepsis risks.

The trust had completed implementation of a maternity patient administration system and advanced bed management system. This enabled antenatal and postnatal wards to visualise capacity on labour ward and make patient transfers at the most appropriate times.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and we found every delivery room had a stock to be used from the time of decision to proceed. We observed completion of the checklist in theatre and reviewed records of two women who had been to theatre. All WHO checklists had been completed correctly.

We observed two surgical procedures and found during the procedures arrangements were in place to ensure checks were made prior to, during and after in accordance with best practice principles.

We observed midwife and medical staff handovers and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. Staff gave updates on labouring women, transfers to and from other wards or theatre and details of patients requiring additional care. We saw staff used a situation, background, action and result (SBAR) framework to transfer patients between teams. This appeared to work well.
We saw evidence the unit used the ‘fresh eyes’ approach, a system that required two members of staff to review fetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation of the heart tracings.

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. Staff could refer women to the trust inpatient diabetes team who would follow up patients using a central database until discharged.

Consultant obstetricians were available out of hours for emergency caesarean section and if a patient’s condition gave rise for concern.

The antenatal day unit used a red, amber and green (RAG) system to prioritise women. Any women who presented with urgent needs were immediately transferred to 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 and we observed some women experiencing long waits because of this.

The service had an agreement in place with the local ambulance service to attend babies born before arrival at home.

**Midwifery and nurse staffing**

Midwife staffing levels were risk assessed six times daily, with fully automated ward rotas, and the service used birth rate plus to manage/balance risk.

Twice a year the trust carried out a full review of nursing and midwifery staffing establishment in each inpatient area. The last such review took place in March 2017 led by nurse directors and matrons with escalation to the chief nurse or deputy chief nurse and no concerns were raised regarding maternity staffing here or via the trust incident reporting system.

Data supplied by the trust showed that in the last 12 months a total of 36 nursing assistant shifts and 66 other staff shifts were filled by bank staff on the labour ward. On Maple ward the figures were 33 and one respectively and 20 and 17 for Rowan ward. Also, for each area, agency staff were used but the numbers of shifts that used agency were in single figures. When used, agency staff were checked on compliance for mandatory training, up to date Disclosure and Barring Service (DBS), up to date CV and nursing PIN numbers. We saw an up to date induction policy for new staff.

In the last 12 months one staff member was dismissed for failing to re-validate.

At our last inspection in 2016 we reported the service did no collect data on the number of women who received one to one care in labour and there was no audit process in place to ensure the provision of one to one care. At this inspection we noted the service recorded monthly the percentage of patients who received one to one care during labour. The rate was 100% for 10 months out of the last 12 and it dropped below 100% for only 2 months, once to 99% and once to 98% in December 2017.

Staff we spoke with told us although the midwife to birth ratio was higher (worse) than the national recommendations, they were assured women received one to one care through audit and friends and family survey results. We spoke with two women who said they had received one to one care in labour.

We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing levels. However, labour ward was regularly one registered midwife short for each shift. Staff on labour ward told us this was managed well and did not affect
women’s care. However staff on antenatal and postnatal wards told us they often had difficulty in giving or receiving information from labour ward and patient transfers were regularly delayed.

We observed morning and evening handovers on the labour ward. The handovers were detailed and concise. Staffing and patient allocation was discussed. However, the handovers we observed did not include a ‘topic of the week’ which we were told was used to communicate wider issues which needed dissemination, for example, learning from incidents.

From November 2016 to October 2017, the trust reported a vacancy rate of 5% in maternity for nursing and midwifery staff. The trust did not provide an overall target for vacancies. *(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

At our last inspection we were told the service was actively recruiting to the vacancies. Staff felt the “remarkable people, extraordinary place” recruitment strategy had been effective. At this inspection staff we spoke with told us recruitment to vacant posts was on track with plenty of skilled applicants for each post.

From November 2016 to October 2017, the trust reported a turnover rate of 11% in maternity for nursing and midwifery staff. This was worse than overall trust target of 9% for turnover. *(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

Staff we spoke with told us there were a number of midwives approaching or at retirement age and the team were exploring development opportunities for qualified staff to move into more responsible roles. The service retained student midwives and had a recruitment plan for more newly qualified staff.

From November 2016 to October 2017 the trust reported a sickness rate of 6% in maternity for nursing and midwifery staff. This was worse than overall trust target of 4% for sickness. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) recommend a ratio of one midwife to 28 births (1:28). At our last inspection we reported the service had completed a business case to review the midwifery establishment and work towards the recommended ratio of 1:28. At this inspection we noted the service was still not meeting the standard and the trust target had been raised from 1:30 to 1:32. Therefore, no trust target breaches had occurred in 2017.

As of June 2017 the trust had a ratio of one midwife to every 32 women, which is worse than the national average of one midwife to every 27 women. *(Source: Electronic Staff Records – EST Data Warehouse)*

**Medical staffing**

Consultants provided at least 98 hours of cover each week and regularly provided more, up to 109 hours per week. This was in line with or better than the trust target of 98 hours per week. In the last 12 months only 28 shifts were filled by a locum doctor in training.

There was a resident consultant on labour ward Monday to Thursday 8am to 7pm, then on call 7pm to 8am the following day. On Fridays the on-call consultant was available until 8:30pm. A resident consultant then provided cover from 8:30pm to 8:30am the following day. The resident consultant for Saturday and Sunday was on site from 8am to 11am, on call 11am to 8:30pm and then resident from 8:30pm to 8:30am the following day.

Daily antenatal and postnatal ward rounds took place in line with current guidance. 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.
Staff reported consultants were contactable when required 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.

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.

In August 2017, the proportion of consultant staff reported to be working in maternity at the trust was higher than the England average, while the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 32.1 whole time equivalent staff working in maternity at Hull and East Yorkshire Hospitals NHS Trust.**

```
<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>40%</td>
<td>46%</td>
</tr>
<tr>
<td>Junior*</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>
```

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (Str) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

**Records**

We reviewed six sets of records and found them to be legible, detailed, signed, and safely stored. Records showed each woman had a named midwife responsible for their care, individualised care plans for pregnancy and labour were documented and venous thromboembolism (VTE) risk assessments were completed.

Patient records were a mix of electronic and paper patient notes (for instance, nursing care plans were paper based). Paper records were stored on site and maternity used an electronic case management system so data could be shared with other services. The service had implemented the introduction of fully revised maternity records. The trust had been transitioning to electronic patients records and at the time of our inspection records within maternity services were almost fully electronic.

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. Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives we spoke with told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.
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 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 the trust electronic system.

Staff we spoke with told us senior midwives undertook a monthly spot check record audit of records and results were reported at ward meetings. Any trends or good practice were disseminated to clinical areas. Checks of documentation within records were part of the midwife competency framework and we observed senior staff carrying out reviews as part of preceptorship for newly qualified staff.

Medical records on the labour ward were stored securely in line with the trusts data protection policy. However, we noted on Rowan ward records were stored in an unlocked cupboard in an unlocked room. There was a risk that people could easily access confidential patient information. Staff we spoke with felt assured staff were almost always present in the room but would look into finding a more secure solution for storage of records.

The ‘fresh eyes’ approach was used to review CTG’s and we saw evidence of this in patient records.

**Medicines**

We checked the storage of medicines on the wards we visited. We found that medicines were stored securely in appropriately locked rooms and fridges and stocks were in date.

We checked the storage and administration of controlled drugs, which require specific controls, 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.

Medicines 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 we spoke with understood their responsibilities for raising concerns if the fridge temperature went out of range and said they would contact pharmacy.

In 2016 to 2017 trust records showed 58 nursing and midwifery staff in maternity had completed medicine management training.

The trust told us about measures they had taken to improve management of medicines. Electronic prescribing was being rolled out which staff hoped would provide improvements, for example missed doses performance. Medicines reconciliation was measured in real time. Wards were audited monthly for medicine storage by a pharmacist and senior ward nurse and an action plan would be created as necessary.

We checked six prescription charts and found these had been fully completed, patients received medicines promptly and any allergies were clearly recorded.

The trust told us regular audits of the quality of antimicrobial prescribing were carried out by pharmacy staff, with any areas requiring improvement highlighted to the service.

**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 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 November 2016 and October 2017 there were 937 incidents reported within maternity services to the National Reporting and Learning System (NRLS). Eight hundred and eight of these (75.7%) resulted in no harm, 80 (7.5%) resulted in low harm, 29 (2.7%) resulted in moderate harm, and six (0.6%) resulted in severe harm. There were no incidents recorded as resulting in death.

Themes of incidents reported included: staffing resources, shoulder dystocia, reduced fetal movements and staff communication problems. Staff completed details of actions taken to prevent a recurrence of an incident and for serious incidents they also identified and documented areas of good practice followed by staff.

Staff we spoke with said feedback from incidents was shared in a number of ways including; ward meetings, HEY247 and face to face feedback. At our last inspection in 2016 staff told us labour ward discussed ‘topic of the week’ at handover to share any lessons learnt. However, handovers we observed on labour ward at this inspection did not include a ‘topic of the week’.

The trust told us senior midwives and medical staff held weekly maternity case review meetings to discuss individual cases and identify lessons learned.

The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). The trust provided one set of minutes from January 2018 where serious case reviews were discussed. There were no lessons learned from previous cases discussed at this meeting and it was not clear how long it had been since the latest perinatal mortality meeting.

We saw examples of how the service learned from incidents. One example related to the work the service had done on retained swabs. We saw posters reminding staff about the need to count swabs and in theatres we saw that the system put in place to count swabs was in use. The trust told us that in January 2017 all midwifery and consultant staff in the service attended a DVD event to learn lessons about retained swabs. Another example concerned learning from a serious incident involving a new member of staff. We saw that the escalation procedure had been changed to ensure new members of staff could not be escalated onto the labour ward if they had not previously rotated on that ward.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The trust reported no incidents which took place from November 2016 to October 2017 and were classified as never events for maternity.

In accordance with the serious incident framework 2015, the trust reported seven serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:
- Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with three (43% of total incidents).
- Maternity/obstetric incident meeting SI criteria: mother only with two (29% of total incidents).
- Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (29% of total incidents).
(Source: Strategic Executive Information System (STEIS))

The trust told us they had improved the management and quality of incident and serious incident investigations. Actions included structured judgment reviews for mortality and reduced numbers of SIs. Senior staff had completed resilience training and a major accident test was carried out in
June 2017 with the full multiagency team.

Staff produced a monthly lessons shared bulletin and delivered more targeted messaging through a quality safety bulletin. Themes identified specifically for maternity services were cardiotocograph interpretation. This had been escalated to the trust clinical incident review creating a maternity staff learning environment group.

We reviewed two root cause analysis reports (RCA) from serious incidents where babies had died and found actions plans and lessons learnt were identified. Actions included providing feedback to staff.

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. We found there were mandatory fields to complete in the incident reporting system. Compliance was monitored monthly on a quality safety dashboard, and teams used performance scorecards and risk reports. In period November 2016 to October 2017 maternity had applied duty of candour 43 times.

Staff we spoke with understood and could describe duty of candour requirements and understood the importance of being open and honest with patients. It was evident in the serious incident investigations we reviewed that the duty of candour had been applied.

**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. However, the full NHS 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.

The trust told us they found overall, performance with the safety thermometer remained relatively positive, but continued to be reviewed monthly. Each ward received individual feedback and results and ward sisters/charge nurses developed actions to address these.

The maternity safety thermometer allows 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 identifies 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.

Staff used the maternity safety thermometer to gather feedback from patients. One example we found was a number of babies had been separated from their mum due to the need for the baby to have intra venous antibiotics in the neonatal intensive care unit (NICU). Following this feedback staff had undergone training to be able to administer antibiotics on the mother’s ward.

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.

**Is the service effective?**

**Evidence-based care and treatment**

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and
Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access guidelines, policies and procedures on the trusts intranet website. We saw that clinical leads took responsibility for determining compliance with new NICE guidance which was monitored by a central trust committee. A regular programme of audits took place to demonstrate compliance with NICE guidelines. Actions were monitored by the clinical audit and effectiveness team. Clinical leads within the service took responsibility for identifying any gaps and creating an action plan to address them.

We reviewed a sample of the trust’s pathways and policies and saw that they were all in date and had an author and review date and referenced NICE and RCOG guidance. For instance, the sepsis pathway which complied with NG51 NICE guidance. This was an improvement from the last inspection where we found some policies and pathways were out of date.

In March 2016 the service completed an audit of massive obstetric haemorrhages; to ensure compliance with trust guidelines and RCOG guidelines. The audit recommended further training for staff on the estimation of blood loss. At this inspection staff we spoke with told us how they put this into practice in theatre by adding to the total estimate the weight of all swabs used during a procedure.

We saw midwifery teams were using growth assessment protocol (GAP) which was based on standardised fundal height measurements and plotting on a customised growth chart.

**Nutrition and hydration**

Staff provided nutrition and hydration to patients and supported breastfeeding or feeding with formula milk for new born babies. We saw lots of initiatives to encourage women to breastfeed including provision of leaflets and posters about breastfeeding, training of staff to support women to breastfeed, and use of breastfeeding volunteers. For those women who chose not to breastfeed we saw that they were supported to use their own formula milk. For example, by supplying a milk kitchen with bottle warmers, single use bottles, and labelled formula milk in a fridge. All fridges had their temperatures monitored daily and we saw completed logs for this with no gaps.

Women on the labour ward were provided with water and toast or a sandwich, and women on the antenatal or postnatal ward had a choice from a menu of hot food plus water. Patients we spoke with were satisfied with the meals they received and menus showed different dietary and religious requirements were catered for.

For women on the labour ward, staff we spoke with told us they would monitor hydration levels using a fluid balance chart in certain cases, for example, if the woman had sepsis, was on intravenous fluids, or had an epidural.

All wards offered protected meal times to support women to obtain their nutrition in a more relaxed environment.

Women who had specific eating needs could be seen by the dietitian and staff we spoke with told us about and showed us the system in place to alert catering staff to those women who had special dietary needs. We observed staff helping some women on the antenatal and postnatal wards make choices from menus to ensure they received adequate nutrition. Community staff also checked for issues with mothers’ nutrition, such as weight loss.

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 and a re-assessment was due in May 2018. The assessment report recognised the significant improvements the trust had made and included the number of women who had been shown how to hand express, women who understood baby led feeding and how to recognise feeding cues and women who 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.

Women we spoke with said they felt supported with feeding their baby. Rowan ward had a milk kitchen where mothers could store their own formula and staff showed new mums how to make up feeds correctly.

In the antenatal day unit there were drinks and snack machines that patients or their carers could use.

In the community, staff we spoke with confirmed that they were involved in monitoring the weight of the baby and were also trained to undertake new born baby checks as well as being trained to support women to breastfeed.

**Pain relief**

We saw that the service had a range of systems both medical, such as epidural or nitrous oxide and oxygen (Entonox®) piped directly into all delivery rooms, and non-medical, such as birthing pools or relaxation balls, to help women manage their pain. Patients we spoke with did not report any issues with how their pain was being managed and pain relief was discussed and offered regularly throughout their labour. Birthing plans showed different options for pain relief were available to women.

The service provided 24/7 anaesthetic cover so that, staff we spoke with told us, a woman requesting an epidural would wait, on average, no longer than an hour to receive one. However, staff we spoke with told us they aimed to provide an epidural to a woman within 30 minutes of the request. In addition, the service had many birthing pools and other non-medical aids and equipment to support a woman to relax and manage their pain. Telemetry permitted continued monitoring while the woman was in the pool.

For women who were unable to describe their pain, for instance because of a learning disability, staff we spoke with told us they used a visual pain management tool.

In the community staff told us they took with them Entonox® and medicines to support women to manage their pain.

**Patient outcomes**

We saw that the service had systems and processes in place to monitor patient outcomes, such as reviews of data using maternity dashboards, maternity safety thermometers, and by taking part in audits, all with a view to improving the experience of its patients.

The service used a maternity dashboard to monitor various patient outcomes. The dashboard monitored activity, workforce, morbidity for mother and baby, risk management and complaints. The results of the monitoring were discussed at regular weekly and monthly meetings and actions agreed and monitored through audits.

A sample of the audits undertaken are shown below together with a brief comment, where necessary, about the audit outcome.

In the 2016 National Neonatal Audit, the Hull and East Yorkshire Hospitals NHS Trust’s performance was as follows:

**Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?**

There were 58 babies born at <32 weeks included in this audit measure for the trust. Ninety eight per cent of these babies had their temperature measured within an hour of birth; this was better than the national average, where 96% of eligible babies had their temperature measured within
an hour of birth.

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 153 eligible mothers identified for inclusion in this audit measure for the trust. Eighty six per cent of these mothers were given a complete or incomplete course of antenatal steroids; this was equal to the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

**What proportion of babies <33 weeks gestation at birth, were receiving any of their own mother’s milk at discharge to home from a neonatal unit?**

In order to more confidently attribute feeding outcomes to the unit, only babies who had a final neonatal discharge to ‘home’ at the end of their first episode of neonatal care were included in this analysis. Babies who were transferred between neonatal units at any point were excluded.

There were 60 babies born at <33 weeks who met the criteria for inclusion in the unit. Sixty per cent of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was better than the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

Staff we spoke with told us that many of the midwives, both those who were core on the wards and those on rotation in the community, had been trained to do new born baby checks, and that this had helped them to achieve good audit results.

From July 2016 to June 2017, the total number of caesarean sections and standardised caesarean section rates for emergency caesarean sections were similar to the expected rates. However, rates for elective sections were higher than expected. The trust was notified by CQC it was a maternity outlier for elective caesarean sections.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England Caesarean rate</th>
<th>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST Caesareans (n)</th>
<th>Caesarean rate</th>
<th>Standardised Ratio</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective caesareans</td>
<td>12.1%</td>
<td>737</td>
<td>14.1%</td>
<td>130.1 (z=2.4)</td>
<td>Higher than expected</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>738</td>
<td>14.1%</td>
<td>93.6 (z=-0.5)</td>
<td>Similar to expected</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.5%</td>
<td>1,475</td>
<td>28.2%</td>
<td>108.9 (z=1.2)</td>
<td>Similar to expected</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

The trust told us that it was aware that the elective caesarean rate was higher when compared to the England average but it was within the range of trusts in the region.

To address this, broadly speaking, the service had addressed two main areas. This involved working with women who had never had a section and also working with women who had previously had a section, both with a view to avoiding an unnecessary section where it was safe to do so.

For women who had never had a section, the service had put in place measures to try and capture women earlier, say through parenting classes, with a view to referring them to the new midwife led unit, where appropriate.

For women who had previously had a section, the service had set up a midwife-led birth after caesarean section (BAC) clinic. This involved such women being seen by a senior midwife to debrief their experience from their previous section birth. If a woman chose to have a repeat
section, remained undecided or had any contraindications to a vaginal birth then they would be seen at a consultant obstetric clinic. To ensure a smooth referral process each consultant obstetrician was aligned to a community midwifery team.

In addition, the service reviewed its data regularly and compared it to the regional range which was between 5.9% - 16.9%. The service scored 14.1% and so was within the range regionally.

This data consideration was supported by a clinical expert group, where indicators from dashboards were discussed and good practice was shared across the region to support individual areas for improvement. In addition, the Humber coast and vale strategic partnership group included a local maternity system work stream that considered the data.

In relation to other modes of delivery from July 2016 to June 2017, the table below shows the proportions of deliveries, recorded by method, in comparison to the England averages.

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,475</td>
<td>28.2%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>496</td>
<td>9.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,252</td>
<td>62.1%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>14</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,237</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The trust took part in the 2017 MBRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.9. The comparator group was 6.9.

Comparing this provider to other trusts with similar service provision in the 2017 MBRRACE-UK Perinatal Mortality Surveillance Report for Births in 2015, performance was worse than expected for stabilised and risk-adjusted extended perinatal mortality rate. There is currently no national aspirational standard for this audit.

(Source: MBRRACE UK)

The trust told us the service had done a lot of work around stillbirths. A stillbirth audit undertaken in 2017 showed a reduction in stillbirths at the unit. Staff reported a further reduction in the year to date. They had created a customised growth chart and implemented the West Midlands Perinatal Institute maternity hand held records. Staff provided women with a leaflet about movements of a baby and midwives had completed a skills package around cardiotachograph interpretation (used to monitor baby heart rates). All stillbirths were reviewed at the maternity case review meetings.

The unit reported no maternal deaths in 2017.
Shoulder dystocia occurs when a baby’s shoulder becomes stuck behind the mother’s pelvic bone. The number of shoulder dystocia cases recorded on the incident reporting system ranged between 2 and 5 per month. This was better than and below the trust target of less than six a month. All the cases were discussed at the weekly maternity care reviews.

**Competent staff**

From April 2017 to October 2017, 69% of staff within maternity at the trust had received an appraisal. This was worse than the trust target of 85%. Nursing and midwifery staff achieved a completion rate of 64%. Medical and dental staff had an appraisal completion target of 90% and were the only group to meet their target with 92% receiving appraisals.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>11</td>
<td>12</td>
<td>92%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>18</td>
<td>20</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>36</td>
<td>50</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>101</td>
<td>157</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>3</td>
<td>5</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with at the inspection told us figures gathered by department managers for nursing and midwifery appraisal showed that, as at December 2017, nursing and midwifery staff were at 81.5% overall compliance with appraisals not 69% as shown above. Staff we spoke with told us the January 2018 figure had improved again and so no action plan was required to reach the 85% target.

We found that the service had systems and processes in place to ensure staff were competent in their roles and received yearly appraisals to ensure that their competencies were reviewed.

Many of the staff had undergone, or were in the process of, starting the professional midwife advocacy role which replaced the supervisor of midwives role. We saw posters promoting the role of professional midwife advocate. Staff we spoke with confirmed they had access to advice and support 24 hours a day if midwives were supported with their requirements for revalidation.

Staff we spoke with confirmed that they had received preceptorship training. This is training given when a midwife first starts. We saw an example of a preceptorship training record. This showed the staff member was allocated a team of qualified midwives who would mentor them. The record also showed what skills the new midwife had to acquire and how they were signed off as competent by qualified staff. 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’.

The service had two educational midwives who were responsible for providing in house training for midwives and doctors at all levels. In addition it had a number of specialist midwives, such as for bereavement, safeguarding, and health promotion. A vulnerabilities midwife saw women with
substance misuse, mental health problems, alcohol abuse, learning difficulties and teenage pregnancies.

We saw that staff received training in additional skills over and above their mandatory training such as for epidurals and top-ups, cardiotachograph (CTG) interpretation, scrub-in training for working in theatres on caesarean sections, and newborn screening. Community midwives attended annual skills and drills training and midwives undertook training for working in theatre.

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 clinical supervision. They felt well supported by the ward team and could approach senior colleagues for advice if needed.

**Multidisciplinary working**

We saw evidence of communication between staff within clinical areas, in teams and from different disciplines working together to provide effective services to patients. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.

We saw evidence of midwives working with consultants well. For instance, whilst on inspection we learnt about how midwives and consultants had managed a birth together to avoid the need for a section by managing to turn a baby. Staff we spoke with contacted the critical care outreach team if they were concerned that a patient was deteriorating. We saw anaesthetists attended the multidisciplinary team handover on labour ward and were made aware of any high risk women.

We saw midwives working with paediatricians as part of the paediatric clinic. We also saw staff working with hearing screeners, student midwives, GP trainees and consultants from the acute team, for example, in relation to infection control and baby feeding. Staff we spoke with told us how they attended outpatient department meetings to see what they could learn from them.

Staff we spoke with had worked as part of the core acute team or rotated into the community. This supported staff in understanding the needs of each part of the service and improved multidisciplinary working. For instance, one issue staff told us about concerned taking correct triage information when providing out of hours cover for the antenatal day unit and how staff, having worked in different teams, had a better appreciation of how important it was to ensure the correct information was taken.

We noted from speaking with staff that there were good links with the perinatal mental health team. Women with a suspected mental health illness were referred to the perinatal mental health team for further assessment and treatment. Staff we spoke with described how the team had supported them with women who had depression.

In the community staff we spoke with told us about how they regularly attended multidisciplinary meetings attended by social workers, psychiatrists, health visitors and school nurses.

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. This ensured timely information was available for community and primary care teams who took over care for mother and baby when they returned home.
The vulnerabilities midwife worked closely with community midwives, and there was a process in place for women who did not attend antenatal appointments. The perinatal team mental health team concentrated on multi agency working, and included midwives, substance misuse services and their wrap around services.

**Seven-day services**

With the exception of the antenatal day unit and antenatal clinics, the service was open 24/7 with 98 hour consultant availability and 24/7 access to two obstetric theatres with dedicated anaesthetic cover. However, out of hours, a theatre assistant would be called to attend from the main theatre department when they were available. Staff we spoke with told us of two instances when cases where delayed when staff where not available for the second theatre. A consultant anaesthetist 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 conducted two ward rounds a day with consultants on call out of hours. Out of hours, the on-call consultant was required to attend within 30 minutes when needed as per the trust policy. We spoke with staff who confirmed consultants would regularly attend less than 30 minutes of being called. Staff reported consultants were contactable when required and this included out of hours and weekends.

The antenatal day unit was open Monday to Friday from 8:30am until 8pm, and weekends from 8:30am until 5pm. Out of hours cover was provided by the antenatal ward.

Antenatal clinics were open Monday to Thursday from 8:30am until 6pm, and Fridays from 8:30am until 5pm.

Staff reported good access to ultrasound scans while the antenatal clinic or day unit was open and we observed a sonographer coming to the unit to undertake scans. This was an improvement since the last inspection when it was reported that there were not enough slots for sonographers.

**Health promotion**

We saw that the service took action to promote health by using a combination of an information pack given to women at their booking appointment, leaflets, posters, its website, parenting classes, and by offering bespoke clinics.

We saw that the service provided a series of leaflets and posters about health issues, such as smoking cessation or keeping the air around the baby free from smoke, plus advice on its website about healthy lifestyles. The trust told us a new maternal smoking in pregnancy project had commenced in April 2017. The initiative involved ensuring all midwives, midwifery assistants, volunteers, GP’s, practice nurses and family nurse partnerships that had contact with pregnant women, were trained in giving very brief advice and information around smoking cessation. They had also been trained in recording carbon dioxide readings.

The service had recently taken responsibility back for providing parenting classes that supplied parents with advice about healthy lifestyles.

In terms of bespoke clinics, the service had appointed a healthy lifestyle midwife (HLM) who was specifically involved in contributing to the obesity agenda and reducing smoking in pregnancy to enable good maternal health.

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

The trust reported that from April 2017 to October 2017, Mental Capacity Act (MCA) training had been completed by 87% of nursing and midwifery staff in within maternity services. During the same period, Deprivation of Liberty Safeguards training had been completed by 92% of nursing
and midwifery staff.

This was better than the trust target for both training courses of 85%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>174</td>
<td>190</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>165</td>
<td>190</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14/P49)

We saw that the trust had an up to date policy to guide staff on consent, mental capacity act and deprivation of liberty safeguards, consent and physical restraint.

Staff we spoke with knew the importance of obtaining patient consent to treatment and demonstrated an understanding of the MCA. At the time of our inspection there were no patients subject to a Deprivation of Liberty application.

Our review of records showed that where a surgical procedure such as a caesarean section or instrumental delivery was being carried out patients had signed a written consent. To support patients in consenting in an informed way patients were given relevant background information at the booking appointment in addition to information before supplying written consent. Consent forms detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines. For routine non-surgical tasks, such as taking blood pressure, staff we spoke with told us they would seek verbal consent.

Women we spoke with told us that they had been given the information they needed about their pregnancy, to enable them to make an informed choice about the delivery of their baby, and all their questions were answered.

Following the last inspection, we said (with the exception of staff in the pregnancy advisory service) that staff could not articulate what was meant by Gillick competence (about consent for young persons), although Gillick was referenced in July 2016 guidance. At this inspection this had improved; we noted that guidance on Gillick was incorporated into mandatory training and the guideline for vulnerability was updated. Staff we spoke with were able to describe the use of Gillick competence checks.

The trust told us it worked closely with a local trust that provided mental health provision and liaised with staff about the care and treatment of the patient. Staff we spoke with described good support from the perinatal mental health team.

The trust’s safeguarding team provided advice and support to staff for patients under the mental health act. The trust told us the vulnerability midwife delivered a caring for vulnerable women training package to midwifery staff.
Is the service caring?

Compassionate care

Friends and family test performance (antenatal), Hull and East Yorkshire Hospitals NHS Trust

From November 2016 to October 2017, the trust's maternity friends and family test (antenatal) performance (% recommended) was generally similar to the England average.

In January 2017 (90%) and June 2017 (89%), test performance dropped below the England average but recovered on both occasions. The table also showed a slight drop in October 2017 (90%), however data records do not continue past this point, so we were unable to ascertain if performance recovered or declined in the latter months of 2017.

For the most recent month (October 2017), the trust performance was 90% compared to the England average of 96%.

Friends and family test performance (birth), Hull and East Yorkshire Hospitals NHS Trust

From November 2016 to October 2017, the trust's maternity friends and family test (birth) performance (% recommended) was generally similar to the England average.

During this period, the table showed the trust performed slightly better than the England average with some months achieving 100%. However, performance uncharacteristically dipped to 80% in May 2017, before returning to 100% in June 2017.

For the most recent month (October 2017), the trust performance was 100% compared to the England average of 96%.
Friends and family test performance (postnatal ward), Hull and East Yorkshire Hospitals NHS Trust

From October 2016 to October 2017 the trust’s maternity friends and family test (postnatal ward) performance (% recommended) was generally similar to the England average.

The table above showed the trust performed slightly better than the England average throughout the entire period, with slight dips in performance during March 2017 (87%) and July 2017 (91%). On both occasions, performance recovered.

For the most recent month (October 2017), the trust performance was 98% compared to the England average of 94%.

Friends and family test performance (postnatal community), Hull and East Yorkshire Hospitals NHS Trust

From October 2016 to October 2017 the trust’s maternity friends and family test (postnatal community) performance (% recommended) was generally similar to the England average.

Throughout this period, the trust performed slightly better than the England average. In May 2017 and September/October 2017 there was no data, therefore we were unable to ascertain if the trust would have maintained this performance in these months too.

The last month with data provided (August 2017) showed the trust to be scoring 100% performance in comparison to the England average of 98%.
(Source: NHS England Friends and Family Test)

The trust performed about the same as other trusts for 16 questions and worse than other trusts for two questions asked as part of the CQC maternity survey 2017.

The trust performed worse than other trusts for the questions:
- ‘At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?’
- ‘If attention was needed after the birth, a member of staff helped within a reasonable amount of time’
The highest scores achieved were:
- 9.6 in response to the question, ‘If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?’
- 9.4 in response to the question, ‘Thinking about your care during labour and birth, were you spoken to in a way you could understand?’

In both instances, the trust performance was about the same as the England average.

The lowest score achieved was:
- 5.4 in response to the question regarding delays in discharge, although this score was about the same as the England average.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>Worse</td>
<td>7.8</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.0</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.1</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour, did a member of staff help you within a reasonable amount of time?</td>
<td>About the same</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.9</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the</td>
<td>About the</td>
<td>7.3</td>
</tr>
</tbody>
</table>
Information or explanations you needed? | same |
---|---|
Discharge from hospital being delayed | About the same | 5.4 |
If attention was needed after the birth, a member of staff helped within a reasonable amount of time | Worse | 6.4 |
Thinking about your stay in hospital, how clean was the hospital room or ward you were in? | About the same | 9.1 |
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? | About the same | 8.2 |

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

The trust told us it reviewed the privacy, dignity and wellbeing of patients on all wards using the fundamental standards audit tool. The results from the audits were presented on the ‘Quality and Safety Boards’ located on the entrance to each ward and was reported to the trust board on a quarterly basis.

We saw letters and cards of appreciation and positive comments about people’s experience displayed on ward noticeboards.

We spoke with eight 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 and staff introduced themselves.

We observed staff reacted promptly to call bells in all areas we inspected.

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.

**Emotional support**

Staff valued and cared for families’ emotional needs in all departments we inspected.

At our last inspection we reported the service did not have a specialist midwife with a specialist interest in bereavement. However, at this inspection a bereavement specialist midwife had been recruited. 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 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 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. Memory boxes were offered to patients who had suffered an early pregnancy 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.

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 trust told us it had 140 young volunteers aged between 16 and 24 based across the organisation and in maternity they might be used to hand out counselling cards to patients following miscarriage.

The trust chaplaincy team responded through the provision of religious, pastoral and spiritual care appropriate to the needs of individual patients as they are referred to the service.

The vulnerable women midwife saw vulnerable women, teenagers and those with late development who wished to continue with their pregnancy.

The trust bereavement survey was undertaken and collated on a monthly basis, with an average response of 24 each month. The latest survey highlighted: 98% of relatives found the information provided within the bereavement pack helpful; 99% of relatives thought bereavement services treated family members with respect; 93% felt relative received a high standard of care; 94% patient and family member was show dignity and respect by ward team; 83% kept informed at all times regarding patient’s condition; and 98% bereavement services were helpful in dealing with loss.

**Understanding and involvement of patients and those close to them**
The service had opened a new midwifery led unit giving women more choice in labour. This had been made possible by a large donation from a local family.

Some elements of the induction of labour process had changed following feedback from women who had used the service. Certain processes could be provided in an outpatient facility.

Feedback from the maternity safety thermometer indicated a number of babies being separated from their mother due to the need for the baby to have intravenous antibiotics which previously had to be given on neonatal intensive care unit in a separate area. Core staff had undertaken robust training to enable them to administer the antibiotics on the ward therefore eliminating the need to separate mum from their from baby.

Partners could visit Rowan ward from 9am to 9pm. However, the ward also facilitated, where possible, time for partners to spend on the ward with their partner and baby following transfer from the labour ward and allowed them to stay overnight if it is possible.

Women we spoke with 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 reviewed we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.

The service told us midwives completed birth plans to support women with complex and difficult birth choices.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
We spoke with the senior leadership team of the service who confirmed that they had regular meetings with their commissioners to ensure that service delivery met the needs of local people.

In addition, the service took part in a maternal voices partnership and staff told us they had recently met with 30 women to listen to their views about the service.
Staff told us the senior team met quarterly with their commissioners to discuss the local maternity work plan. The work plan looked at issues including: creation of specialist roles, such as the specialist midwives already created; health promotion, such as the stop smoking programme; obesity, addressed by the healthy midwife clinic; and the need for parenting classes, addressed by taking parenting classes back in house.

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 were held in the designated antenatal clinic area and ran from Monday to Friday for higher risk women.

When speaking with community teams we learnt how they were organised to try and respond to the needs of local people. For example, midwives with experience of working with vulnerable women, teenagers or asylum seekers were rostered to work in the areas where these groups were most concentrated.

Women had the option to deliver at home, or on the labour ward under consultant led care, or with midwifery led care. Since the opening of the alongside midwifery led unit in April 2017 the number of women opting for midwifery led care was still low and during our inspection we saw no women using the rooms in this suite. However, we noted from discussions with the senior leadership team that various initiatives were in place to try and increase the use by women of the midwifery led unit.

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 continuing to develop transitional care on Rowan ward. Transitional care was provided for babies who needed a little more support and 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.

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 venous thromboembolism (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.

**Meeting people’s individual needs**

The service had systems and processes in place to support it in meeting the individual needs of women using the service.

Women we spoke with 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 vulnerabilities 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. Midwives identified those who needed support and completed a referral at the booking appointment. Midwives used a recognised list of questions and at the time of our inspection the vulnerabilities midwife had a caseload of 40 women. They offered advice, education, and training such as fetal alcohol syndrome (FAS), safe sleeping, ensuring
women attended neonatal checks and supported carousel events for the HEY baby parenting classes.

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 including, drug or 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.

At our last inspection we reported we did not see any written information in different languages on the wards we visited. However at this inspection we did see leaflets printed in several languages and stored together with those printed in English.

For women whose first language was not English midwives we spoke with described how to access interpretation services through either booking a planned appointment or using a telephone translation system. Community midwives and ward staff had access to electronic tablets which had a translation application.

Browse aloud had been added to the trust’s website which supported page translation as required. The trust said they could supply patient information and leaflets in over 45 different languages and had approximately a 95% fill rate for requests.

The trust obtained British Sign Language (BSL) support via freelance BSL interpreters. At the time of our inspection all interpretation services were under review and a contract with a new supplier for interpretation, BSL and translation services was due to be completed in the few weeks following the inspection.

To support staff in complying with the accessible information standard, the trust told us it had developed a communication support request form which staff sent to the trust’s appointment and referral centre (ARC) so that the needs of a patient could be flagged on the trust’s electronic patient record. Women could opt to receive information via email or SMS text messaging. They also told us if a GP had not provided details of the patient’s preferences, then the trust would advise the GP via a specific letter template through the electronic administration system.

The trust told us they had introduced the use of QR codes for trust-published patient information leaflets. This enabled the user to scan a leaflet code with a QR reader installed on a mobile phone or tablet and download a copy of the leaflet directly on to their device.

Midwives we spoke with told us, and we saw, 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.

Following pregnancy loss women were offered a choice in the disposal of the pregnancy remains. They were also offered support with funeral arrangements. Families who experienced pregnancy loss were offered a post mortem.

The service worked closely with the Doula project. The project trained volunteers to offer support to vulnerable women.

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 were used as a screening tool to identify potential
depression. A positive response triggered a referral to the appropriate agency for example, GP, health visitors and the perinatal mental health team.

Women were offered flexibility because the service supported women attending for induction of labour to attend outpatients to have a balloon catheter fitted. This meant they could return home and carry out normal activities until their labour progressed.

We noted that the service took part in a twins and multiple births association (TAMBA) audit to help it understand how it could better support women who had multiple births. At the time of our inspection it was being re-audited to assess its compliance.

We saw that pregnancy notes completed by women and staff supported midwives and doctors to check on a woman’s mental health. Staff we spoke with reported good support from the perinatal mental health team if a referral was needed.

Women going through bereavement had access to a bereavement room on the antenatal day unit and the Labour Ward. To help ease the grief associated with early pregnancy loss staff had led on creating ‘Forget Me Not’ boxes, and worked closely with the trust’s chaplaincy service and referred women to bereavement charities such as the stillbirth and neonatal death charity (SANDS).

Access and flow
From April 2016 to September 2017, the bed occupancy levels for maternity were generally much lower than the England average, with the trust having 11% occupancy in quarter two 2016/17 compared to the England average of around 60%.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

We found that the service had measures in place to maintain access and flow throughout the service so that it remained responsive to the needs of women.
Women who needed to use the service could self-refer or be referred by their GP. Booking appointments were made with community midwives in a community setting according to national guidelines. Where this was not possible, for example because the woman contacted the service after 13 weeks gestation, an appointment was offered within two weeks of that contact.

Waiting times were monitored by the senior leadership team through the service’s dashboard and more appointment slots were offered if necessary to match demand. At our last inspection we reported the service was not meeting its targets for booking appointments. However, at this inspection we found for the period April 2017 to January 2018 direct access for women before 12 weeks and six days gestation was above and better than the target of 93.2% and booking within two weeks after 13 weeks gestation was above and better than the target of 95%. The senior leadership team met three times a week and at these meetings issues around access and flow were discussed.

At our last inspection we reported 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, at this inspection we saw the service formally collected and recorded this information. 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.

To support the antenatal ward with demand and flow issues, the service operated an antenatal day unit where staff saw women who had any concerns about their pregnancy. Staff at this unit could monitor the baby’s heart rate and also offered scanning by midwives, for example, to check blood flow to the baby, in addition to full scans from a sonographer where needed. Women were triaged in a phone call and then triaged on arrival and allocated to a specific response slot, with red being a 15 minute response time and green up to two hours. Out of hours women could access the same assistance on the antenatal ward. Staff we spoke with told us that they were in the process of making space on the Labour Ward to enable women triaged to red to be immediately seen on the Labour Ward.

The antenatal day unit was open from 8:30am to 8pm Monday to Friday and from 8:30am to 5pm 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 movements.

Staff reported that a recent audit showed waiting times on the day unit were good. However, during our inspection staff and patients we spoke with told us there were regularly long waits on the unit. Examples we were given from women were 90 minutes and two hours for results or to be discharged. One woman told us she had to leave the previous day after a couple of hours to care for her family and she returned again the next morning to complete her visit. Unlike the previous inspection, staff did not report issues with capacity in consultant clinics.

On the antenatal ward there were four recovery beds for women who have had elective caesarean sections which allowed appropriate patients to be moved more promptly out of recovery in the labour ward to the beds in the antenatal ward so improving the flow in the labour ward.

The enhanced recovery pathway for women following an elective caesarean section enabled them to be discharged home the next day. Women were cared for in a designated recovery bay on labour ward immediately following their surgery. Women were then transferred back to the elective caesarean section bay on the postnatal ward where a midwife was allocated to provide care, advice and support prior to discharge.

On the postnatal ward the trust had just introduced an electronic bed flow system so that staff on the postnatal ward could see what beds were free on their ward and transfer appropriate patients from the labour ward. This system was used alongside handheld paper handover notes.
On all of the wards there were co-ordinators whose role it was to monitor the access and flow throughout the ward to ensure the most responsive use of resource and to improve the patient experience.

The service was in the process of updating its escalation procedure. We spoke with staff about the procedure and they reported that it worked well. Managers of community staff knew which of their staff were on duty to support the unit at times of high demand. The rota was planned so that if the allocated staff member was called in managers had other community staff who could take over their colleague's caseload for the next day, so avoiding the need to cancel any community appointments.

Staff told us the discharge process began on admission and the midwife responsible for the care of a patient would ensure that all communication with the patient regarding discharge was recorded in the hand held maternity notes. As the service had access to an electronic patient management system they ensured GP received an electronic discharge letter with all necessary details about the woman and baby. Community staff accessed these records so that they could visit the woman within 24 hours of discharge or learn about a problem with the pregnancy.

At our last inspection we reported 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 had raised concerns that there was not enough capacity to offer women the required number of scans. This had been identified on the service risk register and at this inspection staff we spoke with told us women were receiving scans appropriately and there were sufficient sonographers.

Senior managers told us the maternity unit had not closed to women in labour in the last year.

**Learning from complaints and concerns**

From November 2016 to November 2017 there were 50 complaints about maternity services. Of these complaints, 86% were closed. The trust took an average of 35 days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be completed within 40 days. As of November 2017, there were seven complaints still open and yet to be completed. The majority of complaints about maternity were regarding access to treatment or drugs or patient care including nutrition.

*(Source: Provider Information Request P55)*

The service had a system in place for handling complaints and concerns. Staff we spoke with said they would try and resolve complaints at a local level and were aware of the procedure to follow.

The service had monthly meetings with the patient experience team to discuss complaints and complaints. These were monitored through the dashboard and at clinical governance meetings.

We looked at the register of complaints about the service and identified no themes or trends. The trust measured the time it took to respond to complaints. At the time of our inspection complaints requiring to be met within three days response time was 99%. Complaints requiring 40 days to complete were at 71% and complex complaints that required 60 days were at 95%.

Staff we spoke with told us the service embraced complaints and compliments and used complaints to see how the service could respond to improve patient care. The senior leadership team explained that staff were encouraged to try and resolve any complaints locally by speaking with the patient.

Staff we spoke with told us sharing of lessons learnt from complaints was done during handover on the labour ward. The wards produced a monthly newsletter where lessons learnt from complaints were disseminated.
When on the wards we saw that there were posters and leaflets to support patients to complain about the service they had received. We also saw lots of cards on display containing compliments. Women we spoke with knew how to make a complaint through patient advice and liaison service (PALS) but said they would raise any concerns they had with staff.

We reviewed three written responses to complaints. We saw records included detailed written reports and action plans attached to ensure that any learning was captured. Staff we spoke with told us discussions with staff about learning from a complaint would be noted in the individual personnel record of the staff member concerned.

**Is the service well-led?**

**Leadership**

The maternity service was part of the women’s division which formed part of the Family and Women’s Health Group.

The leadership structure at department level included a clinical lead, a head of midwifery, a lead midwife, and a governance midwife who all who worked closely with a business and human resources manager and finance and quality safety manager. This team reported into the deputy medical director, the nurse director, and the director of governance and so through them staff had access to the trust board and told us they felt listened to. In addition the head of midwifery met twice a month with the chief nurse.

We met the ward level leadership team and the senior leadership team they reported to. We were satisfied leaders and managers were experienced in leading, were approachable and had access to the board. While there was no designated board member as lead for maternity there were non-executive directors who championed the service. The board received regular reports touching on quality about the service. These included performance reports and compliance with fundamental standards such as infection control.

We saw strong leadership at a local level and ward managers told us of the challenges they faced in delivering good quality care and had identified strategies to address these. Staff we spoke with talked positively about ward managers, said they felt confident to raise concerns, felt well supported and listened to.

The leadership team met regularly, at least three times a week, to discuss plans for the service for the week ahead. Leaders met regularly with the ward sisters and shift co-ordinators.

Staff we spoke with told us there was a leadership and management strategy which set out in detail the various initiatives the trust had implemented to ensure staff had the leadership skills required to lead their service.

The local leadership team had vast experience in the midwifery sector being all practising midwives for a number of decades. The governance midwife had recently retired but a successor was actively being recruited and interviews were due to take place in the near future.

The labour ward had a rota of senior midwives who acted as shift coordinators and were supernumerary.

The trust told us medical leaders had a management and leadership programme that supported their medical manager roles and there was a clear leadership development route for all doctors from junior doctors to consultant posts. The programme also aimed to develop personal awareness, personal development, emotional Intelligence and resilience.

We spoke with staff from the community service and they reported that they felt connected with,
and regularly rotated into, the acute part of the service.

**Vision and strategy**
The trust’s vision and strategy for the maternity service was twofold: first, to create a midwifery led unit and secondly to respond positively to any requirements that were agreed as a result of the national maternity review: better births – improving outcomes of maternity services in England: a five year forward view for maternity care (better births).

The women’s division had an operational plan for 2016 to 2018. The strategic vision and goal 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 measurable outcomes. Senior staff were able to articulate these priorities for obstetrics including the development and increase in use of the midwifery led unit on the labour ward.

The trust told us staff induction for all new starters was entirely based around the vision and values, with exercises and discussion sessions designed to encourage staff to think about the meaning of the values. Also, appraisal required managers and their teams to discuss how well staff were demonstrating the trust’s values in their everyday work.

All staff we spoke with knew about the trust’s vision: great staff, great care, and great future and were able to describe what it meant for their service.

From speaking with staff we saw that there were a number of ways in which the trust’s strategy had been taken forward. For example, a midwifery led unit had been set up in April 2017 and staff told us the service was trying to publicise the unit and increase the numbers of women who used it.

The service had responded to the better births recommendations in a number of ways. For example, in terms of personalised care, women were given choices about where and how to give birth, with provision of home birth, a midwifery led unit and an obstetric led unit. We also saw that as part of parenting classes women were encouraged to develop a personalised birthing plan.

With regard to continuity of care, consultants were aligned to community midwifery teams. Also, in terms of safer care, the service had non-executive directors championing the service and regularly discussed its performance as compared to similar services in the local area, such as, in relation to elective section rates.

**Culture**
We found that the culture was positive with motivated staff that were passionate about providing care to women during their pregnancy journey.

Staff we spoke with told us 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 we spoke with were positive about the culture they worked in and mentioned how recent training on behaviours had helped to create a better working environment. Most staff we spoke with told us managers and leaders were visible and approachable and provided good support. Staff reported feeling valued with regular forums to express their views such as at team meetings, appraisals, and by email.

Staff we spoke with told us everyone worked together as a team and at times of pressure they felt staff made extra effort to make the workload more manageable.

Staff were encouraged to be open and honest. We saw examples of duty of candour having been implemented and staff knew about being open and honest with their patients. Staff we spoke with were able to give examples of when this had been implemented.
We spoke with student midwives who had positive things to say about the team, cultural environment and the support they had received during their rotation into the service from their university. Students we spoke with told us they had received good mentorship and they would work at the trust. Staff we spoke with told us most student midwives who had worked in the department applied for posts on graduation.

The trust told us that in addition to the formal whistleblowing policy, there was a staff advice and liaison service (SALS), through which staff could raise concerns about bullying behaviours.

We did not come across any complaints or concerns about bullying or harassment.

**Governance, risk management and quality measurement**

The service had a clear governance framework with specific roles which ensured that quality performance and risk were known about and managed.

The health group’s governance arrangements consisted of a triumvirate leadership group which sat under the board and were supported by the ward level leadership group. The ward leadership group organised business and clinical governance meetings. The ward level leadership team also met with the local maternity services forum to access learning from external bodies.

We saw minutes of weekly business and monthly clinical governance meetings. Standing agenda items included: themes of incidents; learning; management of incidents; feedback on serious incidents; open actions; risk register; safety thermometer; safety alerts; audit plans; NICE guidance; policies and guidelines; complaints; friends and family; claims; service specific issues; external reports and peer review.

The clinical governance midwife reviewed all incidents. They were responsible for facilitating governance and risk management and ensured policies and guidelines were up to date.

The trust told us management and oversight of risks flowed up within the organisation from clinical and non-clinical services to the operational quality committees then to the senior management executive management committee, and were used as part of the board assurance framework.

We saw a comprehensive audit programme was in place to monitor quality and patient outcomes. Each audit had an action plan and we saw examples of action plans that were in place.

The trust told us a corporate performance report including quality monitoring data for each service enabled the board to have a monthly overview of issues that would impact on service quality and safety, including finance, performance and agency staffing. These were scrutinised monthly at health group level along with operational detail around each issue.

The trust board received ‘ward to board assurance’ each month on quality through standing agenda items including the trust-wide quality report and an overview of patient safety, hospital acquired infections, safety thermometer, and patient experience.

We saw minutes of weekly business and monthly clinical governance meetings. Standing agenda items included: themes of incidents; learning; management of incidents; feedback on serious incidents; open actions; risk register; safety thermometer.

Local risk registers assisted the women’s 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.

The maternity service had a risk register which supported the leadership team in tracking risks and ensuring that actions were taken to reduce or extinguish the risk. Each risk had scores
attached to them, review dates and existing controls to mitigate the risks. The local leadership team confirmed that the top risk was staffing. The risk was that the maternity staffing ratios were worse than the recommended levels from the RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. The service had noted the consequence was of increasing poor outcomes for maternity services. We learned about the steps the service had put in place to try and increase the numbers of consultants and midwifery staff, including the system to grow senior staff for the future. New staff were due to join the service which it was hoped would bring the ratio of midwifery staff to patients in line with national guidelines. Another known risk was the demand for the antenatal day unit and this risk was being addressed in part by looking at the access criteria and by creation of a triage space in the labour ward. Lastly, wireless connectivity for community staff was a risk and this was being addressed through new technology.

A risk that had been reported following our last inspection in 2016 was security tagging for babies. This had been 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. At this inspection, there was still no baby tagging system and staff reported that pressure sensitive mattresses were in use and available for every baby. However, we were told these could no longer be replaced or repaired if broken.

There was some alignment between what staff had on their ‘worry list’ with what was on the risk register, for example, staffing.

**Information management**

The senior leadership team and staff we spoke with told us they reported that they had access to information in a digital format that was of use and provided to them in a timely way.

The trust told us that it had invested greatly in the information systems in the last few years, with a huge investment in a business intelligence system to help provide up to date reports for all departments.

Senior staff we spoke with confirmed that they had access to analysts employed by the trust who could supply them with a series of reports to help them understand the performance in their service. For example, weekly appraisal reports were distributed through the health group structures by the associated human resource teams.

**Engagement**

The service had systems and processes in place to engage with staff and the public to ensure that their views were taken into account.

The trust told us of a number of initiatives it had taken to improve staff engagement including a full values review in February 2017. A staff survey working group was established to oversee delivery of the trust’s action plan flowing out of this. A medical engagement sub-group was also established and a work programme was being developed with a focus on clinical leadership. The trust was running a high profile public campaign called the Hull remarkable campaign to highlight remarkable staff.

Staff we spoke with reported being engaged through the staff survey, yearly appraisals, training, and through meetings, bulletins and emails. Each ward had a dedicated staff room where staff could interact and relax.

The trust ran a ‘moments of magic’ scheme which enabled staff or users to nominate staff for great care.

The service also engaged with staff and the public with the born into the city artwork which celebrated births of babies born during Hull’s year as city of culture. This led to a public event at which staff and women and their babies met to celebrate their achievements.
The service engaged with the public through the friends and family test: 93.7% would recommend the service which was about the same as the national average of 95%. At the entrance to each ward there was a board displaying information about the ward for the public to see.

The trust told us each patient was given a feedback form to express their experience in the trust. These were fed back to the service on a monthly basis. Staff from the Patient and Public Council attended patient user groups to gain feedback from patients. All PALS, complaints and compliments were recorded on the electronic incident reporting system and could be located by name and patient ID number. Reports were run weekly by the patient experience department and if any trends or themes were identified for one area of care or treatment this would be escalated to the deputy chief nurse for review and actions. The patient experience department engaged with the community commissioners to update them on lessons learned and any service improvement driven from listening to the user groups.

In the entrance to the women and children’s hospital there was a display about the history of the maternity service with pop up posters about healthy living or breastfeeding. The service took part in a maternity voices partnership (MVP). MVPs are independent formal multidisciplinary committees which come together to influence and share in the decision-making of the local maternity system and its constituent parts. They are underpinned by practical support from local commissioners and providers, including appropriate financial support. Recently the service had met with up to 30 women to obtain their views.

Staff completed the mandatory staff friends and family test quarterly survey questions. The trust also added in the remaining questions from the NHS staff survey (NSS) staff engagement section, so that a continuous measure of the staff engagement score could be undertaken. The top concerns were staff being able to make improvements in the work place. However, in the maternity service, staff we spoke with told us they felt their ideas and suggestions were received favourably. No-one we spoke with felt their opinions were wasted.

**Learning, continuous improvement and innovation**

When we spoke with the leadership team and prior to the inspection, we were told about the following examples of learning, continuous improvement and innovation:

The midwifery led unit opened in April 2017. A band seven lead midwife was appointed to increase the access and choice for all low risk women. This linked into the recommendation in better births around developing a model of continuity of care. The lead for the midwifery led unit worked closely with members of the community midwifery team and HEY baby (parent education) to improve the home birth rates.

It was clear from speaking with staff that there were a number of aspirations for the service which were in progress. For example a re-design of the antenatal day unit. The idea was to make better use of the space on offer and deal more effectively with the demand for the service by creating more rooms with beds. The service was looking to re-configure the Labour Ward to allow them to take women triaged as red in the antenatal day unit directly into the Labour Ward. This responded to the safe care aspects of better births by ensuring rapid referral pathways to ensure women could access specialist care when needed.

Staff were working with women to reduce the number of elective caesarean sections. Creation of the birth after caesarean (BAC) offered women in their second or subsequent pregnancy following caesarean section two appointments during their pregnancy to debrief and discuss birth options with a senior midwife. Women would be seen earlier in their pregnancy to give the opportunity to debrief their previous birth and start discussions around birth options in the next pregnancy. A consultant led VBAC clinic had also been implemented.
Since January 2017 every baby born in Hull had a footprint taken which were made into a large scale piece of art for the hospital. The project ‘Born into a city of culture’ ended in January 2018 and there was a celebration reception in the city. Postcards of the project were being sold and the money raised was going back into the project, to improve facilities for women in the unit.

Following the successful implementation of the use of cervical ripening balloons, women were offered the choice of attending an induction of labour clinic in the outpatient setting. This had reduced the length of stay on the antenatal ward and the resulting reduced capacity had enabled the development of a transitional care facility and enhanced recovery area on the antenatal and postnatal wards.

One of the key objectives of Hull CCG’s maternity services strategy 2013-2018 was to ensure that antenatal education was available to all first time mums and their partners, and to those with subsequent pregnancies who require it. The service had recently taken over provision of this service, bringing it back in house from an external provider.

Since the removal of statutory supervision of midwives in April 2017, senior midwifery leaders worked towards implementing the A-EQUIP Model so that five former supervisors had undertaken the bridging programme at the University of Hull. Funding had been secured to facilitate midwifery staff to undertake the long programme in 2018.

Two senior leaders in the midwifery services supported health college students in the city to expose them to NHS environments and work that is undertaken in the trust. The overall aim was to develop potential student midwife recruits. Students were also invited to the parenting events and other birth preparation sessions.

Ten midwives had undertaken bespoke flu and pertussis vaccination in pregnancy training. This would support vaccinating women on an opportunistic basis in the hospital setting.

Midwifery staff had completed competencies to undertake intravenous antibiotic treatments for neonates to reduce and prevent unnecessary separation of baby and mum.

### Facts and data about this service

Hull Royal Infirmary (HRI) is the main hospital site for the Hull and East Yorkshire Hospitals NHS trust. Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the main HRI site. The trust also has several off-site locations delivering outpatient services. There are consultant, audiologist and nurse-led outpatient clinics across a range of specialities, which are provided from this location and in separate dedicated clinics around the hospital. These include:

- Neurology
- Rheumatology
- Nephrology
- Gastroenterology
- Infectious diseases
- Podiatry
- Colorectal
- Vascular
- Neurosurgery
- Upper gastro intestinal
- Urology
- Plastics trauma unit
Vascular (minor theatres)
Trauma and orthopaedics
Paediatrics
Neurology
Physiotherapy
Ear, nose and throat
Occupational therapy
Respiratory medicine
General medicine
Audiology
Ophthalmology
Antenatal
Gynaecology
Dermatology
Orthotics

Outpatient clinics are held from Monday to Friday from 8.30 am until 6pm with some late clinics until 8.30pm. Some Saturday appointments are provided, dependant on specialty.

The previous inspection in 2016 rated outpatients at Hull Royal Infirmary (HRI) as requires improvement: Actions required by the trust following that inspection were:

- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- The trust must ensure that planning and delivering care meets the national standards for the referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to eye services and longest waits.
- 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.

CQC current intelligence identifies:

- Referrals to treatment times are below target.
- 62 day cancer waits (both from GP referral and from urgent screening referral) are worse than average.
- In March 2017, the trust found a serious issue with large number of patients lost to follow up since the introduction of an electronic data base system in June 2015.

During this inspection, we visited the following areas:

- Eye hospital
- Trauma outpatients
- Surgical outpatients
- Plastics outpatients
- Medical outpatients
- Neurology

We also visited the appointments and referral centre.
We spoke with 39 members of staff in outpatients including managers, nurses, radiographers, medical staff and administration staff. We also spoke with 26 patients. We reviewed paper and electronic patient records in outpatients 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.

Between October 2016 and December 2017, the trust had 679,926 first and follow-up outpatient 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, Westbourne NHS Centre and Bransholme Health Centre.
Between October 2016 and December 2017, there were 403,610 attendances at HRI. The highest number of attendances at HRI was in ophthalmology, with 59,000 attendances during the last 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 (OP) services were provided in each of the four health groups.

Following our last inspection in 2016, Outpatient services are now managed within the family and women health group.

**Total number of appointments compared to England**
The trust had 679,926 first and follow-up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)
Number of appointments by site
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hull Royal Infirmary</td>
<td>403,610</td>
</tr>
<tr>
<td>Castle Hill Hospital</td>
<td>270,644</td>
</tr>
<tr>
<td>The East Riding Community Hospital</td>
<td>30,734</td>
</tr>
<tr>
<td>Bransholme Health Centre</td>
<td>3,980</td>
</tr>
<tr>
<td>This Trust</td>
<td>740,558</td>
</tr>
<tr>
<td>England</td>
<td>103,794,079</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Number of appointments by specialty
We received data from the trust, showing the number of patient episodes or appointments by specialty. The highest number related to ophthalmology with 59,000 episodes, followed by trauma and orthopaedics at 40,586 and then dermatology showing 16,570 and gynaecology 15,310 episodes.

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
The trust set a target of 85% for completion of mandatory training. Senior nursing staff were sent regular updates by the central teams to advise which staff required mandatory training. Staff we spoke with during our inspection told us they received mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in outpatients is shown in the table below;

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
</table>

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The overall completion rate for medical and dental staff at the trust was 78%. The trust met its completion rate target in two out of six mandatory training courses for medical and dental staff in outpatients. It should be noted that the information governance training has a higher target of 95%, so while completion was 86%, the trust did not meet this target. The lowest completion rate was observed for resuscitation training with 64%.

Staff we spoke with told us that they experienced difficulty getting access to a resuscitation course. These courses were booked up quickly. Senior managers acknowledged this issue and were arranging for additional courses to be added to the training schedule.

Mandatory training records were managed centrally, but we saw that a training spreadsheet had been designed by the nursing sister at the eye hospital to ensure training was kept up to date.

Staff we spoke with told us that spreadsheets sent by the central team were out of date. We saw this in four of the outpatient clinic areas we visited.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff in outpatients is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>64</td>
<td>68</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>61</td>
<td>68</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>60</td>
<td>68</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>49</td>
<td>58</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the trust was 89%. The trust met all completion rate targets for mandatory training of nursing and midwifery staff in outpatients, with
the exception of the resuscitation course, which had a completion rate of 72%.

The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.  
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

All staff we spoke with were able to describe their responsibilities regarding safeguarding concerns. They were able to give examples of the types of abuse, for example neglect, physical, domestic violence, sexual and psychological abuse. Staff gave us a specific example of a safeguarding concern that they raised, involving modern day slavery. Staff were clear how to escalate issues and felt they were well supported if they needed to discuss any concerns.

The trust employed a safeguarding lead and we saw that there were several safeguarding champions and supervisors across the department. These people were existing members of staff whom had been given additional responsibilities, specific to safeguarding and acted as a point of contact to support and signpost staff.

We saw that staff had access to safeguarding policies. This also included guidance for staff regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as 'procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons'.

Children attended the trauma and plastics clinic, within the main outpatient department. The numbers of children attending were significant. In October 2017, the plastics and trauma unit saw 116 children. We asked staff working in the clinic if they had completed safeguarding level three training. Only one member of staff told us that they had completed any safeguarding training specific to children. The Intercollegiate Document, third edition (March 2014) made recommendations regarding the level of training and responsibility of healthcare staff. The ‘safeguarding children and young people: roles and competences for health care staff recommendations includes all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns. Those staff with a mixed caseload (adults and children) should be able to demonstrate a minimum of level two and be working towards attainment of level three core knowledge, skill and competence’.

We requested data regarding the number of staff within outpatients who had completed level three children safeguard training. The trust provided data, which showed four staff trust wide, had completed level three within outpatients. The data did not identify which site these staff worked.

A breakdown of compliance for safeguarding level two courses from April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>52</td>
<td>58</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>49</td>
<td>58</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
outpatients, only one (safeguarding adults) met the target completion rate with 90% completion. While the trust did not meet the target for safeguarding children and young people training it had a rate of 84%, which is 1% lower than the target.

A breakdown of compliance for safeguarding level two courses from April 2017 to October 2017 for nursing and midwifery staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>62</td>
<td>68</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust exceeded the completion rate target for both safeguarding courses delivered. The data did not identify which site these staff worked.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene
All areas we visited were visibly clean and tidy.

We saw cleaning schedules were in place to ensure rooms were clean prior to the clinic start times. All the rooms in main outpatients had been cleaned on the day of the inspection. We checked the daily cleaning schedule in two clinic rooms and the theatre. All the schedules showed that the rooms had been cleaned daily across the last three months, with some exceptions for bank holidays and when the theatre was not in use.

In the areas we visited, all seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears and were wipe clean. The areas were free from clutter and there was sufficient space for patients and staff to move freely.

We saw that staff adhered to bare below the elbow protocols and observed staff following the appropriate handwashing procedures between patient contacts. We saw clinic staff participated in hand hygiene audits and hand hygiene practice was discussed within staff huddles.

We reviewed several cleanliness audits, which were completed across the various clinics. Areas audited were given a pass or fail and there were clear actions to be completed were there were areas for improvement.

Staff we spoke with told us that if a patient with an infectious disease was to attend clinic, they would allocate a room for the patient and prioritise them. Staff would use the required personal protective equipment and a deep clean would be carried out once the clinic had completed.

Environment and equipment
Staff we spoke with told us and we saw that there was a lack of natural light in some of the surgical outpatient treatment rooms, which was due to the age and design of the building. All of the rooms we saw were presented in a light and airy style.

Resuscitation equipment was available on trolleys at various locations in the main outpatient area and near other clinics. Daily checks were completed and tamper proof numbered tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed.
weekly. We examined the checklists of two trolleys and saw that appropriate stock was in place and was regularly updated.

The sister in the surgical outpatient’s clinic showed us improvements that had been made to the preparation room. This room had been noted in the previous inspection report as being ‘not ideal’ due to several outstanding maintenance issues. We saw that significant improvements had been made to finish the room to an acceptable standard.

Utility rooms were visibly tidy and equipment was stored appropriately. Four sharps bins were checked throughout the outpatient areas and all were appropriately labelled, signed; the contents were all below the fill lines. We saw that waste bins were available to enable waste to be segregated appropriately.

All staff we spoke with told us they had sufficient personal protection equipment (PPE) such as gloves and aprons.

We checked a range of items including, syringes and dressings. We found all items were within expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Medical equipment was serviced on site. Staff we spoke with told us that technicians were responsive and kept them up to date with any delay via email. We checked 10 pieces of equipment and saw that they were within service date and were electrical safety checked.

Assessing and responding to patient risk
The trust policy required the use of an adapted ‘World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections in outpatients. We reviewed five patient files and saw that checklists were not fully completed for four patients. This was in relation to the sign out procedures.

The trust told us that the WHO checklist had recently been relaunched, six weeks prior to the inspection, with a future plan to roll it out within outpatients. The trust audited compliance with the WHO checklist. Between January 2016 and March 2016, the audit found 100% compliance with the WHO checklist. The trust told us that although there was no audit evidence specific to outpatients at the time of inspection. It was planned that these audits will be rolled out as part of an on-going project.

People who became unwell during an outpatient visit were initially assessed by staff in the department and then taken to the emergency department (ED) if appropriate. Staff used the national early warning score (NEWS) to assess and monitor the patient. We saw scores were completed, for the five patient files we checked.

We saw sepsis posters on the walls of the department.

We asked staff if there was a policy or protocol to manage patients who did not attend their appointment. All staff we spoke with told us there was no formal process. Some staff told us they would ring the patient to check they were ok whilst other staff told us they would pass the patient file to the consultant to re-book another appointment.

Following the inspection, the trust submitted a copy of ‘Referral to treatment’ policy, which included protocols to manage patients who did not attend.

Staff within the trauma outpatient’s clinic told us that a traffic light system was used to prioritise patients waiting to be seen. Children and the elderly were given priority in accordance with trust guidance. The guidance was visible on the walls of the waiting areas.
Patients requiring mental health support would be referred to the safeguarding team in the first instance. Patients whom had previously accessed mental health services would also be given priority under the traffic light system.

Staff we spoke with told us the trust’s mental health liaison team were contactable through switchboard but there was no department mental health link nurse.

Children with mental health needs attending the trauma and plastics clinic were managed through a dedicated pathway.

Staff we spoke with told us they would sometimes get children who have self-harmed through the emergency department and the crisis team would often come with them to the outpatient department. Staff arranged follow up appointments through a social worker.

**Nurse staffing**

Outpatients did not have set staffing levels for daily clinics, we were told staff levels were ascertained by what clinic was on during that day, sickness levels and staff holidays. Staffing was flexible in the department to meet the clinic need. We were told staffing could feel short during clinic opening times.

The surgical outpatient sister was due to leave at the end of the inspection week, creating a band six vacancy within the clinic. We spoke with the band seven for the department, who told us that the band six from Castle Hill Hospital would provide cross-site cover. At the time of inspection, there were no rotas to outline how this support would be provided.

We reviewed the minutes of the Nursing and Midwifery Staffing Report dated December 2017 which showed the following fill rates for Hull Royal Infirmary.

![Graph showing fill rates](image)

The above chart shows that fill rates across the hospital as a whole, have improved significantly, when compared to the previous month.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust
reported a vacancy rate of 7% for nursing staff in outpatients.  
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Following the inspection, we received information about vacancies across outpatients as a whole:
- Plastic trauma clinics had one staff member leave out of a headcount of 10 staff.
- Women and children’s antenatal clinical and antenatal day unit HRI had three staff members leave out of a headcount of 25 staff. The trust told us they were currently reviewing the two band six vacancies.
- DME Day Hosp & O/P Wbourn had two staff members leave out of a headcount of four staff.
- Brocklehurst/Bilton NHS clinics had one staff members leave out of a headcount of nine staff.
- Fracture clinic at HRI had five staff members leave out of a headcount of 37 staff.
- Day Unit CHCC had five staff members leave out of a headcount of 55 staff.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 23% for nursing staff in outpatients. This was worse than the trust’s turnover target of 9%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 5% for nursing staff in outpatients. This was worse than the trust’s overall sickness target of 4%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

All senior staff we spoke with were aware of their vacancies at each clinic. Staff told us that shifts were covered internally and no agency staff were used. We reviewed the data sent by the trust, which showed no agency use within outpatients.

Following the inspection the trust submitted a mapping exercise. This information showed roles and responsibilities required by staff working within the clinics and would help to identify any staffing gaps within the service.

Patients we spoke with told us they thought there was enough staff in the areas visited.

**Medical staffing**

Medical staffing levels were ascertained by the individual specialities across the trust.

The previous inspection found issues with histopathology consultants. We requested the staffing levels during this inspection and the trust provided information showing that the planned whole time equivalent was 14 and there actual whole time equivalent was 11.4.

The trust reported actual whole time equivalent (WTE) and headcount staffing figures from March to October 2017 but these were not provided at core service level or site level.
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 13% for medical and dental staff in outpatients.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

As at November 2016 and October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 0.4% in outpatients. This was better than the trust’s overall sickness target of 4%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Records
Medical records were available electronically in the majority of clinics. This meant that patients were not seen without their medical records being available and enabled clinicians to share information appropriately between departments.

We reviewed five electronic patient records and eight paper records and found them to be comprehensive with access to investigation results. All the records had a diagnosis and management plan documented, showed evidence of discussion with the patient and family members where appropriate. All showed evidence of multidisciplinary team (MDT) input and all were dated and signed appropriately with the name and grade of clinician clearly shown.

Ladybird bookmarks were used to flag patients who have specific needs such as dementia or learning difficulties.

Staff working within the plastics clinic told us that a new patient records scanning process was now in place, for patients who have been discharged. This ensured that all information for discharged patients was collated electronically.

We saw within the vascular and plastics/trauma clinic, that records were placed in boxes outside one of the consulting rooms. Although staff were available in the clinic, there was a risk that records were left unsecure in between patient consultations.

This issue was also discussed within the minutes of the November 2017 outpatient governance meeting. The minutes state that records should be covered if they are in patient areas.

Medicines
Medicines were stored in locked cupboards and refrigerators. We checked a range of medicines and found them to be in date and stored appropriately. The keys to the medicines cupboards were held by the nurse in charge.

We saw that the fridge for the surgical and trauma / plastics outpatient clinic was in the theatre. Staff we spoke with told us that there was no other fridge available and would only access medicines within the fridge outside of theatre time.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in two clinic rooms and saw that daily checks had been completed between December 2017 and January 2018. We saw the temperatures were within acceptable limits.

Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard.

Electronic prescribing had recently been introduced within chemotherapy.

We saw a number of Patient Group directions (PGD) were used across a number of clinics, including ophthalmology, cancer services and bowel screening.

Incidents
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
The trust reported no incidents which took place from November 2016 to October 2017 and were classified as never events for outpatients.

Staff we spoke with told us that they were able to log onto the intranet and review never events across the trust and the learning because of these incidents.

In accordance with the serious incident framework 2015, the trust reported two serious incidents (SIs) in outpatients, which met the reporting criteria, set by NHS England and took place from November 2016 to October 2017.

Both incidents were treatment delays meeting SI criteria; one was at Castle Hill Hospital while the other was at Hull Royal Infirmary. One involved a child.

All incidents were investigated and managed in accordance with the trust incident management policy and were discussed at the clinical harm group.
(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

We asked staff within outpatients about the learning following serious incidents. Staff we spoke with told us there were no recent serious incidents within outpatients that they were aware of. However they were able to discuss another SI, which they understood as the last event and they were able to explain the measures that were now in place to mitigate against further incident.

Following inspection the trust told us that action had been taken and subsequent learning in regard to orthopaedics and device related pressure damage. A trust safety alert assessment tool for assessing patients at risk (red sticker) were used on care plans to alert nursing staff on wards and carers in the community that the patient is at risk.

A red band is placed around the cast/splint to alert nursing staff on wards and carers in the community that the patient is at risk and electronic learning was produced for trust staff caring for patients with casts or splints. The trust told us that training had been completed for casting and bandaging with consultants and theatre staff.

All staff we spoke with understood the incident reporting process and described how they would report an incident. Staff we spoke with told us that incidents were shared through emails and staff handovers. In addition, there was a daily staff huddle, where staff received feedback on incidents and learning was shared. We reviewed three sets of staff minutes from outpatient huddles and saw that incidents were regularly discussed with the team.

We asked staff if cancelled appointments were logged as incidents on the electronic recording system and some staff we spoke with told us that they were not recorded. We requested information from the trust following inspection and saw a data spreadsheet of cancelled appointments from April 2016 to February 2018 from the electronic incident system. We reviewed the data regarding cancelled appointments and saw that there were a number of reasons for the cancellations. Each cancellation was graded in relation to severity and the majority of which did not require grading and were shown as green on the log. A number of incidents were graded as minor. These included cancellations due to mechanical breakdown of equipment, lack of staff, and essential results not ready for appointment.

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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff that we spoke with were aware of the need to be open and honest when something went wrong.
Safety thermometer
The trust was not required to complete the safety thermometer for outpatients.

The head of outpatients told us that all outpatient staff had access to an outpatient dashboard. Not all staff we spoke with knew this.

Following the inspection, we reviewed the outpatient dashboard and saw that it provided clear information such as numbers of patients that did not attend incidents and appointment numbers.

Is the service effective?

Evidence-based care and treatment
Staff used evidence based practice guidelines in the clinics we visited. Trust policies we reviewed were up to date and had review dates.

Policies were reviewed against The National Institute for Health and Care Excellence (NICE) Guidance and the responsibility to audit against and ensure these were kept up to date remained with each health group.

Clinical leads from each directorate ensured services provided were reflective of current best practice and national guidance.

All staff had access to the intranet, which provided guidance, and links to all policies.

We were told that when the outpatient fundamental standards were to be implemented in outpatients, this would enable the service to implement audits for monitoring. We were not provided with any timescales for this.

Nutrition and hydration
We saw water dispensers were available for patients use in the outpatients departments. Staff we spoke with told us that additional dispensers had recently been added across the department.

The main restaurant facilities were close to the main outpatient department where patients and visitors could purchase refreshments.

Pain relief
Staff assessed and managed patient pain levels appropriately.

We observed nursing staff within the eye hospital, asking a patient about their pain levels following a minor procedure.

We spoke with three patients regarding pain management within outpatients who told us staff administered pain relief when they required it.

Patient outcomes
We saw there were several audits carried out within the individual health groups. For example within ophthalmology, there were endophthalmitis, corneal ulcers and cataract audits. Following the cataract audits, intra ocular calculations were completed for patients, which led to an increase in virtual work. This led to the service receiving an award for the outstanding work in this field.

Within outpatients the trust had also completed baseline audits on room occupancy rates in March and September 2017 and clinic referrals to ECG in 2017. Trust wide we saw consent was regularly audited alongside record keeping specific to patient files.

Follow-up to new rate
From October 2016 to September 2017:
The follow-up to new rate for Bransholme Health Centre was much better than the England average, fluctuating between slightly under five and around seven.

The follow-up to new rate for Hull Royal Infirmary was slightly worse than the England average, maintaining a steady rate of just under two.

(Source: Hospital Episode Statistics)

Competent staff
Training was managed centrally and senior staff from each health group had oversight of the training needs of staff within the individual teams.

Staff we spoke with in surgical outpatients told us that some staff were not trained in trauma and plastics and staff required support when covering these clinics. At the time of the CQC inspection the service was working through the HR processes of merging the plastics trauma and surgical outpatients departments. Training had commenced and the trust told us no staff were treating patients they were not competent to treat. A series of shadowing had also commenced.

Senior nursing staff told us that nurses rotated between Castle Hill Hospital and trauma at Hull Royal Infirmary to enhance staff skills and learning in relation to responsive trauma.

A staff mapping exercise identified that not all health care assistants were venepuncture trained. Following this exercise, all staff were allocated training dates for a course that consisted of online training and a practical assessment. This online training course has been developed with an intention of supporting healthcare assistants in the development of their clinical skills. The exercise also highlighted that vascular training for the band five nurses had not been undertaken. Again all staff had since been allocated a training course date.

We saw some workshops had been arranged for staff working within vascular clinics, to provide additional training and support for managing conditions such as leg ulcers. We saw that these staff completed a vascular training workbook and matrons provided guidance at a senior level on all aspects of clinical care.

The head of outpatients provided a statement to us to advise that senior nurses were asked to complete an exercise in which they outlined the key tasks undertaken by health care assistants through to senior nurses. This was competed by all services with support of the practice development nurse and the deputy chief nursing officer. This exercise would help to identify any skill gaps within the workforce.

Staff we spoke with working within the trauma clinic told us that paediatric nurses were available to support staff during busy clinics and all staff had received paediatric advanced warning score (PAWS) training. This enabled staff to identify vulnerable children and escalate appropriately.

Staff working in these clinics completed paediatric resuscitation training one year and adult resuscitation the next, to maintain their clinical practice.

Staff we spoke with working in reception told us that the environment can become busy and they found it could be difficult managing cancelled appointments. They told us patients could become unhappy. Reception staff we spoke with told us they had not been provided with training to support patients in this way.

Following the tracking issue resulting in patients lost to follow up, the trust told us that administration staff were provided with additional training in relation to the use of the electronic patient database.

From April 2017 to October 2017, 78% of staff within outpatients at the trust had received an appraisal. Seventy nine percent of nursing and midwifery staff received an appraisal, which was
worse than the trust, target of 85%.

A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and MidwiferyRegistered</td>
<td>53</td>
<td>67</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>61</td>
<td>78</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Prof Scientific and Technical</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Most staff we asked told us they were up to date with their appraisals or had a date booked to complete it. Overall staff said that they found appraisals were meaningful and identified learning opportunities. All members of staff confirmed that they had regular one to one meetings with their line manager, where they could discuss their role and raise any concerns.

**Multidisciplinary working**

Staff we spoke with told us that they had regular contact with the matron and senior staff within their own health groups.

Each health group held multidisciplinary team (MDT) meetings across all the specialties to provide effective assessment and treatment.

Clinical specialist nurses worked in clinics, including respiratory, colorectal and plastics. These staff worked closely with consultants and specialist support services to improve patient care around specific conditions.

There was a dedicated eye hospital in which two social workers were based. These staff had specific roles supporting patients within the eye hospital.

The head of outpatients was highly regarded and all staff we spoke with felt that work had been done, to reduce the barriers between the health groups and improve communication with each other.

Whilst it was clear that staff saw this as progress, we were not assured that there were robust systems in place to ensure outpatient’s staff as a whole worked collaboratively. All staff agreed that it was work in progress.

**Seven-day services**

Outpatient clinics are held Monday to Friday from 8.30am until 6pm with some late clinics until 8.30pm. Saturday clinics were provided depending on speciality. This was done to attempt to reduce the number of patients on waiting lists.

Plastics trauma and orthopaedic trauma offered a seven day service.
Health promotion
There was a range of information leaflets, literature and posters for patients to read about health promotion, which was specific to their condition. For example, advice about smoking cessation provided by a stop smoking advisor within the respiratory clinic, exercise and the healthy heart.

There was also information on mental health and wellbeing, and substance misuse.

Staff we spoke with told us carers support groups such as the myeloma and lymphoma groups, survivors groups and sun awareness events within plastics were also held.

We saw the trust highlighted various national awareness days.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff we spoke with in outpatients and radiology understood the relevant consent and decision-making requirements of legislation and guidance.

We observed staff requesting consent both verbally and in writing, prior to care and treatment.

The trust reported that from April to October 2017, Mental Capacity Act (MCA) training had been completed by 91% of medical and dental staff within outpatients and 96% of nursing and midwifery staff. This was better than the trust target of 85%.

During the same period, Deprivation of Liberty Safeguards (DoLS) training had been completed by 86% of medical and dental staff within outpatients, as well as 96% of nursing and midwifery staff. This was better than the trust target of 85%.

A breakdown for MCA and DoLS training from April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>53</td>
<td>58</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>50</td>
<td>58</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown for MCA and DoLS courses from April to October 2017 for nursing and midwifery staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Two members of staff described how they would support a
patient who lacked the mental capacity to make a decision about their care.

Staff demonstrated an understanding of best interest decision making and knew how to seek advice when patients were not able to give valid informed consent due to a lack of mental capacity.

Is the service caring?

Compassionate care
We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required.

Administrative staff greeted patients on arrival to main outpatients. Staff were friendly and helpful and would go out of their way to offer assistance.

We spoke with 26 patients. Overall, the feedback was positive and staff were described as being caring and considerate. Patients we spoke with told us they felt supported and treated with dignity and respect.

We saw within the trust wide 2017 patient led assessment of the care environment survey (PLACE) that 79% of patients felt they were provided with privacy, dignity and wellbeing. This was worse than the national average, which was 84%.

Patient-led assessments of the Care Environment (PLACE)

(Source: NHS Digital – PLACE)

Emotional support
Clinical nurse specialists provided additional support and in depth knowledge to patients with a range of conditions and disease specific information. Staff provided leaflets to support this at appointments.

We saw information about the availability of chaperones in the main outpatient waiting room. Staff we spoke with told us that they were able to provide a chaperone when it was required and there were male members of staff available when requested.

Patients we spoke with told us they were involved in the planning of their care.

Understanding and involvement of patients and those close to them

We observed staff interacting with patients and relatives in clinic and imparting information in a way that was appropriate for the patient’s understanding. One patient told us ‘they explain everything to me and take their time’.
Patients received a copy of the letter sent to their GP following consultations. This ensured that patients were kept up to date with all decisions made about their care.

Staff directed patients to appropriate support agencies and self-help groups.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The hospital site was accessible by public transport and provided several car parking areas across the site with various drop off points around the hospital to assist patients who had difficulty with mobility. Some patients told us that at times finding a parking space was difficult. One patient told us that they always arrived early for their appointment to ensure that they had enough time to find somewhere to park.

The main outpatient department was located on the first floor of the tower block building. We saw there were adequate lifts to access the various outpatient clinics and all outpatient clinics were clearly signposted.

The surgical outpatient sister told us that automatic door opening mechanisms had recently been added to assist wheelchair users entering the main outpatient areas.

Most patients told us that they found it easy to find their way around the hospital.

Patient advice information was available both in leaflets and on posters on the walls in all areas we visited.

We saw within the plastics / trauma patient waiting area, posters advising of a prioritising traffic light system that outpatients followed. This enabled children and the elderly to be seen before other patients waiting.

Seating space which was shared between plastics, trauma and surgery was quite compact and staff told us that the area became busy quite quickly. All patients we spoke with told us that they were able to find a seat.

Outpatient clinics were managed by the speciality providing the clinics in outpatients. Several specialities provided rapid access clinics, such as physiotherapy.

Outpatient clinics we visited had waiting areas and toilets were available. We saw there were separate toilets for children visiting the plastics and trauma clinic.

Appointment bookings were made, either at the reception of the outpatient departments if the appointment was required within six weeks or at the central booking centre at Hull Royal Hospital.

Most clinics ran Monday to Friday during the day; however, some specialties offered evening clinics to reduce backlogs.

**Meeting people’s individual needs**

We saw within the trauma and plastics outpatients clinics that those patients deemed to have a specific need such as mobility difficulties were allocated a ladybird marker within the patient file.

This then alerted staff that there was a specific issue. This practice was not consistent applied throughout all of the outpatient clinics we visited. For example, the eye hospital told us that they did not use this system as they had been advised it was only used for inpatients.
There was signage around the hospital to assist patients living with dementia and trust had a number of dementia champions across the trust who had received specific training around dementia care.

We saw a number of leaflets available in the different clinics we visited for patients.

The trust had learning disability nurses that could offer support if required to patients with a learning disability when attending an outpatient appointment.

There was a translation service available for patients whose first language was not English and staff we spoke with told us that this was used regularly and was a very good service.

Wheelchairs were available near the outpatient departments for those with additional mobility needs. The trust told us there were a number of volunteers across several of the outpatient clinics offering three and four hour sessions of general support for patients.

**Access and flow**

The previous inspection found issues with waiting times for patients and referral to treatment indicators not always being met. During this inspection, we found that referral to treatment indicators were still not always met.

We also found that there were appointment backlogs and waiting lists in the majority of outpatient services. During this inspection, we saw there were still appointment backlogs and waiting lists in a number of outpatient services. Each speciality area held responsibility for their own waiting lists.

Senior managers from each health group were clearly able to define where there were waiting lists and the processes they had in place to reduce the backlogs. We saw that these backlogs were included within the risk registers for the specific health groups.

Each health group had developed action plans to specifically reduce their waiting lists. Following inspection, the trust submitted data to show the waiting times for the different outpatient clinics across the trust.

We reviewed the data and saw that the largest clinic waiting lists were within the following clinics:

<table>
<thead>
<tr>
<th>Speciality Area</th>
<th>Waiting List</th>
<th>Follow Up Backlog</th>
<th>Follow Up Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First Appointment</td>
<td>Overdue</td>
<td>Not Overdue</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4364</td>
<td>7011</td>
<td>17390</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1413</td>
<td>2793</td>
<td>4965</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2144</td>
<td>1196</td>
<td>2954</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>1507</td>
<td>1845</td>
<td>7296</td>
</tr>
<tr>
<td>Neurology</td>
<td>1353</td>
<td>4093</td>
<td>10236</td>
</tr>
</tbody>
</table>

The data summary showed that there were 33582 patients waiting for a first appointment across all health groups and 193,046 patients waiting for follow up appointments without outpatients as a whole.

In March 2017, the trust found there had been an issue trust wide with follow up of patients not being followed up. The trust had identified three patient harms from this in urology at the Castle Hill site. This was due to a tracking issue within the electronic database system.

The trust took steps to investigative and work was undertaken to identify and confirm just how wide spread the situation might be, and following the additional administrative and clinical reviews (which took place in July and October 2017) it was agreed that a much wider investigation process was required in terms of reviewing all patients going back to June 2015.
From July through to January 2018 the administrative review continued and a clinical review of all patients affected also commenced.

This review was supported by an external organisation who acted as a critical reviewer, Clinical Commissioning Groups and National Health Service Improvement and updates were regularly shared with National Health Service Improvement (NHSI).

The trust identified that the overall number of patients who required clinical review, follow up, diagnostic test and in some cases inpatient/day case treatment identified and managed to date was 2190, at the time of inspection. The trust told us there is potential for a further 7900 patients who will also require clinical review from the 54,000 patient group.

The clinical validation of patients is due to be completed by March 2018. The trust told us that they anticipated they would meet this deadline.

The Chief Operating Officer told us, to date figures up to the 12th March, were that 4632 clinical reviews have been completed. There were approximately 20% clinical reviews left to do by end of March.

We saw an action plan and flow chart had been developed by the trust with an overall completion date of the 31st March, 2018.

A task and finish group meet weekly to oversee this work.

Outpatients categorised waits in clinic as running late if patients had waited 30 minutes or more for their appointment once arriving in clinic. Clinics highlighted the wait time on the information board in waiting rooms when clinics were running over 30 minutes. The service did not audit the clinics waiting times.

Clinical teams had been running extra outpatient clinics to enable them to treat more patients. For example, weekend clinics were held within ophthalmology and Tuesday and Wednesday evening clinics within plastics.

Patients visiting the trauma clinic were booked directly by consultants and were advised to attend the following morning. A seven day service provision was in place. Some patients would be sent directly to the clinic on the same day and staff told us that the environment was busy but manageable.

Outpatients had considered how often rooms were used and had attempted to match empty rooms with additional activity if they could. An audit was undertaken in March and September 2017 with the outpatient service and the trust’s estates team with support from a local university. From the audit results clinic rooms had been reassigned for use by new consultants and to meet the needs of the service. Appointments were generally sent out by the central booking centre and patients could contact the trust to rearrange if required.

Staff at the eye hospital told us that a walk in facility was provided for patients requiring emergency treatment and there was a specific clinic to support children with learning disabilities.

Booking staff told us that they were not aware if the time patients waited for their appointment was monitored by the trust.

From October 2016 to September 2017,

- The ‘did not attend’ rate for Hull Royal Infirmary, Bransholme Health Centre and The East Riding Community Hospital was higher than the England average. Hull maintained a fairly steady rate of just over 9%. Bransholme Health Centre and The East Riding Community Hospital had fluctuating rates with Bransholme Health Centre ranging between around 7%
and 13% and The East Riding Community Hospital ranging between around 7% and 9%.
(Source: Hospital Episode Statistics)

The trust used text reminders and had produced a poster showing the effect of ‘did not attend’ (DNA) patients on the services to assist in addressing DNA rates across the trust. The hospital improvement team were working with services on what was the cause of patients who ‘did not attend’. Senior staff we spoke with told us they had changed some clinic times to the evening to accommodate patients who could only attend in the evening.

We saw that the trust had developed a ‘referral to treatment access policy’. This included the process for managing patients who did not attend. Patients who missed a first appointment were offered a second appointment. Those patients who missed the second appointment would be referred back to the original point of referral.

The provider dashboard for outpatients showed that provider cancellations in January 2018 was 14%. The dashboard for outpatients for December 2017 showed that 30% of clinics were cancelled clinics under 6 weeks’ notice and in January 2018, 33.3% of clinics were cancelled clinics under 6 weeks’ notice. Before this inspection, some outpatient clinics had been cancelled due to winter pressures.

Reception staff told us that patients affected by cancelled appointments would be managed through the appropriate speciality pathway.

Staff at the eye hospital told us that medical staff were required to provide eight week’s notice of leave, in order to prevent cancelled clinics.

Two nursing sisters we spoke with told us told us that staff worked proactively to reduce the waiting list numbers, providing evening and weekend clinic flexibility where there were back logs.

The trust told us that follow up back logs are reviewed weekly

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways had been worse than the England overall performance. The latest figures for October 2017 showed 85% of this group of patients were treated within 18 weeks. This was worse than the England average of 89%.

**Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Hull and East Yorkshire Hospitals NHS Trust.**

(Source: NHS England)

The trust provided an RTT improvement plan for December 2017. This highlighted the plan to improve the approaches to manage RTT in the trust. The plan included the required timeframe for completion of actions. This varied between actions, some were not yet past the timeframe required for completion, some had been completed and three out of the 90 actions were overdue for completion.
Some clinical staff and service managers attended a referral to treatment (RTT) meeting once a week, for example within ophthalmology.

In addition, the trust had developed an assurance processes to ensure the management of RTT was maintained. This included a performance framework and weekly meetings within the specific health groups.

**Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty**

Five specialties were better the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>90%</td>
<td>82%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Fourteen specialties were worse than the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>93%</td>
<td>96%</td>
</tr>
<tr>
<td>Other</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Urology</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>84%</td>
<td>91%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>82%</td>
<td>89%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>ENT</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>77%</td>
<td>89%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>71%</td>
<td>88%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>58%</td>
<td>91%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – incomplete pathways**

From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways had been worse than the England overall performance. Trust percentages had fluctuated between 84% and 87%, while the England average maintained a steady rate of 89% to 90%.
For the most recent month (October 2017), the trust performance was 87% compared to the England average of 90%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Hull and East Yorkshire Hospitals NHS Trust.

Referral to treatment (percentage within 18 weeks) incomplete pathways – by speciality
Three specialties were better than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>99%</td>
<td>94%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>87%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Cancer waiting times – percentage of people seen by a specialist within two weeks of an urgent GP referral (all cancers)
The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. In the final three quarters, they were also performing better than the England average. The performance over time is shown in the graph below.

Cancer waiting times – percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers)
The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). As the graph below shows, the trust performed better than the England average in the earlier quarters.
however performance declined in the final quarters.

![Graph showing cancer waiting times](image)

(Source: NHS England – Cancer Waits)

**Cancer waiting times – percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

The trust was performing worse than both the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Hull and East Yorkshire Hospitals NHS Trust

![Graph showing percentage of people waiting less than 62 days](image)

(Source: NHS England – Cancer Waits)

**Learning from complaints and concerns**

**Summary of complaints**

From November 2016 to November 2017, there were 123 complaints about outpatients in the trust. The trust took an average of 33 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be completed within 40 days. As of November 2017, there were 25 complaints still open and yet to be completed.

- Hull Royal Infirmary: there were 63 complaints, which took an average of 35 days to investigate and close. Eleven complaints remained open at the time of the trust’s provider information request submission. Themes included: misdiagnosis, poor communication, and delays in treatment.
- The East Riding Community Hospital: There were two complaints, which took an average of 28 days to investigate and close. One complaint concerned poor attitude of consultant, while the other concerns suspected misdiagnosis.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Staff we spoke with told us that they would signpost patients to the patient advice and liaison service if they required further information about complaints. We saw information was available in all the areas we visited advising patients how to make complaints.
All the patients we asked told us they knew how to raise a concern or complaint.

Staff we spoke with told us that complaints were shared within their specific health groups but there was no evidence to support sharing of complaints across outpatient services.

We reviewed three complaints specific to outpatients and saw that they were all managed within 40 days. Where there were delays, patients were advised of this accordingly.

**Is the service well-led?**

**Leadership**  
A head of outpatients had been appointed in August 2016. We had concerns about the leadership capacity in the service due to the size and scope of the service and the amount of change that had taken place and was still to do. The head of outpatients was supported by the specific health group senior managers who had direct oversight of each outpatient clinic within their health group.

All staff we spoke with felt that the outpatient service was now ‘coming together’ and there were channels in which to communicate with each other.

All staff we spoke with knew who leaders of the service were and felt they were visible and supportive.

**Vision and strategy**  
At the time of inspection, the strategy for outpatient services was in draft. We saw goals for outpatients were included within the overarching trust strategy. The overall trust vision was ‘great staff, great care, great future’. In order to achieve this the trust developed seven specific areas in which goals were set.

These were:
- Honest, caring and accountable culture
- Valued, skilled and sufficient workforce
- High quality care
- Great local services
- Great specialist services
- Partnership and integrated services
- Financial sustainability

We saw within the trust strategy 2018 update that one specific goal set under high quality care was to reduce outpatient appointments cancelled by the trust and related complaints. The trust stated that further improvement in this area was required.

We also saw another goal specific to outpatients, which was under great local services. The trust goal was to be within the top 20% in the outpatient survey.

The services had plans to implement the outpatient fundamental standards across outpatient services.

We reviewed a five year business plan for ophthalmology.

**Culture**  
All staff we spoke with were very proud of their service and described a friendly, family like atmosphere and good interpersonal relationships.
Staff we spoke with told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. Staff we spoke with told us that local managers and sisters all worked in clinic when staffing shortages required and that the whole team pulled together to provide the best care to patients possible.

Staff we spoke with felt able to raise concerns and challenge where necessary.

**Governance**
The previous inspection found issues with governance and a lack of cohesive oversight of governance across outpatients.

There had been a newly formed governance committee for outpatients since the previous inspection. Senior managers told us that governance was discussed in the individual specialities across the trust.

We reviewed the minutes from the November 2017 and February 2018 Outpatient Governance Committee meetings and saw that key areas of discussion were included within the agenda. These included risk, complaints, staffing skills and trust wide updates.

These governance meetings were well represented by senior clinical staff across all health groups.

Each health group held specific responsibility for their own governance arrangements. We saw that matrons used a handbook, which was an audit tool covering key areas such as nutrition, medicines management, infection control and tissue viability.

Staff within outpatients had a matron who was aligned to a specific health group. We reviewed minutes from staff huddles, which showed that each health group discussed key issues such as incidents, staffing, training and medicines management.

We were not assured that a system had been developed to bring all of the health groups together collaboratively across outpatients. The head of outpatients told us and we saw that governance processes within health groups were robust but outcomes were not shared collaboratively.

Several pieces of work had been undertaken by the head of outpatients including the staff mapping exercise across surgical and neurosurgery outpatients. This was completed by department nursing sisters.

**Management of risk, issues and performance**
Staff we spoke with told us that any areas of concern were shared through staff emails and meetings. We reviewed the minutes following two outpatient governance committee meetings and saw that serious incidents, escalation of concern and performance delivery was discussed.

During the last inspection in 2016, it was noted by inspectors that there was no risk register for outpatients. Risk registers were in place for each health group and processes were in place to discuss and share the content across the outpatients service. However, at the time of the inspection the trust was implementing improvements to this.

We asked senior managers about the main risks to the services and were told follow up appointments, for example, cardiology and ophthalmology and the environment were the main risks to the services. Outpatients did not have a risk register but we saw these risks were identified within the specific health group risk registers.

We reviewed the trust risk register and saw that there was a risk specific to Ophthalmology. This was added to the register in November 2013 and shows a high risk of patients delayed resulting in loss of eyesight due to lack of capacity for follow up. This risk was reviewed in January 2018.
A quality, innovation, productivity and innovation (QIPP) commissioning programme had been implemented for the financial year 2016 – 2017. The QIPP model identifies productivity challenges in terms of finance, activity and workforce. The model had been used to attempt to reduce the number of ophthalmology patients being seen in the hospital, with increased shared care in the community.

Following the trust wide issue in July 2017 and the loss of patient follow up, the trust set up a process of clinical validation to ensure patients had not suffered harm because of the lost follow up appointments. We saw a flow chart had been developed to ensure all patients affected were reviewed and a patient summary sheet to ensure progress with the validation process. The trust told us that there were 10,000 files still to be reviewed at the time of inspection, but no harm had been identified, in addition to the three patients identified at the Castle Hill Hospital site. The trust told us that all patient files would be reviewed by March 2018.

The trust had a clinical harm review group. All incidents across the trust were reviewed with the specific health groups; however there were no systems in place at the time of inspection to share incidents collectively across the outpatients service as a whole.

**Information management**

Staff had access to the required systems across outpatients. Information was available on the trust intranet and staff received information from team briefs for example.

Staff were positive about the electronic patient record system. They felt the system was effective and easy to access, which improved the quality of care for patients.

- We saw that there was a specific outpatient dashboard in which staff could access key information. The outpatient dashboard was not utilised by all outpatient staff, however we saw several tools which were available to review and monitor outpatient performance. These included; Outpatient Improvement Programme monitoring
  - P and A meeting action tracker
  - Outpatient performance reports from BI
  - Data Quality meeting action tracker
  - Outpatient Fundamental Standard Overview

The trust told us there had been no recent data breaches.

**Engagement**

Managers engaged with staff at regular team meetings in all the areas that we visited. Meeting minutes showed discussion of incidents, complaints and staffing arrangements.

Trust team briefs were sent to staff monthly and we saw within the eye hospital that positive feedback from the friends and family survey were emailed to staff specifically, to acknowledge the positive feedback.

We saw within the outpatient governance committee meeting minutes that patient representation was also included to ensure patient views were included.

We saw that the last outpatient survey was in 2011.

**Learning, continuous improvement and innovation**

Two social workers were based at the eye hospital and worked with patients to resolve issues relating to housing, access to benefits and offered support and guidance to resources that were available to assist patients.
The trust told us that virtual clinics were in process of being established in orthopaedics. Care plans for wounds, splints and casts were being designed as capture data forms, which would be stored in note less clinics.

We saw within governance meeting minutes that further work had been undertaken to understand the outpatient nurses role and improve patient's experience. For example, gynaecology patients now have tests conducted in gynaecology outpatients department, rather than having to cross to another building.

A leg ulcer staff training package had been developed to provide advanced skills in leg ulcer assessments in response to the skills gap identified within the staff mapping exercise.

A trial of a pre operation training package for healthcare assistants to take swabs was introduced to maximise staff skills and in addition, a trial again for healthcare assistants had been completed, to enable them to undertake simple dressing in various outpatients departments.

Work was also underway to improve the environments in outpatients including toys for children with learning disabilities in orthopaedics.

A paper light system was in place within chemotherapy, which reduced the number of written records for patients within this department.

Two research nurses were employed within the eye hospital and were involved in several trials across ophthalmology.

The service had plans to implement the quality boards, to ensure quality systems were consistently reviewed; however, these were not in use during our inspection.

The eye hospital was given an ophthalmology award in 2017, for the introduction of the virtual reviewing service for patients with glaucoma. These awards celebrate outstanding work within ophthalmology practice.

## Castle Hill Hospital

### Acute services

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

### Facts and data about this service

The medical care service at Hull and East Yorkshire Hospitals NHS Trust provides care and treatment for cardiology, clinical haematology, clinical oncology (previously radiotherapy), general medicine, geriatric medicine, nephrology, rehabilitation, respiratory medicine, and stroke medicine.

Medical services at Castle Hill Hospital included specialities such as infectious diseases (20, moving to ward 7) cardiology (C26, C28), cardiac catheter laboratory plus five day cardiology unit, cardiac monitoring unit (CMU), clinical haematology (C33), clinical oncology (C30, C31, and C32) and rehabilitation (C29).

A site breakdown can be found below:

- Castle Hill Hospital: 163 beds are located within nine wards

(Source: Routine Provider Information Request - Acute-Sites)
The trust had 68,478 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 32,209 (47%), 3,030 (4%) were elective, and the remaining 33,239 (49%) were day case.

Admissions for the top three medical specialties were:
- General medicine: 19,227 admissions, up 2% compared to previous year
- Gastroenterology: 11,708 admissions, up 6% compared to previous year
- Medical oncology: 6,837 admissions, up 11% compared to previous year
(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
Mandatory training was provided on a monthly basis. Ward managers would receive a monthly training matrix that advised which staff had completed and required training. Staff were encouraged to complete training, however due to some pressures on the wards training would sometimes need to be cancelled. There was a variance between wards if staff received time back for completing in their own time. Staff could also look at the online system to see when their training was due. One senior sister told us that staff could not progress through the next gateway for their appraisal if they were not up to date with their training.

The trust set a target of 85% for completion of mandatory training apart from information governance which has a target of 95% for completion.

A breakdown of compliance for mandatory courses from April to October 2017 for medical and dental staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>246</td>
<td>267</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>243</td>
<td>267</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>227</td>
<td>267</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>202</td>
<td>267</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>200</td>
<td>267</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>195</td>
<td>267</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at the hospital was 82%. The health and safety, and infection control modules met the trust completion target.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>554</td>
<td>579</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>550</td>
<td>579</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>521</td>
<td>579</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>520</td>
<td>579</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>495</td>
<td>579</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>408</td>
<td>579</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the hospital was 88%. The information governance and resuscitation modules were the only mandatory training not to meet the trust completion target.

Only 70% of nursing and midwifery staff had completed the resuscitation module with only 76% medical and dental staff completing this module.

The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

New staff on the wards told us that they received corporate induction training and mandatory training was part of this. Newly qualified staff that had commenced posts recently had training days where they would attend the required courses. Staff told us that they had completed sepsis awareness training and were aware of the pathway and policy.

**Safeguarding**

Annual reports were completed by the trust for safeguarding children and adults. The amount of referrals and type of abuse were documented; the medicine health group completed the highest amount of referrals. Information submitted by the trust showed that 228 adult safeguarding referrals had completed from November 2016 to October 2017.

Safeguarding policies were in place and staff knew how to access them. The policy detailed the different types of abuse and which issues staff should report. We spoke with staff who told us how to make referrals and discussed circumstances where safeguarding issues were raised.

Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the medical wards.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for medical and dental staff in medicine is shown below:
The overall completion rate for safeguarding training modules by medical and dental staff at the hospital was 87%. The training target was met for the safeguarding adults module and was almost met for the safeguarding children and young people module.

A breakdown of compliance for safeguarding courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>239</td>
<td>267</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>223</td>
<td>267</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for safeguarding training modules by nursing and midwifery staff at the hospital was 90%. The trust target was met for all applicable modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There were safeguarding adult specialist nurses based at the hospital who supported the assistant chief nurse to manage the governance for safeguarding. Safeguarding issues were discussed weekly with the chief nurse with open access to the chief executive.

Safeguarding audits were completed on each ward as part of the trust’s fundamental standards. Information provided by the trust showed that all the medical wards received a score of 97% or above. Four ward areas received a rating of 100%.

**Cleanliness, infection control and hygiene**

All staff completed infection prevention and control training as part of their mandatory training requirements. Information provided by the trust showed that compliance with this training in the medicine health group was 91% for medical staff and 96% for nursing staff in 2017. This was higher than the trust standard of 85%.

Areas we visited had suitable hand washing facilities and wall mounted hand gels. We saw staff washing their hands and using the hand gel. We observed staff to have arms bare below the elbows and using personal protective equipment, such as gloves and aprons, when required. On ward 26, there was a recorded reminder to people to wash their hands as they entered the ward.

All wards we visited had some single rooms that enabled patients to be isolated if necessary. We saw that doors were closed and signs placed on the door to inform staff and visitors that infection control precautions were necessary.
The areas we visited were visibly clean and tidy. Equipment had ‘I am clean’ stickers in place to indicate that cleaning had taken place and we saw staff cleaning equipment after use.

Ward cleaning standard, hand washing audit results and the number of *Clostridium Difficile* (*C. difficile*) and MRSA cases there had been in the previous month were all displayed. None of the wards we visited had any cases of *C. difficile* or MRSA in the past month. Handwashing audit results ranged from 96% to 100% and ward cleaning standards ranged from 97.5% to 99.1%.

We observed that separation of clinical and non-clinical waste was in line with trust policy in ward areas and linen was stored appropriately in the areas we visited.

**Environment and equipment**
The Queen’s Centre at Castle Hill Hospital contained the oncology and haematology wards, along with the rehabilitation ward. Ward 20 remained in an old block building surrounded by empty ward areas. The senior management team told us there was a plan in place to move ward 20 to ward 7 at Castle Hill Hospital in April 2018.

All areas we visited were clean, tidy and well organised. The wards were bright with spacious bed areas and were well maintained.

We checked different types of equipment such as infusion pumps, blood pressure monitoring equipment, and electrocardiograms (ECG). All these were in good working order and had been safety tested and checked according to manufacturer’s recommendations.

Staff told us they had access to equipment when they needed it. They had no problems obtaining pressure-relieving equipment, such as mattresses. Resuscitation equipment was available in every area; the trolleys were sealed with a tag. We saw records to indicate that daily checks had been made.

**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 have required a higher level of care. The policy provided guidance as to when to escalate the score, for example a NEWS score between one and four needed to be escalated to the nurse in charge and a decision made of the escalation. A score between five and six required a review from the medical team within 30 minutes. A score above seven required a review from the medical team within 15 minutes.

On the medical wards at Castle Hill Hospital, electronic observations were in use. This enabled staff to record observations on a hand held device, which would calculate the NEWS score. This sent an alert to the nurse in charge and clinician when the NEWS score was escalated and alerted nursing staff when the next set of observations were due. We reviewed eight patient records and looked at the NEWS scores. All records contained accurate NEWS scores, which identified escalation when required.

The cardiac catheter laboratory provided day cases five days a week. We saw that the appropriate checks were completed prior to undertaking the investigation.

Since our last inspection in June 2016, a new form for triage of the PCI had been developed and implemented. The co-ordinator would answer the phone and review the ECGs sent by the ambulance service to identify if the patient was to be sent to the cardiology department. A pre-alert call was taken during our inspection, the registered nurse completed an appropriate assessment and the triage form was completed. We observed the patient arrive at the department and escorted into the catheter laboratory. The doctor arrived and explained the procedure to the patient.
An enhanced care team had been piloted for around four months, which allowed patients with enhanced dementia training to provide one to one care to patients. Previously when patients had required one to one assistance it had been provided by security staff who may not have engaged with the patient. By providing staff that had specialist knowledge of the patient’s condition it allowed them to understand the patient’s situation. We were told from staff that had accessed the team they found them very beneficial and effective.

**Nurse staffing**

The trust used a safer care tool to work out the care hours per patient needed. The acuity of the patient was entered onto the system and it would display how many nursing hours short the ward was. This tool was used to identify which areas needed more support and staff would be moved as appropriate. The tool was updated three times a day and matrons attended a trust safety briefed to discuss staffing across the trust. Staff would be moved between sites to provide cover if needed. However, one ward manager told us that different criteria were used on the system for different wards and it did not appear to be a fair system.

Staff told us that the trust had acknowledged, after the last inspection, that staffing was a problem and there had been a recruitment drive. However, five out of the seven wards we visited were not meeting the planned level of registered nurses. On ward 29, the ward manager had to stay to cover staffing for the late shift. They had three patients that required 1:1 care, which made staffing difficult. The ward manager told us that staff meetings were supposed to be held twice a year but they had to be cancelled due to staffing pressures.

The cardiology day ward, which was open from 7am on a Monday morning until 8pm on a Friday evening, had planned staffing levels of four registered nurses but staff told us they were running on an actual number of two registered nurses. Staff told us they escalated the staffing problems, but there was often no one able to provide cover.

The required staffing levels for the cardiology monitoring unit (CMU) were four registered nurses plus a co-ordinator. We were told that the actual levels of staffing did not reflect this and the unit often had three staff. In December 2017, the average fill rate for registered nurses was 74% within the day and 79% in January 2018.

The trust reported the percentages of ward’s staff fill rate to the board monthly. The fill rate for registered nurses during the day was lower than the minimum standard of 80% for two and three wards out of nine in December 2017 and January 2018. This affected the cardiology wards. The staff fill rates on the oncology wards had improved since our last inspection, where the fill rates now met in the safer staffing report, we reviewed; August 2017, December 2017 and January 2018.

Each month the amount of red flags was published, the highest area was ward 29 (rehabilitation) with 149 red flags in December 2017. The number of red flags fluctuated for each ward however the trend showed that the areas which had highest number of red flags had the larger number of nursing vacancies. The trust collated trust wide data into the reasons why wards would be identified as a red flag. In December 2017, 88% was due to patients requiring an increased level of monitoring and supervision such as one to one observation. This included patients who may have been violent or aggressive who required a security staff member to ensure safety was maintained. Shortfall in registered nurses time accounted for 10% of red flags. Staff told us that many patients on ward 29 required an increased level of monitoring due to their medical condition.

Ward managers told us that they were allowed one management day a week, but due to staffing issues they did not always get to have a management day as they had to work clinically. Some managers were finding it hard to fit staff appraisals in and others told us they had to do some work at home or stayed late after their shift in order to keep up to date.
The trust was dedicated in supporting unregistered staff to develop in their career with some advancing into nursing positions. Staff had been seconded into nurse associate roles and supported to complete specific courses to meet the requirements needed to undertake such roles as nurse associates and student nurses. As a consequence new staffing models were being reviewed to take into account how the newer roles would fit into the requirements for safer staffing levels. Ward 26 had a trainee band 4 associate nurse. The band 4 associate nurse role was introduced to assist and support the care given by registered nurses.

New staff to the wards were supported and provided with a supernumerary period in order for them to become confident and competent in completing patient care and clinical skills. This allowed staff to perform these skills in a period where they did not have the pressure of being part of the numbers required to meet the safe staffing levels. We spoke with new staff members who told us that they had been supported by their team and provided with the relevant training.

From November 2016 to October 2017, there was a vacancy rate of 15% for nursing staff. The trust did not submit an overall target vacancy rate. There was a vacancy rate of 11% in medicine for all staff groups in the same date range.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, there was a turnover rate of 23% for nursing staff which is over the trust target of 9%. There was a turnover rate of 18% in medicine for all staff groups with the turnover rate in the latest month much higher than the rest of the year’s data across all the wards where turnover data was supplied.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, there was a sickness rate of 4% for nursing staff which is the same as the trust target.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The calculation of bank and agency staff usage as a proportion of the total number of shifts available including those covered by permanent staff due was not possible. This was because the total number of bank, agency and unfilled shifts was higher than the total number of available shifts reported by the trust.

Medical staffing
It was identified at our last inspection that there was a lack of senior medical cover on ward 29 (specialist rehabilitation) and this had been highlighted on the risk register. This was still a concern and it remained on the risk register. The service had previously tried to recruit a new consultant, but was unsuccessful. At the time of our inspection, a new consultant had been appointed that week.

Two locum cardiology consultants provided long-term cover in the hospital. They also covered consultant cover at the Hull Royal Infirmary site. The consultants provided cover 8am to 5pm on weekdays and also weekend cover seeing all new patients and acutely ill patients. We reviewed the consultant rota for primary percutaneous coronary intervention (PPCI) which indicated 24 hour cover. There were no gaps identified in the rota.

There were shortages in the middle grade rota. Middle grade doctors had to do 50% more shifts and they told us this was having an impact on their training and experience. In January 2018 there were 6 vacancies, three had recently been appointed to. The trust was trying to recruit to the other positions. The doctors were covering the shortfall between them and completing a one in six rota. We reviewed the weekly rota for middle grade cover in January and February 2018 and found there were occasional vacant slots. Consultants were also stepping down in to the middle grade rota at times to provide patient care.

The junior doctor rotation for ward 29 was shared with acute stroke and neurology and at times

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there was no junior doctor cover. During our inspection, we were told that the consultant was on leave and that there was no junior doctor cover for the following Monday. A specialist doctor, who was on maternity leave, had offered to cover the shift in their own time. The service was reliant on medical staff from oncology and haematology for the on call rota.

We observed both medical ward rounds and safety brief meetings. These were thorough and efficient with all information clearly communicated. All staff members had the opportunity to contribute to the meetings.

In August 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 297 whole time equivalent staff working in medicine at Hull and East Yorkshire Hospitals NHS Trust**

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<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>29%</td>
<td>23%</td>
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</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics (01/08/2017 - 31/08/2017))

From November 2016 to October 2017, there was a vacancy rate of 11% for medical and dental staff. The trust did not submit an overall target vacancy rate. There was a vacancy rate of 11% in medicine for all staff groups in the same date range.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, there was a sickness rate of 1% for medical and dental staff which is under the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The calculation of bank and locum staff usage as a proportion of the total number of shifts available including those covered by permanent staff due was not possible. This was because the total number of bank, locum and unfilled shifts was higher than the total number of available shifts reported by the trust.

The trust has identified areas in medicine which had some of the highest uses of medical bank and agency staff at the trust. These were oncology (Queen’s Centre) at Castle Hill Hospital. It attributed the high figure due to the high vacancy rate and planned to mitigate this by recruiting more doctors.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Records**

Care plans were divided into care bundles, which related to certain risks such as falls, nutrition, pressure care and venous thromboembolism. The care bundles were generic assessment with an
area for individualised care to be added for each patient. Intentional rounding documentation was in place for each patient and we saw these documented within the records. This was a document where staff completed regular checks with patients at set intervals carrying out scheduled tasks or observations. These included reviewing pain, altering the patient’s position and checking whether they required any further assistance such as drinks or food.

We looked at thirteen records consisting of medical and nursing notes and reviewed specific information within the records. All nursing records consisted of the intentional rounding; these were completed consistently across different wards.

At our inspection in June 2016 we noted that nutritional assessments were partly completed. This included the use of the food charts where the amount of food consumed was recorded during the day and then given a RAG rating to identify their overall malnutrition risk. At this inspection we reviewed seven patient’s food charts to identify if improvements had been made. We found that four patient’s food charts were completed to identify what the patient had eaten and had been RAG rated to identify their overall risk. One patient had been on the ward for 17 days, eight food charts had been completed fully and nine had not been RAG rated to identify the malnutrition risk. The patient was identified as being as high risk after 17 days and was referred to the dietitian.

The trust completed an action plan after our last inspection in relation to this and identified they wanted to increase compliance within the wards and review the audit process in place on the wards. The action plan showed that they would monitor nutrition and hydration through care plan in place on the wards. Each month the matrons reviewed ten patients to identify if the food charts had been accurately completed, with the RAG rating included.

At our inspection in June 2016 we noted that falls risk assessments were not always completed. The falls assessment consisted of a booklet which contained reviews of the patient’s ability to mobilise and the use of bed rails. A comprehensive multifactorial assessment could then be completed by answering yes to any of the three questions raised or the patient being over 65 years. We reviewed nine falls risk assessments and found them to be completed and contained the multifactorial assessment completed if required. The trust completed an action plan after our last inspection in relation to this and identified they would review the applications of falls assessment for over 65s. They also identified to complete audits and incorporate the multifactorial assessment tool into moving and handling training.

Information provided by the trust showed that documentation audits had been completed on wards in 2017. Action plans and recommendations were attached to the audit in how to improve compliance. The audits identified how the results would be shared to improve compliance. We saw on the cardiology audit that the results would be shared on a departmental teaching day, which would capture many staff.

Records were paper based. We saw that records were stored in unlocked trolleys, meaning that there could be unauthorised access.

**Medicines**

Medicines were stored securely with access restricted to authorised staff members. The rooms were tidy and well organised. Policies and procedures were available on the trust intranet and links were available to guidelines and reference sources.

We reviewed 14 medication charts and found most of them had been fully completed including allergies and VTE assessment. This had an improvement significantly since our last inspection in June 2016. We saw one medication chart had not completed codes for reason for non-administration.

At our inspection in June 2016 we found that controlled drug checks were not completed daily on most wards. At this inspection daily checks for controlled drugs had been completed each day and
on all wards we visited. This had improved significantly since the last inspection. Controlled drugs were audited every week by registered nurses on the ward and every six months by the pharmacist. Any actions and learning was fed back to the ward manager and a report issued to the medicines safety group.

On two wards, staff had identified issues with the records for patients own controlled drugs. These issued had been investigated and resolved, however the reason was not always clearly documented and they had not been recorded as an incident so that lessons could be learnt. At our inspection in June 2016 we found on several wards, fridge temperatures checks had not been performed and there were many examples where the fridge had been recorded as out of range and no corrective action had been taken. At this inspection we checked fridge temperature records on four wards. On three wards, we found that temperatures had been recorded daily and the thermometer had been marked as reset after checking.

We found there were two fridges on ward 30, one for chemotherapy and one for other medication. The chemotherapy fridge had temperatures checked and recorded every day but there were 32 days in January and February 2018 that the thermometer had not been reset. The fridge for other medication had not had the thermometer reset on 27 days. On two occasions the temperature had been recorded as outside the maximum value but there was no record of any action been taken and it had not been rechecked after one hour as the documentation suggested.

On ward 33 there were a small number of occasions where the temperature was outside normal range with no action. We reported this finding to the chief pharmacist and the time of the inspection.

We observed two medication rounds, on one the registered nurse wore a ‘do not disturb’ tabard. However the nurse was interrupted by medical staff. The medication trolley was securely locked when the registered nurse entered the patient’s room. All the appropriate checks were made to ensure patient safety; these included verifying the patient’s identification and checks allergies.

A medication round on ward 32 was observed, we saw a nurse sign the medication chart for a medicine they stated they had given earlier three hours earlier in the day.

Medicines reconciliation was completed by ward based pharmacists and pharmacy technicians. The trust had set a target of 70% for medicines reconciliation within 24 hours of admission, this target was not achieved. The trust had set a target of 83% for medicines reconciliation at any one time, this target was achieved. This had improved significantly since the last inspection in June 2016. The pharmacy department was currently piloting a new daily report which identified patients who have been admitted for over 20 hours without medicine reconciliation. These patients would then prioritised by a dedicated pharmacy team.

The trust had a self-administration policy and staff were able to describe how they would use this policy. However we found two patients on ward 33 that were self-administering medicines without having a risk assessment in place in line with policy.

Arrangements were in place to ensure that medicine incidents were reported, recorded and investigated through the trust governance arrangements. Staff we spoke with knew how to report incidents involving medicines. Significant incidents were discussed at the safe medication practice committee and appropriate actions taken in response to concerns.

To reduce delays in discharge some wards were piloting a system of pharmacists transcribing medicines onto the discharge letter. We also saw that patients’ ‘take home’ medicines were dispensed by pharmacy staff on some of the wards, which helped to reduce waiting times for discharge medicines.
Antibiotic prescribing audits were completed monthly looking at indication, appropriateness and review/stop dates.

**Incidents**

Staff knew how to report incidents using the electronic reporting system and told us they were encouraged to do so. However, staff we spoke with told us they did not routinely report any staffing concerns.

Staff told us they either received feedback about incidents via email, team meetings, verbally or through monthly lessons learnt bulletin. Staff could give us examples of changes that had occurred as a result of an incident.

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 the need to be open and honest with patients and their families. On ward 26 we saw a duty of candour poster on display.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2016 to October 2017, the trust reported no incidents classified as never events for medicine.

(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017))

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:
- Pressure ulcer meeting SI criteria with six (33% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with six (33% of total incidents)
- Treatment delay meeting SI criteria with four (22% of total incidents)
- Medication incident meeting SI criteria with one (6% of total incidents)
- Slips/trips/falls meeting SI criteria with one (6% of total incidents)

Site specific information can be found below:
- Castle Hill Hospital: zero incidents

(Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

We looked at examples of serious incident investigations and found they had been investigated thoroughly. Staff, patients and relatives had been involved with the process. The reports were open and honest. Any learning from the incident was documented and the incident shared at meetings to review the content of the report.

**Safety thermometer**

The safety thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.
The trust completed a monthly safety thermometer newsletter which provided trust wide compliance with the patient harms. Staff could access this on the trust website.

Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 31 new pressure ulcers, 15 falls with harm and 31 new catheter urinary tract infections from November 2016 to November 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Hull and East Yorkshire Hospitals NHS Trust

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<thead>
<tr>
<th>Total Pressure ulcers (31)</th>
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<tr>
<td><img src="chart1.png" alt="" /></td>
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<table>
<thead>
<tr>
<th>Total Falls (15)</th>
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<td><img src="chart2.png" alt="" /></td>
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<table>
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<tr>
<th>Total CUTIs (31)</th>
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There was a fluctuating but general trend in reduced incidence of pressure ulcers in more recent months.
(Source: Safety thermometer - Safety Thermometer)

During our inspection, we saw safety thermometer information displayed at the entrance to each ward, which showed how many falls and pressure ulcers there had been during the previous month.

Only one ward, ward 28/CMU recorded one pressure ulcer for January 2018. The number of falls were recorded: ward 29 – four, ward 32 – three, ward 30 - four and ward 26 – three. Staff told us they used slipper socks, sensors and posters informing patients to ask for help, to try to reduce the number of falls.
Is the service effective?

**Evidence-based care and treatment**
Care and treatment was provided based on national guidance and was evidence based. Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE).

Staff told us they had access to policies, procedures and care plans on the trust intranet. The policies we reviewed all had identified authors with review dates in place. Policies were reviewed and discussed at the quality governance and assurance committee meetings. Any overdue policies were reviewed and added to an action tracker to monitor progress and identify problems. We were told that the intranet contained sections with a variety of different resources. For example, there was a section on falls that provided staff with knowledge and information, how to prevent falls and included and the trust’s documentation.

The trust participated in national audits such as lung cancer audit, percutaneous coronary interventional procedures (PPCI), heart failure, myocardial ischaemia national audit project (MINAP), and diabetes. We saw the trust completed reviews of the findings and provided action plans to either maintain or improve the results. As a result of the finding from the national diabetes inpatient audit (NADIA) an action had been created to introduce a formalised foot risk assessment by June 2018.

At our last inspection in June 2016 the trust completed audits that reviewed fundamental standards on each wards. These consisted of nine key areas:

10. Staff experience
11. Patient environment
12. Infection control
13. Safeguarding
14. Medicines management
15. Tissue viability
16. Patient centred care
17. Nutrition and hydration
18. Patient experience

The trust continued to complete the fundamental standards and display the information at the front of each ward. Specific guidelines were used to ensure consistency across all the areas; following the assessment process a rating was given for the overall score which then calculate the review time period.

Results from the fundamental standards were documented with the trust's board meetings and we saw improvement for individual wards from our last inspection in June 2016. The results from the fundamental standards had improved for many wards and the majority of wards were in the correct timeframe for their reviews. The only exception to this was the reviews for infection control which some wards were awaiting their review from October 2017 to December 2017.

**Nutrition and hydration**
Patients we spoke with told us they were able to choose their meals for the day from a menu that was given to them every morning. Patient’s requests for specific diets were observed and managed in order to be able to meet their individual needs. A patient with learning difficulties was offered choices from the children’s menu as there was no food choices they liked on the acute adult menu and this suited their requirements more.

Drinks were regularly provided to patients and they told us that staff would make them hot drinks any time they asked for one. We saw that most patients had food and drinks in reach on their
Patients in the discharge lounge had access to food and drink whilst waiting for the transport or medication.

Ward 29 held a breakfast club every weekday morning, to encourage patients to eat together. This was assisted by therapists and nursing staff.

Each ward was audited in regards to the nutrition fundamental standard, this reviewed compliance to the trust’s nutrition and hydration policy. At our last inspection in June 2016, we found that the nutritional fundamental standard was not met on ward 28 and 33 with scores of 78% and 57%. The time periods set for the standard to be reviewed had lapsed by six months. At this inspection we found that all areas were up to date with their review period and had been audited.

No wards were below 80%, four wards had been assessed since September 2017. Two wards had increased their score; ward 31 had increased from 81% to 94%. Ward 33 had improved their score significantly from our last inspection in June 2016; the score was now 94.5%. Two wards had reduced their score slightly but remained in the highest scoring system of above 80%. Ward 28 had been assessed previously and was at 92%.

The rationale for the lower score was due to the incomplete food charts where food charts had not rated at the end of the day to identify if the patient was at risk of malnutrition. One ward manager we spoke with said that when they had spoken to staff about the audit results staff told them they were not aware of the new charts and how they should be completing them. Another ward manager we spoke with felt that the charts were not being completed correctly due to staff not having time and was encouraging staff to complete them after medication rounds.

We saw results displayed on each ward for their fundamental standards audits, which included nutrition and hydration. However some of the boards had not been updated with their latest assessment results. For example on ward 33 the boards displayed showed that the ward had a rating of less than 80%.

**Pain relief**

We were told that staff responded quickly to when patients needed pain relief. One patient was given medication that did not manage their pain; this was reviewed and changed to another analgesia that was effective. As part of one medication round, we observed staff reviewing patient’s pain level and offered analgesia as a result.

Staff had access to the trust’s acute pain service to review and manage their pain more effectively.

**Patient outcomes**

PPCI is a surgical treatment for heart attack patients which unblocks arteries which carry blood to the heart. At our last inspection in June 2016 we saw that the patient outcome performance data for PPCI was variable and not consistently met. The standard for receiving PPCI from the initial phone call for help to the procedure within 150 minutes showed the target was not met for several months.

Information provided by the trust for 2017 showed that percentage of patients that received PPCI from the initial phone call for help to the procedure within 150 minutes showed the target was not met for several months.

Regular MINAP meetings were held where the performance standards for PPCI were discussed. We reviewed the minutes for October and November 2017 and found reasons for the breaches were discussed. The ten breaches were detailed to why the times had been delayed; seven of these were due to ambulance administration or procedural delays. Further work was being completed around reviewing the ambulance on scene times.
Further information was sent from the trust which showed the percentage of patients who received PPCI within 90 minutes from arrival to the hospital. The national target was 90%, this was met for all months from January 2017 to December 2017, seven months received 100%.

Initial phone call to PPCI procedure in 150 Minutes

![Call to Balloon in 150 Minutes (CTB150) Performance](chart)

Initial phone call to PPCI procedure in 120 Minutes

![Call to Balloon in 120 Minutes (CTB120) Performance](chart)

Castle Hill Hospital
From September 2016 to August 2017, patients at Castle Hill Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.
Elective Admissions - Castle Hill Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in medical oncology and clinical oncology (previously radiotherapy) had a higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a much higher than expected risk of readmission for elective admissions

Non-Elective Admissions - Castle Hill Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

- Patients in clinical oncology (previously radiotherapy) had a similar too expected risk of readmission for non-elective admissions
- Patients in medical oncology had a lower than expected risk of readmission for non-elective admissions
- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions

Heart Failure Audit

In-hospital Care Scores
Results for Hull and East Yorkshire Hospitals NHS Trust in the 2016 Heart Failure Audit varied hugely across the sites for two of the metrics (cardiology inpatients and input from consultant cardiologist) with Castle Hill Hospital performing much better then England and Wales average and Hull Royal Infirmary performing much worse. Castle Hill Hospital performed better than the England and Wales average for all of the four of the standards relating to in-hospital care. Hull Royal Infirmary performed better than the England and Wales average for one of the four standards, similarly to one of the four standards and worse than two of the four standards relating to in-hospital care.
Discharge Scores
Castle Hill Hospital’s results were better than the England and Wales average for seven of the nine standards relating to discharge.

National Diabetes Inpatient Audit
The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to
people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 142 inpatients with diabetes at Hull and East Yorkshire Hospitals NHS Trust. This was equal to 18% of the beds audited which places them in quartile 3. 76% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 1. (Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**
All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 97% of nSTEMI patients were admitted to a cardiac unit or ward at Castle Hill Hospital and 100% were seen by a cardiologist or member of the team compared to England averages of 96% and 56%.

The proportion of nSTEMI patients who were referred for or had angiography at Castle Hill Hospital was 98% compared to an England average of 83%. (Source: National Institute for Cardiovascular Outcomes Research (NICOR))

**Lung Cancer Audit**
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 13%, which was does not meet the audit minimum standard of 90%. The 2015 figure was 84%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 32%, this is significantly better than the national level. The 2015 figure was 22%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 63%; this is not significantly different from the national level. The 2015 figure was 57%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 66%; this is not significantly different from the national level. The 2015 figure was 71%.

The one year relative survival rate for the trust in 2016 is 35% which is significantly worse than the national level. (Source: National Lung Cancer Audit)

**National Audit of Inpatient Falls 2017**
Castle Hill Hospital did not participate in this audit. (Source: Royal College of Physicians)

**Competent staff**
At our last inspection in June 2016, some staff did not possess specialist competencies required. At this inspection we found that on ward 33, a nurse had been seconded to a trainer role to work alongside staff to provide training and assess competencies. On ward 28/CMU 55% of staff had completed accredited cardiology courses. All staff (91%) with the exception of new staff had completed intermediate life support.

Staff had completed training relevant to their role, such as blood transfusion, PIC line,
cannulation, telemetry and reading ECG’s. Most staff had completed sepsis training. Staff told us that a new sepsis bundle had been introduced and the sepsis lead for the trust had done the training.

Ward managers told us there were some issues with staff attending immediate life support (ILS) training and advanced life support (ALS) training. On ward 28, some of the staff were advanced life support (ALS) trained but the ward could not support staff to attend this training going forward. On ward 26, four staff members had not had ILS training, two of which were booked to attend the training in May and two staff were on maternity leave. Those staff that were not ILS trained could not escort patients off the ward; however the ward manager told us she always ensured there was an ILS trained nurse on each shift.

Preceptorship packages were in place for new staff and they were supernumerary for the first four to six weeks. We spoke to a staff nurse on ward 28/CMU who had worked on the ward for one year, having previously worked on the oncology wards. She told us that she had a good induction package to the ward, having two mentors and competencies to complete.

We spoke with a band 4 trainee associate nurse who told us they had competencies to complete. They had received training in NEWS, sepsis and observations. They felt well supported by the practice development matron, who ran the programme, and their manager. They had been provided with a mentor and an associate mentor.

From April to October 2017, 76% of staff within medicine at the trust had received an appraisal. The figure for medical and dental staff was 83% and the figure for nursing and midwifery staff was 70% compared to a trust target of 90% for medical and dental staff and 85% for other staff groups. Two staff groups met the trust target appraisal rate these were allied health professionals and healthcare scientists.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>49</td>
<td>53</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>66</td>
<td>78</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>71</td>
<td>86</td>
<td>83%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>20</td>
<td>26</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>161</td>
<td>210</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>116</td>
<td>152</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>252</td>
<td>362</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>16</td>
<td>24</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working
Staff on all wards worked well as a multidisciplinary team (MDT), carrying out daily board rounds. We saw examples of staff interacting to discuss patient’s care and seek advice from colleagues. Staff spoke positively about close MDT working and felt they had good relationships.

Ward 29 had a dedicated team of physiotherapists, occupational therapists, speech and language therapists, dieticians, medical staff and nurses. Regular goal setting meetings, attended by the members of the multidisciplinary team, were held with patients.

Staff told us they had good links with the mental health team, who attended the ward if needed.

Discharge assistants worked on the wards and supported staff in discharging patients. They would involve other services, such as social workers and find out why the discharges were delayed. The discharge assistants communicated with the social workers daily to update and review the plans required for the patients. They also liaised with community practitioners, such as community heart failure nurses and the respiratory team, which ensured that discharges were a lot quicker.

Joint meetings between cardiology staff and the ambulance service were held every two months. This allowed staff to discuss all patients receiving calls to PPCI, if patients were not accepted to this was discussed and a root cause analysis completed if it was agreed they should have been accepted.

Seven-day services
Discharge assistants worked five days a week. However, staff told us that there had been discussions about making this a seven-day service.

Staff told us they could access the mental health liaison team if they had any concerns. A crisis team were available 24 hours a day.

The physiotherapy team offered a seven day service across the wards. Physiotherapists were available at a weekend and on call out of hours when required.

The critical care outreach team covered both hospital sites, providing 24 hours cover every day. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them through an increased NEWS score. The team supported patients who were on both respiratory support unit and ICU that required NIV.

The pharmacy department was open seven days a week, 365 days a year. An on-call pharmacist was also available when the department was closed. The pharmacy intranet site contained guidance for ward staff and for managers on how to access medicines and pharmacy advice when the department was closed.

We were told the phlebotomy service was not always available; as a result junior doctors had to complete the procedure on several patients.

Health promotion
We saw health promotion information displayed in the wards we visited. On ward 26 there was a poster display with a focus on nutrition and a display about diabetes in the day room. On ward 28/CMU there was a display centred around heart disease and risk factors. There was information to help patients quit smoking. There was also a poster about risk factors for blood clots and preventative advice.

Nicotine replacement therapy was offered to patients during their stay. We saw one staff member counselling a patient on smoking cessation and supporting them make a lifestyle choice.
In ward 33, there were five cubicles for patients undergoing stem cell transplants. In each room, there was an exercise bike, which encouraged patients to stay active.

We saw information displayed which encouraged patients to wear their own clothing and stay mobile whilst in hospital. This was inspired by a national campaign called ‘End PJ Paralysis’.

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

The knowledge and understanding of mental capacity and deprivation of liberty safeguards (DoLS) varied between staff. Some staff articulated when a DoLS would require to be completed and others were not sure. We spoke with staff regarding their understanding of DoLS; they did not recognise the use of bed rails or bed tables as a restraint.

The trust had a policy covering the use of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for patients who lacked capacity.

Staff we spoke with said that medical staff responsible for the patient’s care undertook Mental Capacity Act (MCA) assessments. We did not receive assurance that assessments were formally recorded. We reviewed two sets of notes where the patient lacked capacity, one of these patients we were told could make simple decisions. No assessment was recorded discussing about the patient’s mental capacity. We discussed this with the ward manager who felt that it was an oversight.

We saw one patient had a DoLS application that expired in January 2018; no request for an extension was documented within the notes. A best interest meeting was completed and the patient required one to one supervision due to the patient’s behaviours and condition. There was no capacity assessment found in the medical records.

Patients told us that staff asked for consent prior to completing any care and procedures. We saw that one patient was reluctant to have a procedure and the doctor discussed that it would not be completed until the patient fully understood and consented to the treatment.

We saw that patients who had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were completed in line with national best practice. They had been completed to identify who discussions had taken place with.

On ward 28/CMU we saw DoLS information displayed for patients and relatives.

The trust reported that from April 2017 to October 2017 Mental Capacity Act (MCA) training had been completed by 89% of medical and dental staff within medicine and 94% for nursing and midwifery staff in medicine. Both staffing groups met the trust target of 85%.

Deprivation of Liberty Safeguards (DoLS) training had been completed by 89% of medical and dental staff within medicine and 94% for nursing and midwifery staff in medicine. Both staffing groups met the trust target of 85%.

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for medical and dental staff in medicine is shown below:
A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for nursing and midwifery staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>238</td>
<td>267</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>238</td>
<td>267</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>545</td>
<td>579</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>547</td>
<td>579</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

During our inspection we heard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff were always polite, kind, respectful and professional in their approach.

We spoke with 10 patients, relatives and carers. Patients we spoke with described staff as ‘wonderful’ ‘caring’ ‘friendly’ and ‘helpful’. They said that staff were responsive to their needs. We saw that one staff member held a patient’s hand during their procedure to calm and reassure the patient.

Staff respected patient’s privacy and dignity. One of the patients we spoke to in CMU said they had been moved out of a bay in to a single room to prevent them being in a bay with patients of the opposite sex.

The Friends and Family Test response rate for medicine at the trust was 23% which was worse than the England average of 25% from November 2016 to October 2017.

The average of all participating medical ward’s annual recommendation score was 92%. The majority of the wards scored over 90% for recommendation rates.
Friends and family Test – Response rate from 01/11/2016 to 31/10/2017 by site.

![Graph showing response rates for various wards]

### Emotional support

Patients, families and carers told us that they felt they received good emotional support from staff. A patient on ward 29 told us that the staff on the ward provided emotional support; they felt like family members and were always willing to spend time with the patient and provide support when needed.

Patients were given support to cope with a cancer diagnosis. The Oncology Health Centre offered psychological support for patients and relatives. They offered drop in support and patients had access to clinical nurse specialists and clinical psychologists.

On ward 29 (specialist rehabilitation), the average length of stay was three months. There was a clinical psychologist for the ward and patients told us they spoke to the psychologist every week. A chaplaincy service was available to provide pastoral, religious and spiritual support for patients and relatives. We were told that chaplains and volunteers would visit the wards on request or as part of their routine visits.

(Source: NHS England Friends and Family Test)
Understanding and involvement of patients and those close to them

Patients told us that staff explained their care and treatment to them in a way they could understand. They felt they were involved with their decision making and could make informed decisions. We spoke to young people and patient’s with learning difficulties who told us that staff asked them if they understood the information they had been told and provided them with time to ask questions.

Family members could discuss more details with both nursing and medical staff on the telephone; they were given specific codes in order to receive more information. Relatives on ward 90 told us that staff talked through the options available and they felt they had everything to make difficult decisions. Staff were flexible regarding visiting out of the agreed ward times to discuss with medical staff patient's ongoing care.

On ward 32, we observed a doctor involving a patient in their care. They showed the patient the scan, then sat and talked through the results of the recent scan and compared it to previous scans. This allowed the patient to understand the progression of their condition and then they asked questions to which the doctor responded. The patient stated that they felt much more reassured and that they felt the doctor had gone ‘above and beyond’ in taking the time to sit and explain things thoroughly.

We spoke with two patients on ward 29 who told us that they felt fully involved in their care. They found the regular goal setting meetings helpful as members of the multidisciplinary team attended and discussed the patients care with them. Family members could attend the meetings and there were opportunities for the patient and family to ask questions.

We spoke with two patients on CMU. One patient told us they were kept fully informed and full explanations were given to them during procedures. The second patient we spoke with spoke highly of the nursing staff and said they tried to keep them fully informed. However, the patient had a procedure cancelled twice and they said that they had not been given enough information by the medical staff about the reasons for cancellation and when the procedure would next take place.

Is the service responsive?

Service delivery to meet the needs of local people

The oncology, haematology and rehabilitation wards were situated in the Queen's Centre at Castle Hill Hospital. The Queen’s centre was a contemporary building that provided light, spacious accommodation.

Ward 33 contained the teenage and young adult inpatient service for 19-24 year olds. This provided an age appropriate environment and the service worked closely with the Teenage Cancer Trust.

A new service had been commissioned to help support families through the decision to place a family member in residential or nursing care home. They would then be matched with homes that most suited their needs. Families and the patient are then supported to visit the care home and move within a few days.

The trust worked closely with the local commissioning groups (CCGs) stakeholders, patients and staff to plan and deliver services to meet the needs of local people.

Meeting people’s individual needs

The service took account of people’s individual needs. A learning disability nurse specialist offered support for those patients with particular needs. However, staff we spoke with were unaware if
these patients were flagged on the electronic system. Services had picture charts that they could use to help them communicate with patients.
We saw that individual needs were met on the teenage cancer ward; there was a variety of different activities for young people to interact with. These included internet access, pool table and juke box and a ‘chill out’ area. We saw this room in use during our inspection. One patient told us that it was important to them to be able to video chat to their family whilst in hospital.

A trust wide dementia and delirium screening tool was used for all patients on admission. Staff contacted the mental health team if they required support. The service used the butterfly scheme for patients with dementia, which allowed delivery of person centred care for patients with dementia or delirium whilst in hospital. Patients with dementia were identified on the electronic patient system.

On ward 26, we saw a dementia corner; an area of the ward that had been designed to resemble an old style sitting room with a radio, magazines and twiddle muffs. A twiddle muff is a knitted muff with items attached to keep dementia patients’ hands active and busy.

Staff told us they could access interpreter services if needed for those families where English was not their first language. This included access to British Sign Language interpreters.

The computer devices held translating services and applications to translate into other languages. Staff who could also speak in the patient’s first language could be accessed. We were told that for consent issues translating services were used. We saw one the medical team speak to the patient in their own first language. They observed that the patient was wearing a bracelet for religious reasons and respected they may not want to remove this for their investigation.

Social events were undertaken on some of the wards, previous patients and bereaved family members were invited to return. Staff members have taken part in fundraising activities and wards have received funding from charities to improve the environment.

**Access and flow**
Staff at Castle Hill Hospital told us that they did not have any medical outliers at the hospital. This was confirmed from data provided by the trust.

A cardiology bleep holder coordinated admissions to the cardiac wards and would attend the board round three times a day. However, some staff told us that this sometimes caused a problem when the bleep holder had accepted an admission in to a bed without informing the ward staff.

**Castle Hill Hospital**
From October 2016 to September 2017 the average length of stay for medical elective patients at Castle Hill Hospital was 3.3 days, which is lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.8 days, which is higher than England average of 6.6 days.

**Elective Average Length of Stay - Castle Hill Hospital**

![Elective Average Length of Stay - Castle Hill Hospital](image)

*Note: Top three specialties for specific trust based on count of activity.*
Average length of stay for elective specialties:
- Average length of stay for elective patients in cardiology is lower than the England average.
- Average length of stay for elective patients in clinical oncology (previously radiotherapy) and clinical haematology is higher than the England averages.

**Non-Elective Average Length of Stay - Castle Hill Hospital**

<table>
<thead>
<tr>
<th></th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>7.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Medical Oncology</td>
<td>9.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Clinical Oncology (Previously Radiotherapy)</td>
<td>9.2</td>
<td>5.4</td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

Average length of stay for non-elective specialties:
- Average length of stay for non-elective patients in cardiology is similar to the England average.
- Average length of stay for non-elective patients in medical oncology and clinical oncology (previously radiotherapy) is higher than the England averages.

*(Source: Hospital Episode Statistics)*

The discharge assistant’s role was to support the patient’s discharge and reduce the patient’s admission. They monitor how long patients have been waiting for scans and referrals to services such as social services and therapists. If the timescale reaches waiting periods of more than 24 hours the discharge planner raises an alert which then allowed the patient to be prioritised. Discharge assistants ensured that patient discharges were well organised. Discharges had become a lot quicker since the introduction of this role.

The trust reported that from October 2016 to October 2017, 75% of individuals did not move wards during their admission and 25% moved once or more, one of these moves being for a patient ‘at end of life’. This had improved since our last inspection in June 2016 where 46% of patients had no moves and 54% moved once or more.

Site specific information can be found below:
- Castle Hill Hospital: 72% of individuals did not move wards during their admission and 28% moved once or more

*(Source: Routine Provider Information Request (RPIR) P51 – Bed moves)*

The ward manager on ward 26 told us that patients were often moved from cardiology to a cardiothoracic bed when capacity was an issue. They were then moved back to a cardiology bed. One patient had been moved eight times in this way.

Staff told us there was no time set aside in the cardiac catheter lab for an acute list, which meant that patients requiring a procedure that hadn’t been booked often had a long wait. We were told that some patients had waited over a week. Staff told us this was an ongoing problem and they had raised this issue with the service managers. During our inspection, we spoke with a patient who had been transferred from Hull Royal Infirmary for insertion of a pacemaker. The patient had been waiting four days and on two days, the procedure had been cancelled.

The trust told us after the inspection that there were daily acute intervention sessions (ten per week). In addition to these lists two mornings per week there was also acute devices lists.
Additional acute devices lists were also added mid-week if a device consultant was on call. Acute patients were also added to elective lists on a daily basis depending on demand and capacity.

Between November 2016 and October 2017, referral to treatment rates for admitted pathways were fairly consistent but worse than the England averages. In the most recent month October 2017, referral to treatment rates at the trust showed that 75% of patients were treated within 18 weeks versus the England average of 90%.

(Source: NHS England)

Staff we spoke with on the cardiac day care unit told us that lists did not appear to be coordinated properly. On some days, there may be five patients on a list and on others there could be up to 15 on a list. Consultants appear to be booking complex patients to come in on a Friday, when the unit shuts on a Friday evening, this has meant that staff are sometimes having to find beds for the patients to stay overnight at 9pm on a Friday evening. Staff have fed this back to managers but have not heard anything back.

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>95.1%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>96.2%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>92.1%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.2%</td>
<td>91.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

From November 2016 to November 2017 there were 125 complaints about medical care. The trust took an average of 33 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be completed within 40 days or 60 days if the complaint is classed as complex. As of November 2017, there were 25 complaints still open and yet to be completed. The majority of complaints were regarding access to treatment or drugs or patient care including nutrition.

- Castle Hill Hospital: There were 16 complaints which took an average of 39 days to investigate and close. Three complaints remained open at the time of the trust’s submission (Source: Routine Provider Information Request (RPIR) P61 Complaints)

We saw information displayed in ward areas setting out the complaint process and explaining to patients how they could raise a concern.
Patients we spoke with told us they were aware how to make a complaint if they needed to. One patient that we spoke with had wanted to raise a complaint and the ward staff had provided them with an information leaflet on how to do so.

Staff we spoke with told us they would try to resolve any complaints or concerns at ward level if they could. Complaints were discussed at team meetings. We saw that complaints were also discussed at the quality governance and assurance committee meetings and lessons learnt documented.

Is the service well-led?

Leadership
Medical services at Castle Hill Hospital were managed by three health groups. The cardiology department were under the medicine health group. Oncology, haematology and rehabilitation were managed by the clinical support health group. Ward 20 (infectious diseases) was managed by the clinical support health group.

We met with both medicine and clinical support health group’s senior management team. These consisted of medical director, an operations director and a director of nursing. The triumvirate met daily to review ongoing issues. They were aware of the challenges they faced and were proactive in looking at new models of care to address current and future challenges.

Matrons provided support to clinical areas and would visit wards daily to review the staffing and identify any issues that required to be escalated. Matrons provided feedback at safety briefs in regards to these concerns. We were told that staff found the matrons supportive.

Ward managers were in place in all areas. We spoke with staff who said that ward managers were approachable, supportive and listened. They were approachable and visible. However, staff on the cardiac wards told us they felt a bit isolated as part of the medicine health group as they were the only ones at Castle Hill Hospital.

It had been agreed due to winter pressures and demands on services that ward managers would work within the numbers to ensure patients were cared for appropriately by the correct amount of staff. This reduced their capacity in being able to spend time completing their managerial work as they only had one day per week in this role.

Most teams had ward meetings on a regular basis. In some teams this had been identified within their individual appraisal that they were expected to attend a number of times in the year. Staff were encouraged to add items to discuss within the meetings.

Most of the staff we spoke with told us they did not see the chief executive or chief nurse, unless they attended any trust events. However, the staff on ward 26 and ward 28 told us the chief executive and the finance director visited the ward regularly. Ward 26 was the Lord Mayor’s recognised charity and as part of a charity event the chief executive had agreed to be part of a raffle, where a ward could win his services for the day.

Vision and strategy
The senior management team for medicine and clinical support services were clear on their ongoing vision for the departments. The medicine team were aware that the bed base for patients needed to be increased and proposals were in place to expand speciality areas. The clinical support services were focused on improving outcomes and expanding a hub and spoke approach with services. Part of the vision was working with other organisations and supporting them in providing some services for the patients to be seen in a timely manner.
Each division had developed between two to five year plans. This then fed into the health groups summary strategies.

The trust said that they were on a journey and felt they were moving forward towards meeting their goals along with implementing further changes. The trust were changing their status in April 2018 to become a teaching hospital trust.

Staff we spoke with were aware of the trust values. However, some were unaware of the service vision. We saw that the operational plan and trust strategy were available on some of the ward’s notice boards. New staff to the trust told us that the trust’s vision and strategy was discussed in the corporate induction along with the trust values.

**Culture**

We found a positive culture with staff being open, honest, and willing to share information with us on inspection. Staff were loyal to the organisation but were prepared to challenge leaders if they thought patient safety was compromised.

The majority of staff we spoke with told us that morale was good and that they all worked well as a team and supported each other. Staff told us they pulled together to overcome challenges. There was a good mix of staff new to the trust and others who had worked at the hospital for a number of years. However, staff on the cardiac day care unit told us that morale was low due to staffing issues.

It was apparent that senior leaders and managers were proud of their staff and praised them in their work. They felt that staff had gone above and beyond to provide the care to patients when extreme pressures had been placed on the hospital. The senior management team told us that all the health groups worked well together over the winter period when patient capacity and demand was very high. Staff on ward 26 told us how proud they were of the staff on the ward and covering extra shifts to provide the safe staffing levels.

Staff success was celebrated through trust events such as golden heart awards and moments of magic. Nominations from both staff and patients allowed patients achievements to be recognised and rewarded.

Teaching sessions for medical staff had been provided and staff were supported to attend. However we were told that some medical staff were not managing to attend sessions due to the low levels of medical staff available to provide patient care.

**Governance**

The medicine health group had a clear governance structure. Governance structures were in place that provided assurance of oversight and performance against safety measures. We reviewed the quality governance and assurance committee minutes and found comprehensive discussion around current risks and performance. Information was discussed at these meetings from the different speciality groups. We found that some of the concerns that we had at our inspection had been identified by the trust and actions were in place to improve compliance. These included the documentation of risk assessments.

We reviewed morbidity and mortality where deaths were discussed in detail to identify if the correct actions were taken. An in-depth analysis of the situation was discussed and the rationale presented for why decisions were made. A mortality review was completed on each patient which identified if the reviewer felt there was any concerns regarding the care received. We spoke with the operational lead for mortality who told us they monitored for any mortality trends and fed this back to the speciality teams.

Each ward had completed the fundamental standards of care audits and had there had been improvement within the results. The number of scores below 80% inadequate ratings had reduced
and moved toward requires improvement or good ratings. The findings were discussed in various
minutes we reviewed and were presented at the trust board meetings to provide an overview.

Ward managers were given an area of patient care to audit and review each month. Previous
audits have included auditing controlled drug compliance, uniform compliance. The audits were
completed and the findings submitted into an action plan which was cascaded to staff.

Matrons provided a handbook monthly to review the care given on wards. They reviewed patient’s
records and medicine charts to identify if they had been completed. Patients were asked a series
of questions regarding their experience, opinions and observation. Staff members were observed
completing clinical observations such as recording blood pressure and temperature. Staff were
asked a range of questions reviewing their knowledge on National Early Warning Score (NEWS)
and other information.

**Management of risk, issues and performance**

There was a departmental risk register, which measured the impact and likelihood of the risk and
documented the controls and mitigations in place to manage the risk. This fed in to the corporate
risk register so that the board were sighted on local risks. We saw that the risk register was
discussed and reviewed in the quality governance and assurance committee meetings. Staff
contributed to the risk information and new risks were added at the request of staff.

Bed flow meetings were in place several times a day. Safety briefs took place three to four times a
day depending on the demand on the hospital. At these meetings staffing was reviewed and
patients factors such as the requirement for one to one supportive care. We attended a briefing
and found that measures were put in place to identify the wards where red flags had been
identified as areas where staffing was not adequate. The trust had a minimum standard whereby
no ward was left with fewer than two registered nurses on shift. The red flag areas were reviewed
first and vacancies were filled through agency or the movement of staff from other areas.

A further meeting was in place at the evening, where staffing and bed status were reviewed. Two
site matrons covered the medical areas overnight, one monitored the flow in the emergency
department and one managed the medical ward areas. Part of their role was to visit each area at
least twice during the night to provide support and assurances to the staff.

A meeting between the trust and ambulance providers was in place where the percutaneous
coronary interventional procedures (PPCI) target was discussed. Breaches to the standard were
documented and ways to manage and improve the target were discussed.

Operation wintergreen was generated due to the demand and strain put on the hospital through
the winter period. It allowed a plan of action to be put in place to manage the demand to the
services. This included a senior person reviewing patients in order to make a clinical decision in
their care. Pharmacy and therapy staff were increased to provide more cover and non-clinical staff
provided support and assistance.

The trust had recruited staff from international areas and had supported them with accommodation
and other training and assessments. Staff were working as healthcare assistants until
they had completed their objective structure clinical examination (OSCE). This was an exam that required to
be passed in order to register with the Nursing Midwifery Council (NMC) and practice as a
registered nurse.

**Information management**

Live information management systems allowed senior management to monitor and review the
capacity and demand within the hospital. The system allowed staff to be aware of where bed
availability was and this was updated by staff on the ward. In turn this then provided staff at the
safety brief meeting a true reflection of the current issues. The system allowed the senior
managers to review and plan where the risks were to nurse staffing and manage these safely and
effectively. A record of the decision made were made during the meetings and logged onto the system to provide an audit trail.

The IT systems could be viewed by other health groups in order for them to understand the pressures on departments. Staff could view the system to see which patients were waiting in ED to be admitted to the ward and prepare and plan where they would go.

Several different organisations had visited the trust to review the information systems and how to use them to monitor patient care and improve quality.

Computers were readily available on each ward and we saw that the majority of times the computer was locked when not in use.

**Engagement**

Staff were kept up to date with what was happening in the trust with emails and a monthly newsletter. Staff told us that they could access all the information they needed via the trust intranet.

An initiative called ‘Freed up Friday’ had been introduced where one member of the executive team would visit the wards.

The trust’s website outlined opportunities to contact the trust and express opinions. It also supplied information on the services and hospital. The trust utilised social media as an engagement tool with the public and a list of social media accounts was listed on the website.

**Learning, continuous improvement and innovation**

The trust were committed in supporting their non-registered staff in order to apply for nurse associate and apprenticeship roles. This included completing further education in core subjects within their working day. We spoke with some of the nurse associates who were very positive about their career progression and support from the trust.

Ward 29 had won the best stand award at the National Dignity Day when they promoted the campaign to try to get patients out of gowns or pyjamas and in to their own clothes.

The trust were working with local colleges to promote people to join the trust. Part of their role ensured that they could work towards qualification such as NVQs in healthcare.

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**Surgery**

**Facts and data about this service**

The trust has 16 surgical wards and 33 operating theatres across two sites. The trust covers 11 surgical specialities:

- Trauma & orthopaedics
- Neurosurgery
- Colorectal surgery
- General surgery
- Gastroenterology
- Urology
- Upper gastro-intestinal surgery
- Breast surgery
- Vascular surgery
- Cardiothoracic surgery
- Ophthalmology
The health group has 381 surgical inpatient beds.  
(Source: Routine Provider Information Request (RPIR) – Acute-Sites)

Surgical services have eight surgical wards on the Castle Hill Hospital site. The hospital has nineteen operating theatres covering main and day theatres.

The trust had 55,614 surgical admissions from October 2016 to September 2017. Of these admissions:
- 13,001 (23.4%) were emergency admissions
- 29,854 (53.7%) were day cases
- 12,759 (22.9%) were elective admissions

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
At the 2016 inspection, the trust target for mandatory training compliance was 85% compliance; training data we reviewed showed an overall training compliance rate for the surgery health group of 85.1%.

Staff we spoke with said they were up to date with mandatory training. Staff also said that training link staff on their wards sent reminders when training was due and reminders when training had expired.

A breakdown of compliance for mandatory courses from April to October 2017 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>380</td>
<td>418</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>361</td>
<td>418</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>360</td>
<td>418</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>308</td>
<td>418</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>299</td>
<td>418</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>295</td>
<td>418</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at the hospital was 80%. This had decreased slightly from the 2016 inspection. Of the six mandatory training courses delivered by the trust to medical and dental staff, only two met the completion rate target of 85%. The trust did not meet its completion target for the information governance training it delivered. The completion rate for this course was similar to other courses at 86% but the trust target for this course is higher than other targets at 95%.
A breakdown of compliance for mandatory courses from April to October 2017 for nursing and midwifery staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>811</td>
<td>860</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>809</td>
<td>860</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>779</td>
<td>860</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>754</td>
<td>860</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>727</td>
<td>860</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>627</td>
<td>859</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the hospital was 87%. This had improved from the 2016 inspection. Of the six mandatory training courses delivered by the trust to nursing and midwifery staff, the completion rate target was met in four cases. The lowest completion rate attained by the trust was 73% for resuscitation training. The trust also did not meet the target for information governance training. While the completion rate for this course is similar to other courses at 91%, the trust target for this course is higher than the other targets, at 95%.

The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

At the 2016 inspection, the training target level for safeguarding adults training was 85%. The training level was 84.6% compliance for all staff within the health group.

At this inspection, the training levels were met by nursing staff for both safeguarding adults and safeguarding children and young people. Medical staff met the target for safeguarding adults but were slightly below the compliance rate for children and young people.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for medical and dental staff in surgery is detailed below:
### Name of course

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>361</td>
<td>418</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>353</td>
<td>418</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Of the two safeguarding courses delivered by the trust to medical/dental staff, one (safeguarding adults) met the target with 86%. The course that did not meet the target (safeguarding children and young people) had a completion rate of 84% which was 1% below the target.

A breakdown of compliance for safeguarding courses from April 2017 to November 2017 for nursing and midwifery staff in surgery is detailed below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>787</td>
<td>860</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>737</td>
<td>860</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust met the target of 85% completion rates for both of the safeguarding training courses delivered to nursing/midwifery staff.

(Source: Trust Provider Information Request P18)

At this inspection, staff we spoke with said that they completed adult and children’s safeguarding as part of their mandatory training. They also said the trust safeguarding team were accessible and supportive when staff needed advice about safeguarding concerns.

The service had systems in place for the identification and management of adults and children at risk of abuse.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and which issues staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and how to raise them. The safeguarding policy included information on the PREVENT strategy, which is a government anti-radicalisation directive.

Staff we spoke with were able to detail the actions they had taken in relation to safeguarding concerns.

### Cleanliness, infection control and hygiene

At our inspection in 2016, we found significant improvements in compliance with infection prevention and control audits and compliance with theatre engineering performance measures and annual servicing.

At this inspection, we found wards and departments we visited visibly clean and tidy, and we saw ward cleanliness scores displayed in public corridors. We reviewed patient led assessments of the
care environment (PLACE) reports for the trust and noted 97.9% compliance between March 2017 and June 2017, marginally below the 98% England average.

The trust had an infection prevention and control (IPC) policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices.

Records we reviewed and conversations with staff confirmed that staff received and completed training in infection control.

We saw information displayed on the wards and departments visited on the number of days since the last hospital acquired clostridium difficile (C. difficile) infection and Methicillin-resistant Staphylococcus aureus (MRSA) isolate.

The trust reported one case of hospital acquired MRSA from October 2016 to September 2017. The trust reported 44 cases of C. difficile in the same reporting period. This was lower that the trajectory of 53 cases, the agreed threshold for 2017/2018.

The trust had a policy to screen surgical patients for Methicillin-resistant Staphylococcus aureus (MRSA) and some patients for Methicillin-sensitive Staphylococcus aureus (MRSA) as per best practice guidance.

During the inspection, we observed that staff were compliant with hand hygiene policies including ‘bare below the elbows’ and personal protective equipment practices. Staff we spoke with were aware of their responsibilities in relation to infection prevention and control, for example, bare below the elbows and decontamination of their hands before and after patient contact, or contact with the patient environment.

Handwashing advice was clearly displayed and facilities for hand hygiene were available in the foyer area of the hospital and at the entrance to all wards. Hand hygiene compliance data was displayed on the wards and departments we visited. Staff used both at the point of use and personal issue alcohol gel.

We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for use. We observed staff performing clean and disinfection of reusable equipment between patients, which followed the trust policy. We saw that staff used a specific label to identify that equipment was clean and ready for use. We reviewed 15 pieces of reusable clinical equipment and found these to be clean and labelled. One area, ward 15 was not using cleaning indictor labels; this did not provide assurance to patients that reusable items were clean and ready for use.

Staff we spoke with said they had access to appropriate personal protective equipment (PPE). We observed staff, using sterile gloves and appropriate aseptic techniques.

We saw appropriate processes for clinical waste in wards and departments we visited; including colour coded waste bags for clinical and non-clinical waste. Staff were able to dispose of waste at the point of use. Sharps bins were used by staff to dispose of used disposable instruments, such as sharps, needles, and glass ampules. Sharps bins in most of the areas visited were secure, dated and signed, and stored off the floor in all areas we visited. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Rooms were available for patients requiring isolation, and patients requiring isolation were isolated appropriately.

Infection prevention and control (IPC) training was delivered to staff working in the health group, IPC training compliance rates from April to October 2017 showed 86% for nursing and medical staff had received training, above the compliance target of 85%.
Infection prevention and control audit results for November 2017 showed that all areas scored over 80% compliance.

At the time of the inspection, we highlighted some concerns with the reuse of sterile jugs on ward 15, staff were labelling these and washing them through, this did not comply with best practice guidance.

Environment and equipment
At the 2016 inspection, we told the trust they must ensure staff follow the established procedures for checking resuscitation equipment in accordance with trust policy.

At this inspection, we saw that improved processes had been implemented for checking resuscitation equipment and all equipment we reviewed was clean, tidy, and ready for use and staff had checked the equipment as per the trust’s policy. Trolleys we inspected were all locked, appropriately stocked, all equipment was in date and there was evidence of stock rotation.

Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of good stock rotation.

We looked at 15 pieces of equipment all were found to have been electrically safety tested within the review date and serviced in line with manufacturers’ guidelines.

Within the theatre environment we saw rust on some equipment (storage trolleys) and we saw damage to stools allowing the inner foam to be seen. Damage to equipment makes it difficult to keep clean and could lead to contamination.

We also saw that some reusable equipment in theatres was not managed appropriately, for example; we saw that reusable laryngoscope blades had been removed from its packaging therefore there would be no traceability of this piece of equipment. We raised these concerns with staff at the time of the inspection.

We reviewed the trolley used for difficult airway access within theatres and noted from visual observation it was not easy to identify equipment in each drawer, as per best practice requirements.

Assessing and responding to patient risk
At the 2016 inspection, we told the trust to ensure that staff are knowledgeable about when to escalate a deteriorating patient using the trust’s national early warning score (NEWS) and escalation procedures; that patients requiring escalation receive timely and appropriate treatment and; that the escalation procedures are audited for effectiveness.

During this inspection, the trust used the national early warning score (NEWS) tool; surgical areas used an electronic system to record the early warning score. Nursing staff automatically alerted any patients of concern to medical staff. Nursing staff we spoke with were able to articulate the deteriorating patient and were able to describe when they would escalate to senior staff for further review. The clinical trigger response chart was not located on the NEWS chart however staff we spoke with knew where to access this information. Staff we spoke with also said that, out of hours, they could contact the outreach team for support if they recognised a patient deterioration.

At the time of the inspection, only registered nurses were able to monitor and record NEWS scores, this was in agreement with commissioners following a number of serious incidents related to the deteriorating patient. The trust had recently updated the NEWS policy and had revised the levels of escalation.

We reviewed four sets of patient notes in these we saw appropriate evidence of escalation of deteriorating patients. The matrons reviewed compliance with clinical observations in relation to
NEWS as part of the matron audits, results from January 2018 showed that on the majority of occasions records reviewed showed compliance with the audit criteria, and appropriate escalation of deteriorating patients.

We asked to review internal compliance data of the checks by the trust, this showed that the trust had reviewed ten sets of records on each ward in January 2018, within surgical areas 274 records had been reviewed and 344 (90%) had frequency of observations stated. Late observations were only recorded on 22 occasions 7% of occasions and staff calculated NEWS score incorrectly on 20 occasions (7%).

Staff we spoke with confirmed registered nurses completed NEWS and sepsis training. A sepsis care plan was available to support staff. This training and further support was provided by the critical care outreach team.

At the 2016 inspection, we also said the trust must ensure the effective use and auditing of best practice guidance such as the ‘five steps to safer surgery’ checklist within theatres and standardising of procedures across specialities relating to swab counts.

At this inspection, the hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. During the inspection, we did not observe consistency with five steps to safer surgery including the World Health Organisation (WHO) surgical safety checklist.

From our observations it was apparent the five steps to safer surgery checklist, was not embedded as a routine part of the surgical pathway. For example we observed that on one occasion no sign in was observed, on another occasion all elements of the check list were not verbalised and on another occasion when verbalised did not have everyone’s attention. We only observed one occasion when the checklists were completed fully. We raised this as a concern with staff we spoke with who explained that a new WHO checklist had been recently changed, there was also inconsistencies over who could lead and sign the checklists. Managers we spoke with also confirmed that training had not been completed with all staff and was due completion in the next few weeks.

The trust had relaunched the safer surgery checklist six weeks prior to the inspection. There was an action plan including national safety standards for invasive procedures (NatSSIPs) and the local safety standards for invasive procedures (LocSSIPs), this was comprehensive and the health group was on track with implementation and training.

Patient safety briefings were carried out pre-operatively this included discussion around the order of patients on the list, the addition of any emergency cases and the instrument and equipment requirements.

We reviewed six sets of surgical notes containing surgical safety checklists. On four of the occasions the checklists were complete, however during the inspection we saw variable levels of engagement from the clinical team, this did not provide assurance that this was an effective process.

We asked to review internal compliance data of the checks by the trust, as the trust had only recently relaunched the checklist, they were unable to supply these, but we were able to review the associated implementation and action plans.

The trust had reported three never events all associated with wrong site surgery or wrong prosthesis being implemented. We could therefore not be assured that the checklist was being used correctly consistently.
We saw that consumables such as needles, scalpel blades and swabs were recorded on a whiteboard in the theatre. A verbal and visual check was completed by the scrub and circulating practitioners and an instrument count undertaken.

At the 2016 inspection, we told the trust they must ensure that elective orthopaedic patients are regularly assessed and monitored by senior medical staff. During this inspection, we saw improvements in the documentation of elective reviews and staff we spoke with did not highlight any issues with the current processes. We reviewed risk assessments including pressure damage acquisition, malnutrition, falls, bed rails, moving and handling and venous thromboembolism (VTE) compliance in the majority of patient records we found that these were completed. Where necessary we saw that patients identified as high risk had been referred to further services such as tissue viability teams or dietitians or provided with additional equipment such as pressure relieving devices as required.

**Nurse staffing**

At the 2016 inspection, we said that the trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels on surgical wards.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 15% for nursing staff in surgery. The trust did not provide an overall target for vacancies. *(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 14% for nursing staff in surgery. This was worse than the overall trust target for turnover of 9%. *(Source: Routine Provider Information Request (RPIR) P18 Turnover)*

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 4% for nursing staff in surgery. This was in line with the overall trust target for sickness of 4%. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

Staffing fill rates were reported on the hard truths dashboard. We reviewed the information supplied for December 2017 and saw the majority of registered nurse fill rates consistently above 80% day and night shifts. Two areas ward 14 and ward 16 had scored below 80%, 78% and 62% respectively for registered nurse day shifts.

On the days of the inspection, we saw that some wards were not meeting the planned staffing levels. For example, data we saw displayed on wards 27 and 15 showed they had one less registered nurse than the planned numbers on duty for days and/or night shifts.

On ward 9 staff spoke with us about a recent nursing establishment review that had improved staffing levels on the ward due to the acuity of the patients in this area.

The trust used safecare to monitor patients acuity and plan staffing levels, staff escalated issues through the site management meetings four times a day, these meetings were used to establish patient flow issues, staffing issues and the capacity and demand on each site. Staff we spoke with said there was effective discussion at the meetings which helped them to ensure ward staffing levels remained safe.

Staff we spoke with did highlight that they were asked to move wards and work in other areas they also said that staff being moved had resulted in more pressure in their area of work but they recognised that sometimes staff had to be moved to another ward to maintain patient safety.
On the majority of occasions staffing levels in theatres were in line with the national recommendations for safe peri-operative care (AfPP) 2016. At the time of the inspection, the staff we spoke with said that the trust had no policy for staff working in dual roles in day theatres for example; perioperative practitioners who participate as surgical first assistants, as such were unable to confirm that staff had the appropriate skills, knowledge and competence to undertake these roles.

Medical staffing
At the 2016 inspection, we said that the trust must ensure that there are at all times sufficient numbers (including junior doctors) of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels on surgical wards.

The trust reported actual whole time equivalent (wte) and headcount staffing figures from March to October 2017 but these were not provided at core service level or site level.
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 11% for medical and dental staff in surgery. The trust did not provide an overall target for vacancies.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 17% for medical and dental staff in surgery. This was worse than the overall trust target for turnover of 9%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 1% for medical and dental staff in surgery. This was better than the overall trust target for sickness of 4%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust has reported two of the five areas with highest bank and locum staff use to be in surgery. These are: orthopaedic and trauma (wards C8 and C9) covering both sites, and general surgery (wards C11 and C14) also covering both sites. It attributes this to a high vacancy rate and plans to mitigate this by recruiting more trust doctors.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.
The following chart shows this in greater details:

**Staffing skill mix for the whole time equivalent staff working at Hull and East Yorkshire Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

At this inspection, for all surgical specialties a consultant was present on site 8am till 6pm Monday to Friday. Acute general surgery and trauma had consultant presence at the weekends and bank holidays.

On call cover was provided by junior doctors, one resident foundation level two doctor was available, two registrars were available overnight. Staff we spoke with acknowledged some gaps in the medical rotas; this was highlighted on the health group risk register.

On orthopaedic wards junior staff were available throughout the day and consultants carried out daily ward rounds and a weekly grand round.

Junior medical staff we spoke with said they felt supported working in the trust and felt able to raise concerns as required.

Formal medical handovers took place twice a day during shift changes; we did not observe these during inspection.

**Records**

Paper records were available for each patient that attended the wards and departments; the trust used an electronic patient management system to record key information about the patients hospital stay and anticipated risks.

Electronic whiteboards were available on all wards we visited, these provided staff with easy access to key information, such a discharge dates and review by other members of disciplinary team physiotherapists, dietitians etc.

We reviewed eighteen sets of records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. We did observe that during the inspection notes were not always stored in an organised manner and the majority of the notes we reviewed had loose entries, this potentially could lead to patient’s records going missing or being filed in the incorrect records.
Patient records were all stored in areas that were secure or observed and we did not see any patients notes left unattended.

We saw that patient records held individualised plans of care for example sepsis, pressure area prevention and falls care plans.

Quality assurance audits were carried out on record keeping on a monthly basis; five sets of records were independently audited by the matron each week.

**Medicines**

At the 2016 inspection, we said the trust must ensure staff record medicine refrigerator temperatures daily and respond appropriately when these fall outside of the recommended range.

At this inspection, we saw that staff recorded medicines refrigerator temperatures daily. We also saw actions recorded if the temperatures were not within expected ranges.

Pharmacy services were available at Hull Royal Infirmary and Castle Hill Hospital seven days a week, 365 days per year. On call arrangements were in place if the department was closed.

We checked that controlled drugs were stored safely and securely on areas visited and found these had been checked in line with policy and there were no discrepancies. Controlled drugs were audited by the nurse in charge of the ward on a weekly basis and biannually by a pharmacist. Learning from this audit was feedback to the ward manager and medicines safety group. On ward 14 we saw the controlled drug book was not locked away and we raised this with staff at the time of the inspection, and staff took immediate action to lock it away.

Medicines reconciliation was completed by ward based pharmacists and pharmacy technicians. The trust did not achieve the target for medicine reconciliation within 24 hours of admission; however the trust did achieve the medicine reconciliation at any one time target.

The pharmacy department were piloting a new daily report which identified patients admitted for over 20 hours and had not received medicine reconciliation. These patients were then prioritised by a dedicated pharmacy team.

We saw on four occasions staff administering medicines as per trust policy and checking patient details prior to administration.

We reviewed four medicine administration charts and noted medicines were prescribed and administered within national guidance. We saw that medicine administration records had an order to support staff in the event of patient needed emergency oxygen. Where appropriate we saw this completed on the charts we reviewed.

Antibiotic prescribing audits were completed monthly looking at indication, appropriateness and review/ stop dates.

Medical gases we reviewed were all stored appropriately in designated holders.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The trust reported three incidents which took place from November 2016 to October 2017 and were classified as never events for surgery. All three never events took place at Castle Hill Hospital since August 2017. These were:
- Wrong entry site during surgery for ulna nerve decompression
- Wrong bearing implanted during elective knee surgery
- Wrong rib resected (awaiting RCA report)

(Source: Strategic Executive Information System (STEIS))

At the 2016 inspection, we said the trust must ensure learning from never events is further disseminated and lessons learnt are embedded.

Staff we spoke with in theatres were aware of the never events. Staff also said that the trust intranet displayed information about serious incidents and never events. In addition, staff were sent bulletins via email and lessons learned were also detailed in the trust newsletter. Information regarding the recent never events framework changes had also been shared with staff through the lessons shared bulletins.

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from November 2016 to October 2017.

Of these, the most common types of incident reported were:
- Surgical/invasive procedure incident meeting SI criteria with six (43% of total incidents)
- Treatment delay meeting SI criteria with five (36% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (7% of total incidents)
- Pressure ulcer meeting SI criteria with one (7% of total incidents)
- Slips/trips/falls meeting SI criteria with one (7% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The service had systems in place for reporting, monitoring, and learning from incidents. The trust had an incidents and near miss policy, dated January 2017. This provided staff with information about reporting, escalation, and investigation processes.

Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. In addition, once reported the reporting system sent an alert to other relevant professionals, for example when pressure damage was reported the tissue viability team received notification.

The trust had declared a further two serious incidents with in the health group in November 2017 and three in December 2017, these were in the process of being investigated.

Staff we spoke with described positive reporting cultures within the health group and said they were supported to report incidents.

Ward staff we spoke with said that any learning from incidents was shared at team meetings. We saw examples of changes in discharge procedures post a nutrition related incident and inappropriate removal of drain. Lessons learned briefings were also produced by the trust; again, staff said these were shared with staff at ward level through team meetings. We were assured that serious incidents and never events in other care groups were shared, as staff were able to tell us about these.

Ward managers said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed three serious incident reports; we found theses to include contributing factors, identification of lessons learned and recommendations to prevent recurrence of this incident. Duty of candour requirements was detailed in all the reports we reviewed.
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.

All grades of staff we spoke with were aware of the duty of candour and were able to provide examples of when they would use this.

In the November 2017, operational quality committee and health group board minutes we saw 100% compliance with duty of candour requirements.

Safety thermometer
The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 18 new pressure ulcers, eight falls with harm and seven new catheter urinary tract infections from November 2016 to November 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Hull and East Yorkshire Hospitals NHS Trust

(Source: NHS Digital)
During the inspection, we saw patient safety display boards on the wards we visited, which showed when the most recent patient harm had occurred. For example, we saw that patients on ward 27 had not suffered any hospital acquired unavoidable pressure damage.

Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed showed that the trust was currently failing to achieve the VTE assessment indicator with performance of 90.6% November 2017. This was worse than the trust target of 95%. This had been reported at the quality committee and the committee had agreed actions to improve performance.

**Is the service effective?**

**Evidence-based care and treatment**

During the inspection, we reviewed some of the trust’s clinical protocols and patient pathways used for patients on surgical wards; these included the trust cardiothoracic and orthopaedic joint replacement pathways.

We saw patients’ treatment was based on national guidance, such as the National Institute for Health and Care Excellence (NICE). The Royal College of anaesthetists and the Royal College of Surgeons.

Policies were stored on the intranet and staff we spoke with were able to access them.

Wards and departments we visited participated in local audit programmes called fundamental standards audits; these audits included nine fundamental standards. These audits had been developed to monitor patient care across a number of core elements including; staff and patient experience, patient environment, IPC, safeguarding, medicines management and nutrition and hydration. We saw the results of these audits displayed on ward corridors. Staff used observations of care, discussion with patients and staff to provide assurance on the care delivered. Senior staff rated the assessment and this indicated the frequency of the review required. Following the review ward managers were expected to produce an action plan to improve performance and these action plans were approved by the senior matron for the area. Elements of the audit included infection prevention and control, safeguarding, medicines management and patient experience.

One of the surgical areas on this site had scored below 80% for compliance with tissue viability checks in November 2017. The matrons had undertaken a review and were continuing to monitor the levels.

The health group had a local audit programme and these were discussed during audit meetings. Clinical audit compliance was measured by the health group and we saw that 19 clinical audits had overdue actions; the health group had arranged a meeting to discuss further.

**Nutrition and hydration**

At the 2016 inspection, we said the trust must ensure that patients’ food and fluid charts are fully completed and audited to ensure appropriate actions are taken for patients.

At this inspection, on the majority of occasion’s food and fluid charts were completed, however we did not see that staff always totalled daily intake and output.

Senior staff carried out audits on nutrition and hydration, all of the surgical areas on this site had scored above 80% for compliance with nutrition and hydration in November 2017.

Protected mealtimes were promoted on the wards we visited. Red trays and water jug lids were used to identify patients who needed assistance with food and fluids. We saw that staff supported patients who needed assistance during our visit.
Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. Records we reviewed showed that surgical in-patients were being fasted for too long prior to surgery. Eight out of eight records we reviewed all showed that patients had fasted for longer than six hours and in some cases as long as 12 hours. The trust had a policy for fasting time that was in line with national guidance however, staff we spoke with highlighted concerns about the differing times anaesthetists recommended for fasting, the senior management team agreed to review this further and take appropriate action.

Staff, by using the malnutrition universal screening tool (MUST) documentation, identified patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient notes, we reviewed, showed appropriate levels of completion. Staff re-assessed patient nutritional status during the admission at regular intervals.

The majority of the patients we spoke with said that the food was very good and said that water was replenished twice a day but that could ask for more and staff would bring it for them.

**Pain relief**

During this inspection, we saw patients being offered pain relief, patients we spoke with said that staff offered them pain relief on a regular basis and said that staff checked that pain relief administered had been effective.

We observed staff using pain scoring tools to assess patients’ pain levels; staff recorded this information on the electronic records.

Some surgical patients received intravenous patient controlled pain relief post-operatively. This was in line with national best practice guidance from the British Pain Society.

Nursing staff we spoke with said that the trust pain team were available for support with patient’s pain. We were told that this team was very responsive. A patient we spoke with provided an example of how staff had accessed this service for them post-operatively and they said how valuable this had been.

Patients we spoke with said that staff responded quickly when they needed pain relief; they also said that if pain relief was not effective, they quickly asked a doctor to review their pain relief.

Patients we spoke with on all wards said they received pain relief as soon as they needed it. One said that staff always checked their identity before giving pain relief.

**Patient outcomes**

**Relative risk of readmission**

*Castle Hill Hospital*

From September 2016 to August 2017 patients at Castle Hill Hospital had a better than expected risk of readmission for elective admissions and non-elective admissions when compared to the England averages.
Elective Admissions - Castle Hill Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in urology and cardiothoracic surgery at Castle Hill Hospital had a better than expected risk of readmission for elective admissions when compared to the England averages.
- Patients in upper gastrointestinal surgery patients at Castle Hill Hospital had a similar too expected risk of readmission for elective admissions when compared to the England average.

Non-Elective Admissions - Castle Hill Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

- Patients in urology and cardiothoracic surgery at Castle Hill Hospital had a better than expected risk of readmission for non-elective admissions when compared to the England averages.
- Patients in ear nose and throat specialities at Castle Hill Hospital had a similar too expected risk of readmission for non-elective admissions when compared to the England average.

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 86% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 89%.

The risk-adjusted 90-day post-operative mortality rate was 1% which was better than expected. The 2015 figure was 4%.

The risk-adjusted 2-year post-operative mortality rate was 29% which is worse than expected. The 2015 figure was 19%.

The risk-adjusted 30-day unplanned readmission rate was 9% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major
Resection was 41% which was better than expected. The 2015 figure was 45%. 
(Source: National Bowel Cancer Audit)

At this inspection, we reviewed action plans which included mortality reviews and low levels of anaesthetic risk scoring, this was marked as completed.

The service had implemented a consultant surgeon on call system on the Hull Royal Infirmary site that ensured an upper gastrointestinal surgeon and a colorectal surgeon were on call either during the day or at night each day; this meant that patients requiring emergency theatre were transferred to the HRI site for treatment and had access to an appropriate specialist surgeon within 12 hours of admission.

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10%.

The 90-day post-operative mortality rate was 9%, which was within the expected range. The 2015 rate was 9.5%.

The proportion of patients treated with curative intent in the strategic clinical network was 34%, which is significantly lower than the national aggregate.

This metric is defined at strategic clinical network level (the network can represent several cancer units and specialist centres); the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results 
(Source: National Oesophago-Gastric Cancer Audit 2016)

Despite requesting information from the trust we were not supplied with an action plan for this audit.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17:
- Performance for groin hernias according to both the EQ VAS index and EQ-5D index was about the same as the England average.
- Performance for varicose veins was better than the England average.
- Performance for hip replacements was worse than the England average according to EQ VAS index, but similar to the England average according to EQ-5D index and the Oxford Hip Score.
- Performance for knee replacements according to EQ VAS index was worse than the England average. However, performance for knee replacements according to both the EQ-5D index and the Oxford Knee Score was generally the same as the England average.

(Source: NHS Digital)

At the time of the inspection, the trust was classified as a mortality outlier with the Care Quality Commission for cardiac artery bypass graft. This meant that deaths had been outside of the expected range for this procedure. The trust had undertaken a case note review to determine if the deaths were avoidable and what lessons could be learnt. The trust had identified outcomes and had developed an action plan to reduce the risks to patients. This action plan was near completion.

Competent staff

From April 2017 to October 2017, 78% of staff within surgery at the trust had received an appraisal. The figure for medical and dental staff was 76% which was worse than the trust target of 90%, while the figure for nursing and midwifery staff was 77% which was worse than the trust target of 85%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied Health Professionals</td>
<td>14</td>
<td>13</td>
<td>108%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>63</td>
<td>73</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Add Prof Scientific and</td>
<td>52</td>
<td>63</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
At the 2016 inspection, we saw that the health group had an appraisal target of 85% with 87.7% of nursing staff having an up to date appraisal, appraisal data was not available for medical staff.

During this inspection we saw a decrease in the appraisal rates reported for nursing staff, however staff we spoke with said that they had receive an appraisal within the previous 12 months.

Senior staff we spoke with said that registered nurses were being given the opportunity to complete education modules in anaesthetics to improve their skills and to help address the gaps in operating department practitioners (ODP’s).

Student nurses we spoke with said that they had been well supported by their mentor and that they had enjoyed their placement at the hospital.

The trust employed nurses with extended skills to support patients. For example on ward 27 an advanced practitioner was employed to support cardiac patients. Staff had complete additional competency based training qualifications to allow them to undertake these roles.

Staff were offered extended practice training to enable them to carryout additional roles such as role specific training and nurse prescribing.

Registered nursing staff we spoke with said that systems were in place to alert them to their registration and revalidation dates, staff we spoke with said that they had been supported through revalidation by the trust.

Medical staff we spoke with said that they received time for training, education and portfolio development.

**Multidisciplinary working**

There were established multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses and radiologists.

Staff held daily multidisciplinary huddles on the wards we visited.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

Physiotherapy staff were integrated in to some of the areas we visited for example on orthopaedics.
A patient we spoke with said that the “cleaning team” were also fantastic and said that in their experience that all staff helped each other.

Student nurses we spoke with spoke highly of the experience that they had received during placement and would recommend the wards we visited for other students.

**Seven-day services**

At the time of the inspection, junior medical staff were available seven days a week with support from senior doctors and consultants. Surgical consultants provided a seven-day service. Nursing staff said that medical staff were accessible and supportive when they needed advice.

The trust’s pharmacy and diagnostic imaging departments provided a seven-day service.

The trust’s dietetic department offered a Monday to Friday service.

**Health promotion**

Health promotion information was available on wards we visited. This included display boards and information leaflets for patients on smoking cessation, healthy eating, wound care and infection prevention and control.

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

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>354</td>
<td>418</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>352</td>
<td>418</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for MCA and DoLS courses from April 2017 to October 2017 for nursing and midwifery staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>803</td>
<td>859</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>802</td>
<td>859</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

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.
Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards.

We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards. One staff member spoke with us about ensuring the least restrictive option is always used. We saw where a patient was deemed to lack capacity this was supported by a documented assessment and best interest decision-making.

Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient’s capacity. We saw one patient who lacked capacity and had been unable to consent to treatment had appropriate best interest decision making documented and Deprivation of Liberty Safeguards (DoLs) in place.

Staff also said that support was available from the safeguarding team if an urgent authorisation for a deprivation of liberty was needed for patients who lacked capacity.

The abbreviated mental test score is carried out on patients aged over 75 who are admitted to hospital for more than 72 hours to identify patients who are at risk of developing delirium whilst in hospital and can provided an opportunity for discussion with patients and carers about any concerns. During the inspection, on wards we visited we did not see consistent implementation of the test and staff we spoke with were uncertain on when and who should carry out the test.

Staff we spoke with said that they had access to mental health referral pathways and would use these if they had concerns about any patients.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of care records in line with national best practice. We saw one example of there being no documentation relating to the discussion with a family about a DNACPR order, in the medical notes.

The trust were implementing the ‘ReSPECT’ documentation. ReSPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

**Is the service caring?**

**Compassionate care**

The friends and family test response rate for surgery at the Hull and East Yorkshire Hospitals NHS Trust was 22%. This was worse than the England average of 29%.
The response rate for surgery within Castle Hill Hospital was 20%.
(Source: NHS England Friends and Family Test)

We spoke with twenty patients on the surgical wards at this hospital. One patient said that despite staff being extremely busy they were always there when you needed them. This patient also said that they never needed to use their call bell as staff were always there.

Two patients we spoke with said “the ward was brilliant and that they were glad they were here”.

A patient on ward 12 described the care they had received as “excellent” and that they didn’t have any concerns. They said that staff were “very caring and nothing was too much trouble”.

Another patient provided an example of staff noticing they were awake in the night and provided additional hot drinks to help to settle them.

A patient on ward 11 said ‘nothing is too much trouble’ for the staff. Other patients told us that they couldn’t fault anything on the ward.

During the inspection, patients reviewed had access to call bells and drinks at hand. During the inspection, we did not hear call bells ringing for long periods of time.

Wards and department we visited displayed their friends and family results. Patients we spoke with in the daisy unit said that they would recommend the service to others.

We observed staff closing curtains/doors whilst carrying out personal care.

We read one compliment report where staff had observed the minutes silence at the end of an ex-serviceman’s bed space this had provided comfort for the patients relatives.

**Emotional support**

We saw that ward managers were visible on wards and relatives and patients were able to speak with them.

One patient said that staff had taken the time to support them and spend time with them and their family. Patients also provided examples of staff supporting other patients on the ward prior to surgical procedures.

A patient we spoke with said that staff were very understanding and they took time to talk to them.

Another patient said that the physiotherapy staff were “very kind and held their hand whilst walking”.

A multi-faith chaplaincy service was available for patients.

Clinical nurse specialists were available within surgery and attended wards to provide additional support and advice to patients. Patients we spoke with provided examples of when these nurses had provided additional support, For example helping to decide the position of stomas.

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

A range of information leaflets and advice posters were available on wards we visited these included discharge information, specialist services and general advice about nutrition and hydration. Day case patients we spoke with said that they received all the information they required prior to their procedure.
A patient we spoke with said that staff explained everything to them, and that the medical staff had taken additional time to ensure they understood everything.

A patient we spoke with said that staff made sure that they had received all the equipment they needed pre-discharge.

Patients said that junior medical staff always took time to explain things; one said this was after the consultants had been.

A patient we spoke with on ward 27 said that on here “you are not a number you are you”. This patient said that this gave them confidence in their local services.

Patients we spoke with said they knew who to approach if they had issues regarding their care, and they felt able to ask questions. One patient said that staff “were all really good listeners if they had any problems they wanted to discuss”. Another patient said that “staff were with them every step of the way”.

During the inspection, we overheard a conversation on ward 27 between staff and patient, this was an informative conversation, staff were reassuring and provided all necessary information at a pace for the patient, they kept ensuring that the patient was happy and understood the information.

Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge. One patient provided us with an example of staff arranging additional support from physiotherapists to ensure that the patient was safe for discharge.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

On this site the surgery health group provided elective (planned) surgical treatments for patients.

They also provided non-elective (acute) cardiothoracic surgery.

The health group worked closely with local commissioners to plan and deliver services.

The health group had recently relocated maxillofacial surgery on the Castle Hill hospital site, the senior management team said that this decision had improved patient experiences and reduced levels of cancellations.

**Meeting people’s individual needs**

During the inspection, NHS England had relaxed the requirements around mixed sex accommodation to ease winter pressures. During the inspection we did see male and female patients located next to each other in high observation areas. The trust said was in agreement with commissioners.

The trust had an enhanced care team who were available to support staff when caring for patients who needed one to one care to maintain their safety. Staff we spoke with were aware of the process to access additional support. Staff also described to us a bed watch at night programme where staff could request additional support for patients at risk of falling overnight.

Staff we spoke with said that visiting times were flexible for families and carers of patients who were receiving care at the end of their life, or for example, when patients living with dementia were more settled when family were present. The wards used a butterfly symbol to identify and support patients living with dementia or delirium.
Staff working on ward 15, provided additional equipment for patients living with dementia such as a doll, old photographs, colouring books. Patients living with dementia were located in a specific area and patients had access to dementia friendly aids such as red toilet seats, white plates with red edges, red trays and red lids on jugs. Staff also used a pathway for patients living with dementia; this was written in collaboration with carers and family members.

The trust employed a learning disabilities lead nurse, and staff we spoke with knew how to access this service and provided examples of when they had attended the ward. Surgical wards we visited also had access to a living with dementia link nurse, who had extended training and knowledge.

Patients we spoke with said that staff always respected their privacy and dignity.

Trust data from the patient led assessment of the care environment (PLACE) assessments from March 2017 to June 2017 showed privacy, dignity and well-being (78.7%) and assessment of environment for dementia care as (70.7%) these were both below the national average of 83.7% and 76.1% respectively.

Patients on all surgical wards we visited said staff responded quickly ‘even when they were busy’.

The pre-assessment team or the admitting ward reviewed patients’ needs on admission, in regards to hearing difficulties.

Translation services were available for people whose first language was not English. Staff we spoke with said that this service was very responsive and if consent was being gained, they would often visit the hospital and interpret face-to-face.

Patients with particular health needs were identified at staff briefings for example; those with learning disabilities, mental health conditions and living with dementia.

Specialised equipment for bariatric patients was available on some wards visited such as wheelchairs, commodes and chairs. Other equipment was stored on the other site and staff knew how to request and arrange transportation.

Relevant information for patients was displayed on the walls and corridors of wards we visited, such as audit performance, health promotion and condition specific information.

The wards and departments were accessible for patients with limited mobility and people who used a wheelchair.

Access and flow
At the 2016 inspection, we said the trust must ensure that planning and delivering care meets the national standards for the referral to treatment times. This was because the trust did not meet national performance indicators for surgery.

Referral to treatment (percentage within 18 weeks) - admitted performance
From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently worse than the England average, fluctuating between 60% and 67%. A local trajectory for incomplete pathways (total) had been agreed with commissioners and NHS improvement.
The most recent data from October 2017 shows 62% of this group of patients were treated within 18 weeks versus the England average of 69%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialities were better than the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>81%</td>
<td>74%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>67%</td>
<td>66%</td>
</tr>
</tbody>
</table>

Seven specialities were worse the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic Surgery</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>Urology</td>
<td>76%</td>
<td>77%</td>
</tr>
<tr>
<td>Cardithoracic Surgery</td>
<td>66%</td>
<td>84%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>53%</td>
<td>73%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>44%</td>
<td>62%</td>
</tr>
<tr>
<td>ENT</td>
<td>33%</td>
<td>65%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Average length of stay

Castle Hill Hospital

From October 2016 to September 2017 the average length of stay for all elective patients at Castle Hill Hospital was 4 days, which was worse than the England average of 3.3 days. The average length of stay for all non-elective patients at Castle Hill Hospital was 4.6 days, which was better than the England average of 5 days.

Elective Average Length of Stay - Castle Hill Hospital

Note: Top three specialties for specific trust based on count of activity.

From October 2016 to September 2017 the average length of stay for trauma & orthopaedics,
urology and cardiothoracic surgery elective patients at Castle Hill Hospital was worse than the England averages.

**Non-Elective Average Length of Stay - Castle Hill Hospital**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.6</td>
<td>8.9</td>
</tr>
<tr>
<td>Urology</td>
<td>5.0</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>3.4</td>
<td>2.2</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>2.8</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Top three specialties for specific trust based on count of activity.*

From October 2016 to September 2017:
- The average length of stay for urology and ear, nose and throat (ENT) non-elective patients at Castle Hill Hospital was worse than the England averages.
- The average length of stay for trauma & orthopaedics non-elective patients at Castle Hill Hospital was 1.1 days, which was better than the England average of 8.9 days.

(Source: NHS England)

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The latest information for Q2 2017/18 showed this trust had cancelled 203 surgeries. Of the 203 patients whose surgeries were cancelled, one was not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Hull and East Yorkshire Hospitals NHS Trust**

Over the two years, the percentage of cancelled operations at the trust showed an upward trend to a peak in Q4 2016/17 and has since declined. The number of patients whose operations were cancelled and not treated within 28 days was better than the England average.
Over the two years, the percentage of cancelled operations at the trust and was generally worse than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations. 
(Source: NHS England)

We saw that the surgical admissions care pathway included ward moves on the front page for staff to complete.

During the inspection, we saw that a number of surgical wards had medical patients (outliers) located on them, the trust had recently been through a period of increased demand and had postponed some elective surgery to accommodate additional emergency patients.

**Learning from complaints and concerns**

From November 2016 to November 2017, there were 156 complaints about surgical care. The trust took an average of 37 days to investigate and close complaints, this is in line with their complaints policy, which stated that complaints should be investigated and closed within 40 days.

As of November 2017, there were 16 complaints still open and yet to be completed. Themes included dissatisfaction with surgery results and problems in other areas of health following surgery.

- Castle Hill Hospital: There were 62 complaints which took an average of 41 days to investigate and close. Six complaints remained open at the time of the trust’s submission (Source: Routine Provider Information Request (RPIR) P61 – Complaints)

We saw information displayed in ward areas about how to raise a concern.

Staff we spoke with could describe how they would respond if a complaint or concern was raised. This included offering an initial, sincere apology and then advising that they would escalate the concern to the nurse in charge and offering the trusts’ Patient Advice and Liaison Service (PALS) details.

Themes and trends of complaints were shared within the health group via ward huddles, team meetings and individual conversations.

**Is the service well-led?**

**Leadership**

In 2016, we saw that the senior leadership team were new in post and required further time to develop and become fully effective in their roles. Since the last inspection, the senior team had
remained stable. There was a clear leadership structure; all wards had a substantive ward manager position that was supported by matrons.

Staff we spoke with said that the health group leadership team and described positive, supportive relationships with the senior leadership team and matrons.

We found the ward managers/nurse in charge on the wards we visited knowledgeable and professional. They appeared visible and approachable for the staff they supported.

Junior medical staff we spoke with said they felt supported by senior colleagues.

Staff we spoke with described being able to access leadership training programmes and talent training to improve leadership styles.

**Vision and strategy**
The health group’s values, vision and strategy were visible on posters in the corridors we visited. Staff we spoke with were aware of the trust vision and values.

The health group’s operational strategy was in line with the overall trust strategy.

All staff we spoke with were aware of the trust values and that this was discussed with them on induction.

**Culture**
Staff we spoke with said they felt valued. Staff we spoke with on ward 27 spoke about a positive culture on the ward; staff all worked together especially when the ward was very busy.

The senior management team were aware of cultural issues that can hamper compliance with the surgical safety checklist and were focusing on this to improve compliance, this included human factors training.

**Governance**
The surgery health group had a clear governance structure. The governance structures within the health group provided assurance of oversight of performance against safety measures, from board to ward. We reviewed a report from the health group escalating issues to the operational quality committee and board, this detailed issues for escalation, issues for upward reporting, risks, themes actions and learning. This report also highlighted good news from the health group.

We noted that the health group governance meeting had not been quorate in October and November 2017. Ward managers we spoke with said they attended a quality and safety meeting where governance was discussed, including the health group risk register, complaints and any serious incidents. A business meeting was also held to discuss finance and operational issues.

Morbidity and mortality meetings were held within the health group, patient deaths were discussed in depth to identify if any learning available and review whether the correct actions had been taken. A mortality review was completed on each patient which identified whether there was any concerns regarding the care received. Mortality trends were monitored centrally and fed this back to the speciality teams.

Following the never events that had occurred in surgery in 2017 members of the executive and health group leadership teams delivered a presentation to staff. This included reflections from staff who had been involved in historical never events. There was also a trust wide learning programme in place which involved a range of education and training sessions including human factors, simulation and training from external military agencies.
The chief nurse had set up an additional panel where the fundamental standards audits were discussed, at this panel the group reviewed performance, identified themes and trends and provided board level assurance of the quality of care delivered. The chief nurse presented the finding to the board on a regular basis.

**Management of risk, issues and performance**

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services. Each surgical speciality had individual business plans which included intelligence, command, threats and actions.

The health group had risk registers in place. These highlighted current risks and documented mitigating actions to reduce the risk. Risks were discussed at governance meetings and we saw escalation of the risks to other committees.

We spoke with senior staff within the health group about their highest risks, they identified staffing, implementation of the WHO checklist and finance which included cost of complex orthopaedic surgery as key risks, however not all of these risks were identified on the health group risk register.

The trust had relaunched the safer surgery checklist six weeks prior to the inspection, they had a very detailed programme commencing in July 2017 running through to August 2018, however there was little evidence of action that had been taken following the 2016 inspection, prior to the programme commencing.

The health group held a surgical safety brief each day at 7:45am, this meeting was attended by the nurse in charge from each ward, any safety concerns were identified at this meeting to the ‘zoning representative’ (who was one of the ward managers on a rotational basis). This included any concerns about staffing, patient acuity and risk, bed availability and delayed discharges.

Following this the zoning representative then attended a central briefing meeting at 9:30am, 2pm and 4pm to report the initial and any subsequent concerns that arose for the health group’s wards.

Consultants we spoke with said that they had a half day each month with no clinical work schedule which allowed them to attend departmental, mortality and morbidity and audit meetings.

**Information management**

Information provided by the trust, showed that 89.5% (November 2017) of staff within the health group had completed information governance training. This was worse than the trust’s target level for training of 95%. We did not have any concerns about the security of patients’ records during this inspection.

Computers were available on surgical wards; staff were able to access policies and clinical guidelines via the trust intranet. During the inspection, all computers were locked securely when not in use.

**Engagement**

Staff we spoke with said that the senior management team and some of the executive team were visible on the wards.

The national NHS staff survey showed the trust scored 3.77, average for staff engagement when compared with other trusts of a similar type.

Staff were informed of changes in the trust by electronic communication and a monthly newsletter.
Patient feedback was gained during the fundamental standards audits when staff gained patient feedback and tested whether evidence was available that this feedback had changed practice. Within the health group all scores were above 90% September 2017.

The trust’s website outlined opportunities to contact the trust and express opinions. It also supplied information on the services and hospital. The trust utilised social media as an engagement tool with the public and a list of social media accounts was listed on the website.

Patient representatives were included on committees, for example the major trauma board. The health group had a number of patient support groups within specialties.

The trust had introduced volunteers, young volunteers and young health champions to bring their experience into the organisation and to try to progress them on to apprenticeships. Clinical staff mentored young people from a local sixth form academy.

Colorectal surgeons had developed an improved colorectal/upper GI rota; this development had been supported by the senior management team.

**Learning, continuous improvement and innovation**

Surgeons we spoke with said that they had improved patient outcomes for aortic dissection in their own services through regional collaboration with colleagues, and shared rotas.

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**Outpatients**

### Facts and data about this service

Castle Hill Hospital (CHH) at Cottingham is approximately five miles away from the main Hull Royal Infirmary (HRI) site. The trust also has several off-site locations delivering outpatient services. There are consultant and nurse-led outpatient clinics across a range of specialities, which are provided from this location and in separate dedicated clinics around the hospital. These include:

- Neurology
- Rheumatology
- Nephrology
- Gastroenterology
- Podiatry
- Colorectal
- Vascular
- Neurosurgery
- Upper gastrointestinal
- Urology
- Plastics trauma unit
- Vascular (minor theatres)
- Trauma and orthopaedics
- Neurology
- Physiotherapy
- Ear, nose and throat
- Occupational therapy
- Respiratory medicine
- General medicine
- Audiology
- Breast
- Dermatology
- Rehabilitation
Outpatient clinics are held from Monday to Friday from 8.30am until 6pm with some late clinics until 7.30pm and some Saturday appointments are provided dependant on specialty.

The previous inspection in 2016 rated outpatients at Castle Hill Hospital (CHH) as requires improvement: Actions required by the trust were:

- The trust must ensure that medical records are stored securely and are accessible for authorised people in order to deliver safe care and treatment, especially within outpatient services.
- The trust must ensure that planning and delivering care meets the national standards for the referral-to-treatment times and eliminates any backlog of patients waiting for follow ups with particular regard to longest waits.
- The trust must ensure 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.

CQC current intelligence identifies:

- Referral to treatment times are below target.
- 62-day cancer waits (both from GP referral and from urgent screening referral) are worse than average.
- In July 2017 the trust found a serious issue with large number of patients lost to follow up since the introduction of a new electronic system in June 2015.

There is no ophthalmology, renal and dialysis located at Castle Hill Hospital and the central booking centre is based at Hull Royal Infirmary.

During this inspection, we visited the following areas:

- Main outpatients that held clinics for medical outpatients, surgical outpatients and respiratory outpatients.
- Plastics outpatients
- Cardiology outpatients
- Oncology outpatients
- Orthopaedic Outpatients
- Dermatology outpatients

We spoke with 33 members of staff in outpatients, including managers, nurses, radiographers, medical staff and administration staff. We also spoke with 33 patients. We reviewed paper and electronic patient records in outpatients 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. We reviewed 17 records.

Between October 2016 and December 2017, the trust had 679,926 first and follow-up outpatient appointments at the trust overall, including the off-site locations. In addition to appointments at the Castle Hill Hospital and Hull Royal Infirmary (HRI) hospital sites, the trust ran outpatient clinics at The East Riding Community Hospital, Westbourne NHS Centre and Bransholme Health Centre.

Between October 2016 and December 2017, there were 270,644 attendances at CHH.

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. Following our last inspection in 2016, Outpatient services are now managed within the family and women health group.
Total number of appointments compared to England

The trust had 679,926 first and follow-up outpatient appointments from October 2016 to September 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from October 2016 to September 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hull Royal Infirmary</td>
<td>403,610</td>
</tr>
<tr>
<td>Castle Hill Hospital</td>
<td>270,644</td>
</tr>
<tr>
<td>The East Riding Community Hospital</td>
<td>30,734</td>
</tr>
<tr>
<td>Bransholme Health Centre</td>
<td>3,980</td>
</tr>
<tr>
<td>Total for this Trust</td>
<td>740,558</td>
</tr>
<tr>
<td>England</td>
<td>103,794,079</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Number of appointments by specialty

The trust provided information on the number of appointments by speciality. For example, the speciality with the highest number of appointments between April 2017 and January 2018 was clinical oncology with 56,300 appointments, then cardiology with 25,351 appointments followed by ear, nose and throat with 18,056 appointments.
Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from October 2016 to September 2017.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training
The trust set a target of 85% for completion of mandatory training. Senior nursing staff were sent regular updates by the central teams to advise which staff required mandatory training. Staff we spoke with during our inspection told us they received mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in outpatients is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>53</td>
<td>58</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>52</td>
<td>58</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>50</td>
<td>58</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>43</td>
<td>58</td>
<td>74%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>38</td>
<td>58</td>
<td>66%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>37</td>
<td>58</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at the hospital was 78%. The trust met its completion rate target in two out of six mandatory training courses for medical and dental staff in outpatients. It should be noted that the information governance training has a higher target of 95%, so while completion was 86%, the trust did not meet this target. The lowest completion rate
was observed for resuscitation training with 64%.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for nursing and midwifery staff in outpatients is shown in the table below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control</td>
<td>64</td>
<td>68</td>
<td>94%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>61</td>
<td>68</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>60</td>
<td>68</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>49</td>
<td>58</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing and midwifery staff at the hospital was 89%. The trust met all completion rate targets for mandatory training of nursing and midwifery staff in outpatients, with the exception of the resuscitation course which had a completion rate of 72%.

The trust provided mandatory training information for a 12 month period. The above information is only for a partial year and the trust still have six months to complete training to meet their internal target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Safeguarding**

Staff we spoke with were aware of how to report safeguarding concerns and told us there was a safeguarding team at the trust available for advice.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding level 2 courses from April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>52</td>
<td>58</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>49</td>
<td>58</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Of the two safeguarding training courses delivered by the trust to medical and dental staff in outpatients, only one (safeguarding adults) met the target completion rate with 90% completion. While the trust did not meet the target for safeguarding children and young people training, it had
a rate of 84% which is 1% lower than the target.

The Trust employed a safeguarding lead and we saw that there were several safeguarding champions across the departments. These champions were existing members of staff whom had been given additional responsibilities specific to safeguarding and acted as a point of contact to support staff.

We saw that staff had access to safeguarding policies. This also included guidance for staff regarding abuse such as female genital mutilation (FGM). FGM is defined by the World Health Organisation as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’.

A breakdown of compliance for safeguarding level 2 courses from April 2017 to October 2017 for nursing and midwifery staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
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<th>Completion (%)</th>
<th>Target (%)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children and Young People</td>
<td>62</td>
<td>68</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust was better than the target for both safeguarding courses delivered. 
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

All areas we visited during our inspection were found to be visibly clean and tidy. Departments were cleaned daily and we found most cleaning logs on clinic room doors to have been completed, however we found one cleaning schedule in main outpatients, which had not been completed since July 2017.

Staff adhered to bare below the elbow guidance. Hand gel was available at the entrance of departments to assist in infection control. Chairs we checked could be wiped clean and were generally in a good state of repair.

Staff we spoke with told us that if a patient with an infectious disease was to attend clinic, they would allocate a room for the patient and bring the patient straight into clinic. Staff would use the required personal protective equipment and a deep clean would be carried out once the clinic had completed.

In the minor surgery department for plastic’s outpatients, staff we spoke with told us there was deep cleaning between the morning and afternoon sessions.

Patients, carers and families we spoke with told us toilet facilities were visibly clean.

We saw clinic staff participated in hand hygiene audits. The trust provided us with a patient led assessment of the care environment audit for departments such as cardiology, dermatology, main outpatients, ear, nose and throat outpatient’s and the haematology clinics. For example, cardiology had passed all areas of the cleanliness section apart from the stands areas, which noted that dust was found on the ledges of notes trolleys and passed all areas for hand hygiene and cleanliness. However the report did highlight that cleaning schedules required review.

Dermatology and main outpatients showed passes in all areas of the cleanliness section of the
reports. Ear, nose and throat and the haematology clinics passed most areas of the cleanliness section. These reports were dated November 2017.

**Environment and equipment**
The environment at Castle Hill Hospital outpatients was suitable and spacious. All areas we visited were tidy. Main outpatients had a main entrance where patients could check in electronically or in person with reception staff and would then wait in the main waiting room. Patients would be called by an electronic board through to one of three separate clinic waiting areas where there was seating available to wait to be called into clinic. There was a room available in the department for staff to weigh patients and take patient observations.

During our inspection we found there to be adequate seating available, however staff told us clinics could become busy at certain times of the week. There was bariatric seating available in main outpatients and a private room was available where patients, families and carers could sit if privacy was required.

The chemotherapy ward had been designed to be as open and relaxing as possible and there was an open lounge overlooking the areas outside the hospital.

Equipment checked during our inspection such as resuscitation equipment had been checked daily and was available in main outpatients and cardiology outpatients.

Plastics outpatients had five clinic rooms and a privacy room was available. There were 24 clinic rooms in main outpatients. Toilets were available in the main outpatients department.

We found a utility room in main outpatients to be open and there was a stock cupboard for cleaning items to be used in the department which was unlocked. We informed staff of this and they removed the stock from the unlocked cupboard.

The patient led assessment of the care environment audit for cardiology showed mixed responses in relation to the access of the department. For example, the report showed that there was a hearing loop in the department, however there was no handrails available in the corridors and no bariatric chairs available.

**Assessing and responding to patient risk**
Staff we spoke with told us that if a patient deteriorated during clinic, they would do observations and monitor the patient and staff told us that emergency resuscitation equipment was available if required.

The trust policy required the use of an adapted ‘World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections in outpatients.

Some areas visited carried out minor surgery, for example the plastics department. The department used a version of the WHO checklist which when checked after an afternoon of minor surgery had been completed as required. We saw WHO checklists had been completed in the five notes we reviewed in dermatology.

The trust told us that the WHO checklist had recently been relaunched, six weeks prior to the inspection and it was planned that these audits will be rolled out as part of an on-going project. The trust audited compliance with the WHO checklist. Between January 2016 and March 2016, the audit found 100% compliance with the WHO checklist. The trust told us that although there was no audit evidence specific to outpatients at the time of inspection, it was planned that these audits will be rolled out as part of an on-going project.

We asked staff if there was a policy or protocol to manage patients who did not attend their
appointment. All staff we spoke with told us there was no formal process. Some staff told us they would ring the patient to check they were ok whilst other staff told us they would pass the patient file to the consultant to re-book another appointment.

Following the inspection, the trust submitted a copy of ‘Referral to treatment’ policy, which included protocols to manage patients who did not attend.

There was a hospital mental health liaison team that could be contacted via the switchboard. Staff we spoke with reported the team to be very responsive.

**Nurse staffing**

The previous inspection found staffing levels were variable across outpatients, there were particular concerns previously highlighted around cardiac physiology staffing levels. During this inspection we were told there was a locum echo cardiographer. We were told there were plans to improve cardiac physiology staffing levels through the use of apprenticeship systems. The service had recently recruited two cardiac physiologists.

During our inspection there were two members of staff in main outpatients on sick leave and there was one registered nurse vacancy for 0.4 whole time equivalent in main outpatients and cardiology. The service had a planned total of eight registered nurses in outpatients and the clinics had six currently which were a mixture of full and part time staff. We were told healthcare assistants levels were as planned. There were two vacancies in the echo department in cardiology during our inspection, however the manager for the services told us the situation was better than a year ago.

We were told there was always a registered nurse on duty in main outpatients and generally three registered nurses during morning clinics and two registered nurses on duty during clinics each afternoon. There were generally nine healthcare assistant staff during morning clinics and eight auxiliary staff during afternoon clinics.

During our inspection, plastics outpatients had four registered nurses with one nurse working in the Westwood suite and there were two healthcare assistants working in the department. Staffing levels were ascertained in plastic’s outpatients by the type of clinic which was on and the required number of staff to work in the clinic.

Outpatients did not have set staffing levels for daily clinics, we were told staff levels were ascertained by what clinic was on during that day, sickness levels and staff holidays. Staffing was flexible in the department to meet the clinic need. We were told staffing could feel short during clinic opening times.

There had been challenges with staffing prior to the inspection in pathology services and Castle Hill Hospital had around eight staff in training in the service. This required the department to send some staff to work at Hull Royal Infirmary where there were more qualified biomedical scientists. Managers we spoke with told us there was a three month plan from January 2018 to be completed by May 2018 to address these challenges where four staff would have completed training.

Patients we spoke with told us they thought there was enough staff in the areas visited.

The following information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust has not provided vacancy, turnover and sickness data at site level.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 7% for nursing staff in outpatients.

The trust did not provide a target for vacancy rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a turnover rate of 23% for nursing staff in outpatients. This was worse than the trust’s turnover target of 9%. The trust provided further information for some areas, for example at Castle Hill cardiac centre, the trust told us that out of 55 staff, five staff had left. The trust did not provide a date range for this data.
*Source: Routine Provider Information Request (RPIR) P18 Turnover*

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 5% for nursing staff in outpatients. This was worse than the trust’s overall sickness target of 4%.
*Source: Routine Provider Information Request (RPIR) P19 Sickness*

There was limited use of agency and bank staff in outpatients. Areas such as cardiac physiology had used agency staff to assist in addressing staffing challenges at Castle Hill Hospital.

**Medical staffing**

Medical staffing levels were ascertained by the individual specialities across the trust.

From November 2016 to October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a vacancy rate of 13% for medical and dental staff in outpatients.

The trust did not provide a target for vacancy rate.
*Source: Routine Provider Information Request (RPIR) P17 Vacancies*

As at November 2016 and October 2017, the Hull and East Yorkshire Hospitals NHS Trust reported a sickness rate of 0.4% in outpatients. This is lower than the trust’s overall sickness target of 4%.
*Source: Routine Provider Information Request (RPIR) P19 Sickness*

Medical staffing levels were ascertained by the individual specialities across the trust and this would include bank and locum staff if required.

**Records**

Records we reviewed during our inspection had the relevant areas completed. Patient records in general were stored securely. We saw main outpatients had record trolleys in the outpatient corridors with electronic locks attached and found these to be locked during the inspection.

Records in main outpatients waiting to be sorted for clinic were held in a locked room in the department.

We saw in some outpatient department’s record trolleys in corridors outside clinic rooms which were unattended and unlocked, for example in orthopaedic outpatients and the oncology and haematology outpatients. This records issue was also discussed within the minutes of the November 2017 outpatient governance meeting. The minute’s state that records should be covered if they are in patient areas.

Cardiology had record trolleys in the outpatients department. These were not locked but were closed and were stored outside clinics where staff were present. Patient files to go back the records storage areas were kept in a room in cardiology outpatients along a clinic corridor. However this door did not have a lock attached which meant there was a risk of unauthorised access.

We saw nine WHO checklists in different minor surgery outpatients and found these to be completed as required.
Ladybird bookmarks were used to flag patients who had specific needs such as dementia or learning difficulties. Seven records reviewed included the option to document additional needs such as learning disabilities.

Staff we spoke with told us that when there were no notes available, they would contact the records team and try to get patient notes for clinic. Staff told us they did not cancel clinics where records were not available and they would make temporary patient records if required.

**Medicines**

Medicines we checked in main outpatients were in date and locked in a medicines cupboard. FP10 prescription pads were locked in a cupboard also. We found two medical gas cylinders which did not have expiry dates attached, when we notified staff they told us these would be replaced.

We checked medicines in the cardiology outpatient department where they kept a small stock of medicines. One medicine was out of date by one month and when we notified staff they told us they would remove the medicine. The cardiology outpatient medicines cupboard was kept in a key pad locked room within the department.

Refrigerators temperature logs we checked during our inspection showed that temperatures had been checked and documented daily in outpatients.

We saw a number of Patient Group directions (PGD) were used across a number of clinics, including ophthalmology, cancer services and bowel screening.

**Incidents**

Staff in outpatients used the trust electronic incident reporting system to report incidents and we found a number of incidents had been reported through this system and staff we spoke with were aware of how to report incidents. We were told learning from incidents occurred through team meetings.

We requested minutes for the outpatient meetings and minutes the trust provided from January 2018 showed that health and safety was on the minutes and included the incident reporting system information. However we received staff meeting minutes from December 2017 and this did not show incidents and learning and been shared and discussed.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

From November 2016 to October 2017, the trust reported no incidents classified as never events for outpatients.

In accordance with the serious incident framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from November 2016 to October 2017.

Both incidents were treatment delays meeting SI criteria; one was at Castle Hill Hospital while the other was at Hull Royal Infirmary.

(Source: Provider Information Request (PIR))

The trust provided a serious incident report regarding three incidents which were reported in May 2017 and the type of incident was treatment delay – lost to follow up. These had been found because of an investigation into issues around follow up appointments at the trust.
There had been a number of incidents reported through the trust incident reporting system regarding delay to treatment and follow up appointments. For example, dermatology had reported one incident in January 2018, with regards to a follow up issue. This was completed on the 29th January 2018 and highlighted the service had added additional capacity and skin surveillance. In addition we saw wait times reduce.

In November 2017, an incident had been logged regarding delay failure in access to hospital care in dermatology and was documented as follow up appointment issues. This was logged as an incident to be monitored.

We requested recent lessons learnt or practice changes following incidents and the trust provided information stating that in dermatology a time critical access plan was in place to ensure potential skin cancer patients were seen in a timely manner. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents relating to duty of candour were available via the trust intranet. Staff we spoke with were aware of the duty of candour regulations.

**Safety thermometer**
The trust was not required to complete the safety thermometer for outpatients.

The head of outpatients told us that all outpatient staff had access to an outpatient dashboard. Following the inspection, we reviewed the outpatient dashboard and saw that it provided clear information such as numbers of patients who did not attend incidents and appointment numbers.

**Is the service effective?**

**Evidence-based care and treatment**
Staff used evidence based practice guidelines in the clinics we visited. Trust policies we reviewed were up to date and had review dates.

Policies were reviewed against The National Institute for Health and Care Excellence (NICE) Guidance and the responsibility to audit against and ensure these were kept up to date remained with each health group.

We were told that when the outpatient fundamental standards were implemented in outpatients, this would enable the service to implement audits for monitoring. Senior managers told us that audit was undertaken; however this was carried out in the specialities, for example medicine.

**Nutrition and hydration**
Staff we spoke with in outpatients told us they would offer patients a drink and could request food for patients where transport was delayed for example. Some areas in outpatients had water fountains for patient use.

Staff we spoke with in the plastics outpatient department told us food and drinks could be requested for patients if they were required.

**Pain relief**
Pain relief was generally not given across outpatient departments. However some clinics kept a small amount of pain control medicine. A pain clinic was carried out weekly on a Wednesday afternoon. Staff we spoke with told us they would speak with a clinician if a patient was in pain across outpatients.
**Patient outcomes**

We saw there were several audits carried out within the individual health groups. Within outpatients the trust had also completed baseline audits on room occupancy rates in March and September 2017 and clinic referrals to ECG in 2017. Trust wide we saw consent was regularly audited alongside record keeping specific to patient files.

From October 2016 to September 2017:

- The follow-up to new rates for Castle Hill Hospital and The East Riding Community Hospital were generally similar to the England average of just over two.
- The follow-up to new rate for Bransholme Health Centre was much better than the England average, fluctuating between slightly under five and around seven.

(Source: Hospital Episode Statistics)

**Competent staff**

Some health care assistants in main outpatients were completing the care certificate standards courses to increase their knowledge and skills in the department. Staff we spoke with told us they had received conflict resolution training and some staff had completed their phlebotomy training. Some staff we spoke with had completed a course for assisting patients who may be distressed.

Staff in the plastics outpatients had six to eight weekly skin meetings where people would provide a talk on a specific subject, for example infection, prevention and control. Some staff told us dementia training was available at the trust.

The head of outpatients provided a statement to us to advise that senior nurses were asked to complete an exercise in which they outlined the key tasks undertaken by health care assistants through to senior nurses. This was competed by all services with support of the practice development nurse and the deputy chief nursing officer. This exercise would help to identify any skill gaps within the workforce.

Staff we spoke with told us they had annual appraisals and told us these were an opportunity to discuss training.

Patient feedback in surgical and cardiology outpatients regarding staff having the necessary skills and knowledge to meet their needs was positive.

From April 2017 and October 2017, 78% of staff within outpatients at the trust had received an appraisal. Seventy nine percent of nursing and midwifery staff received and appraisal compared to a trust target of 85%.
A split by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Staff who have received an appraisal (n)</th>
<th>Staff requiring an appraisal (n)</th>
<th>Appraisal rate</th>
<th>Target rate</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and Ancillary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>53</td>
<td>67</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Registered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>61</td>
<td>78</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Additional Prof Scientific and Technical</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

In plastics outpatients, there were three tissue viability link nurses and staff described working closely with the trust tissue viability team.

Main outpatients held a daily brief with the team in outpatients to discuss for example, staffing levels for that day in the department.

Link nurses were available in outpatients, for example there were link nurses for tissue viability and infection, prevention and control.

There were surgical bariatric clinics weekly in main outpatients and the team involved consultants, registered nurses and dietitians. Each Thursday there was a multi-disciplinary team working in the oncology clinic. This clinic included doctors, for example respiratory and oncology doctors, registered nurses and radiotherapists. The gastroenterology doctors worked alongside the trust’s nutritionist specialist nurses to provide the service.

Seven-day services

Outpatients was open Monday to Friday 8:30am to 5pm. Main outpatients had a weekly respiratory Thursday evening clinic and there had been some clinics put on during weekends to assist in dealing with capacity and demand issues across the services.

Cardiology outpatients was open between 8am and 5pm Monday to Friday. Plastics outpatients was open between 9am and 5pm Monday to Friday.

Health promotion

A number of areas we visited had smoking cessation posters. The plastics outpatient department had plans to take part in a sun awareness day at the trust.

The trust told us carers support groups such as the myeloma and lymphoma group were supported across outpatients as a whole.

We saw the trust highlighted various national awareness days.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with had awareness of consent and the mental capacity act. We looked at five sets of records following plastics minor surgery and found that consent forms had been completed in all.

Staff we spoke with in the dermatology clinic told us they had received mental capacity act training, safeguarding training and deprivation of liberty safeguards training. We looked at five sets of records in dermatology and found the consent forms had been completed. We looked at seven sets of records in outpatients and found that consent was documented.

The trust reported that from April to October 2017, Mental Capacity Act (MCA) training had been completed by 91% of medical and dental staff within outpatients and 96% of nursing and midwifery staff.

During the same period, Deprivation of Liberty Safeguards (DoLS) training had been completed by 86% of medical and dental staff within outpatients, as well as 96% of nursing and midwifery staff.

This was better than the trust target of 85%.

A breakdown for MCA and DoLS training from April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>53</td>
<td>58</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>50</td>
<td>58</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown for MCA and DoLS courses from April to October 2017 for nursing and midwifery staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards</td>
<td>65</td>
<td>68</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with demonstrated an understanding of best interest decision making and knew how to seek advice when patients were not able to give valid informed consent due to a lack of mental capacity.
Is the service caring?

Compassionate care
We spoke with 79 patients during our inspection at Castle Hill Hospital and feedback regarding outpatients was positive. Patients, carers and family members told us that staff were caring.

We asked staff about chaperone availability and we were told chaperones were available to patients in clinic and there were posters on the walls highlighting chaperones were available.

Patients we spoke with in surgical outpatients about their overall impression was positive, however most patients were not aware chaperones were available. We spoke with seven patients about the attitude of staff in clinics and the feedback was positive.

Patients we spoke with told us they felt supported and treated with dignity and respect.

We saw within the trust wide 2017 patient led assessment of the care environment survey (PLACE) that 79% of patients felt they were provided with privacy, dignity and wellbeing. This was worse than the national average, which was 84%.

Patient-led assessments of the Care Environment (PLACE)

<table>
<thead>
<tr>
<th>This trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>79%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Emotional support
Staff we spoke with told us they encouraged patients to walk freely around the department to reduce any anxieties when attending future clinics. Clinic rooms could be made available for vulnerable patients if required. Some staff we spoke with told us they could get additional advice for patients with mental health needs.

Across the clinics there were a number of privacy and counselling rooms available to assist in maintaining privacy and dignity when patients were attending the clinics. The psychiatry team used the counselling rooms when required.

Most patients we spoke with told us they were involved in decision making about their care and treatment.

Understanding and involvement of patients and those close to them
Staff ensured privacy and dignity was maintained in clinics by ensuring clinic doors were closed during consultations. Dermatology had patient information leaflets available for people attending clinics and contact details were provided to patients attending clinics.

We spoke with fourteen patients about their views being listened to and acted upon and most patients were positive about this question.

Patients we spoke with told us they felt encouraged to be involved in their care.
We saw within the outpatient governance committee meeting minutes that patient representation was also included.

### Is the service responsive?

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

Outpatient clinics were managed by the speciality providing the clinics in outpatients. There was chest pain rapid access clinics available in the cardiology unit and patients referred to the rapid access clinics were to be seen within 14 days of the referral being received. We were told during our inspection that this could be a struggle to meet the demand, but extra clinics slots would be added to see patients. The rapid access one stop clinic included for example an echo cardiogram, seeing the consultant or blood test.

Outpatient clinics we visited had waiting areas and toilets were available. Main outpatients had an electronic check in and a reception desk for patients. Departments were signposted in the different clinics we visited. Clinics we visited had privacy rooms which could be used by patients, visitors and carers. The trust provided information highlighting there were volunteers in some areas of outpatients, for example in oncology and cardiology outpatients.

Staff in main outpatients also worked across cardiology outpatients at Castle Hill Hospital and rotated regularly through both departments.

Outpatients ran clinics for a number of specialties across the trust, for example, gastroenterology, respiratory and urology. The stop smoking team had recently started to attend the Thursday chronic obstructive pulmonary disease COPD clinics to provide additional links to services for patients attending clinics. Most clinics ran Monday to Friday during the day; however some specialties had an evening clinic on a Thursday. There were limited weekend clinics available and these were not routinely offered.

Appointment bookings were made either at the reception of the outpatient departments if the appointment was required within six weeks or made at the central booking centre at Hull Royal Hospital.

The hospital site was accessible by public transport and provided several car parking areas across the site with various drop off points around the hospital to assist patients who had difficulty with mobility. There was varied views across the trust about car parking.

From October 2016 to September 2017,
- The ‘did not attend’ rate for Castle Hill Hospital was generally similar to the England average and maintained a steady rate of around 6%.

#### Meeting people’s individual needs

There were a number of leaflets available in the different clinics we visited for patients. Chaperones were available in clinics we visited and there were posters on display in clinics highlighting the chaperone service to patients, carers and families.

Staff in the plastic’s outpatient department told us they would prioritise vulnerable patients in clinics, for example frail patients. Some staff we spoke with told us they could contact a trust mental health crisis team if required. Dermatology outpatient staff were able to contact outreach workers for patients with mental health conditions if needed; however staff across the different services were not always aware if there was mental health advice available for patients in outpatients.

Staff we spoke with told us interpreter services were available.
Specialist nurses were available in a number of clinics across the trust, for example cardiology had specialists nurse to provide further care and advice to patients.

We were told clinic appointment times varied depending on the clinic, but in general a new appointment would be 30 minutes and a follow up appointment would be 15 minutes. The rehabilitation clinics had reduced the numbers of patient seen in clinic as appointments could be up to an hour due to complex patient requirements.

There was a weekly bariatric clinic in main outpatients which was provided by a multidisciplinary team and rooms which were used to assist in maintaining privacy had bariatric chairs available.

Wheelchairs were available near the outpatient departments for those with additional mobility needs. Volunteers were available in some areas to help patients as required.

**Access and flow**
The previous inspection found issues with waiting times for patients and referral to treatment indicators not always being met. During this inspection, we found that referral to treatment indicators were still not always met.

We also found that there were appointment backlogs and waiting lists in the majority of outpatient services; during this inspection, we saw there were still appointment backlogs and waiting lists in a number of outpatient services. Each speciality area held responsibility for their own waiting lists.

Senior managers from each health group were clearly able to define where there were waiting lists and the processes they had in place to reduce the backlogs. We saw that these backlogs were included within the risk registers for the specific health groups.

We were told that the wait time for first appointments in the cardiology clinics was around nine weeks and for cardiac physiology was around two weeks. Follow up appointments in cardiology were more difficult to achieve within the required follow up timeframe.

Senior managers told us that patient administration was validating the backlogs initially and then these were receiving clinical validation if required afterwards. For example, dermatology were validating around 50 patients per week. The services were adding additional clinics to address backlogs of follow up appointments at the trust. We were told there was a new standard operating procedure for tracking, access and clinical validation.

We reviewed the data and saw that the largest clinic waiting lists were within the following clinics:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Waiting List</th>
<th>Follow Up Back Log</th>
<th>Follow Up Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First Appointment</td>
<td>Overdue</td>
<td>Not Overdue</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>4364</td>
<td>7011</td>
<td>17390</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1413</td>
<td>2793</td>
<td>4965</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2144</td>
<td>1196</td>
<td>2954</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>1507</td>
<td>1845</td>
<td>7296</td>
</tr>
<tr>
<td>Neurology</td>
<td>1353</td>
<td>4093</td>
<td>10236</td>
</tr>
</tbody>
</table>

The data summary showed that there were 33582 patients waiting for a first appointment across all health groups and 10166 patients waiting for follow up appointments without outpatients.

In March 2017, the trust found there had been an issue trust wide with follow up of patients not being followed up. The trust had identified three patient harms from this in urology at the Castle Hill site. This was due to a tracking issue within the electronic database system.

The trust took steps to investigative and work was undertaken to identify and confirm just how widespread the situation might be, and following the additional administrative and clinical reviews (which took place in April and May 2017) it was agreed that a much wider investigation process...
was required in terms of reviewing all patients going back to June 2015. From July through to October 2017 the administrative review continued and a clinical review of all patients affected also commenced.

This review was supported by an external organisation who acted as critical reviewer, Clinical Commissioning Groups and National Health Service Improvement and updates were regularly shared with National Health Service Improvement (NHSI).

The trust identified that the overall number of patients who required clinical review, follow up, diagnostic test and in some cases inpatient/day case treatment identified and managed to date was 2190, at the time of inspection. The trust told us there is potential for a further 7900 patients who will also require clinical review from the 54,000 patient group.

The clinical validation of patients was due to be completed by March 2018. The trust told us that they anticipated they would meet this deadline.

The Chief Operating Officer told us, to date figures up to the 12th March, were that 4632 clinical reviews have been completed. Approx. 20% clinical reviews left to do by end of March.

We saw an action plan and flow chart had been developed by the trust with an overall completion date of the 31st March, 2018. A task and finish group meet weekly to oversee this work.

Outpatients categorised waits in clinic as running late if patients had waited 30 minutes or more for their appointment once arriving in clinic. Clinics highlighted the wait time on the information board in waiting rooms when clinics were running over 30 minutes. The service did not audit the clinics waiting times.

Outpatients had considered how often rooms were used and had attempted to match empty rooms with additional activity if they could. Appointments were generally sent out by the central booking centre and patients could contact the trust to rearrange if required.

Plastics outpatients did have a waiting list and additional clinics were put on to assist in dealing with waiting lists. Staff we spoke with told us that the two week wait was being met.

The trust used text reminders and had produced a poster showing the effect of ‘did not attend’ (DNA) patients on the services to assist in addressing DNA rates across the trust. The hospital improvement team were working with services on what was the cause of patients who ‘did not attend’. Senior staff we spoke with told us they had changed some clinic times to the evening to accommodate patients who could only attend in the evening.

We spoke with ten patients about waiting times for appointments and most patients were positive about waiting times in surgical outpatients and cardiology outpatients. We spoke with 18 patients about waiting times once in clinic and most patients were positive about waiting times once in clinic.

The provider dashboard for outpatients showed that provider cancellations in January 2018 was 14%. The dashboard for outpatients for December 2017 showed that 30% of clinics were cancelled clinics under 6 weeks’ notice and in January 2018, 33.3% of clinics were cancelled clinics under 6 weeks’ notice. Before this inspection, some outpatient clinics had been cancelled due to winter pressures.

We saw that the trust had developed a ‘referral to treatment access policy’. This included the process for managing patients who did not attend. Patients who missed a first appointment were offered a second appointment within two weeks. Those patients who missed the second appointment would be referred back to the original point of referral.
Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for October 2017 showed 85% of this group of patients were treated within 18 weeks versus the England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Hull and East Yorkshire Hospitals NHS Trust.

(Source: NHS England)

The trust provided a referral to treatment (RTT) improvement plan for December 2017. This highlighted the plan to improve the approaches to manage RTT in the trust. This highlighted the completion and the required timeframe for completion varied between actions, some were not yet past the timeframe required for completion, some had been completed and three out of the 90 actions were overdue for completion.

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Five specialties were better than the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>90%</td>
<td>82%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87%</td>
<td>83%</td>
</tr>
</tbody>
</table>

14 specialties were worse than the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>93%</td>
<td>96%</td>
</tr>
<tr>
<td>Other</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Urology</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>84%</td>
<td>91%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>83%</td>
<td>87%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>82%</td>
<td>89%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81%</td>
<td>86%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>ENT</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>77%</td>
<td>89%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>71%</td>
<td>88%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>68%</td>
<td>91%</td>
</tr>
</tbody>
</table>

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – incomplete pathways
From November 2016 to October 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. Trust percentages have fluctuated between 84% and 87%, while the England average maintained a steady rate of 89% to 90%.

For the most recent month (October 2017), the trust performance was 87% compared to the England average of 90%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Hull and East Yorkshire Hospitals NHS Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
Three specialties were better than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medicine</td>
<td>99%</td>
<td>94%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>87%</td>
<td>86%</td>
</tr>
</tbody>
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Cancer waiting times – percentage of people seen by a specialist within two weeks of an urgent GP referral (all cancers)
The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. In the final three quarters, they were also performing better than the England average. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within two weeks of an urgent GP referral (all cancers), Hull and East Yorkshire Hospitals NHS Trust

(Source: NHS England – Cancer Waits)
Cancer waiting times – percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers)
The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). As the graph below shows, the trust performed better than the England average in the earlier quarters however performance declined in the final quarters.

(Source: NHS England – Cancer Waits)

Cancer waiting times – percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment
The trust was performing worse than both the 85% operational standard and the England average for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Hull and East Yorkshire Hospitals NHS Trust

(Source: NHS England – Cancer Waits)

Learning from complaints and concerns
Staff we spoke with told us that they would signpost patients to the patient advice and liaison service if they required further information about complaints. Staff we spoke with in outpatients told us that complaints relating to waiting lists would be sent to the speciality providing the outpatient clinic to be investigated and that complaints relating specifically to the outpatients department would be shared at team meetings which were monthly. Senior staff we spoke with in outpatients also told us minutes were sent to staff by email.

No patients we spoke with during our inspection had made a complaint to the services. We did not see complaint leaflets in departments readily available.

We reviewed three complaints specific to outpatients and saw that they were all managed within 40 days. Where there were delays, patients were advised of this accordingly.

From November 2016 to November 2017, there were 123 complaints about outpatients in the
trust. The trust took an average of 33 days to investigate and close complaints, this was in line with their complaints policy which states complaints should be completed within 40 days. As of November 2017, there were 25 complaints still open and yet to be completed.

- Castle Hill Hospital: There were 58 complaints which took an average of 31 days to investigate and close. Fourteen complaints remained open at the time of the trust's submission. Key themes included: poor care, misdiagnosis, and poor communication. (Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

A head of outpatients had been appointed in August 2016. We had concerns about the leadership capacity in the service due to the size and scope of the service and the amount of change that had taken place and was still to do. The head of outpatients was supported by the specific health group senior managers who had direct oversight of each outpatient clinic within their health group.

Staff we spoke with were positive about local leadership and told us local leadership was supportive and had an open door policy; however we were told senior managers were less visible. In plastics outpatients we were told senior outpatient staff were visible.

We spoke with twelve patients in outpatients and cardiology and most thought the services were well managed.

**Vision and strategy**

At the time of inspection, the strategy for outpatient services was in draft. We saw goals for outpatients were included within the overarching trust strategy. The overall trust vision was ‘great staff, great care, great future’. In order to achieve this the trust developed seven specific areas in which goals were set.

These were:

- Honest, caring and accountable culture
- Valued, skilled and sufficient workforce
- High quality care
- Great local services
- Great specialist services
- Partnership and integrated services
- Financial sustainability

Senior managers across the services told us they had reviewed what they provided over the previous months for outpatients and had moved some services between the three trust sites.

We saw within the trust strategy 2018 update that one specific goal set under high quality care was to reduce outpatient appointments cancelled by the trust and related complaints. The trust stated that further improvement in this area was required.

We also saw another goal specific to outpatients, which was under great local services. The trust goal was to be within the top 20% in the outpatient survey.

The services had plans to implement the outpatient fundamental standards across outpatient services.
Culture
Most staff we spoke with told us morale was generally good. There was a monthly staff meeting in main outpatients and we were told this is where staff would discuss changes in practice, information would be shared from the trust, and that information around incidents would be shared. The daily team brief in outpatients was used to discuss staffing levels.

The trust provided outpatient meeting minutes and this included agenda items such as staffing, clinics, trust brief, infection control, health and safety and key performance indicators.

Governance
The previous inspection found issues with governance and a lack of cohesive oversight of governance across outpatients.

There had been a newly formed governance committee for outpatients since the previous inspection. Senior managers told us that governance was discussed in the individual specialities across the trust.

Each health group held specific responsibility for their own governance arrangements. We saw that matrons used a handbook, which was an audit tool covering key areas such as nutrition, medicines management, infection control and tissue viability.

Staff within outpatients had a matron who was aligned to a specific health group. We reviewed minutes from staff huddles, which showed that each health group discussed key issues such as incidents, staffing, training and medicines management.

We were not assured that a system had been developed to bring all of the health groups together collaboratively across outpatients. The head of outpatients told us and we saw that governance processes within health groups were robust but outcomes were not shared collaboratively.

Several pieces of work had been undertaken by the head of outpatients including the staff mapping exercise across surgical and neurosurgery outpatients. This was completed by department nursing sisters.

The trust provided dermatology business and governance meeting minutes. Minutes from December 2017 showed agenda items such as clinical outcome audit, business continuity, skin surveillance and nursing capacity, finance and serious incident feedback. The minutes also included incident management, performance, risk register, staff training and complaints for example.

Management of risk, issues and performance
During the last inspection in 2016, it was noted by inspectors that there was no risk register for outpatients. Risk registers were in place for each health group and processes were in place to discuss and share the content across the outpatients service. However, at the time of the inspection the trust was implementing improvements to this.

A quality, innovation, productivity and innovation (QIPP) commissioning programme had been implemented for the financial year 2016 – 2017. The QIPP model identifies productivity challenges in terms of finance, activity and workforce. The model had been used to attempt to reduce the number of ophthalmology patients being seen in the hospital, with increased shared care in the community.

Following the trust wide issue in March 2017 and the loss of patient follow up, the trust set up a process of clinical validation to ensure patients had not suffered harm because of the lost follow up appointments. We saw a flow chart had been developed to ensure all patients affected were reviewed. The trust told us that there were 10,000 files still to be reviewed at the time of
inspection, but no harm had been identified, in addition to the three patients identified at the Castle Hill Hospital site. The trust told us that all patient files would be reviewed by March 2018.

The trust had a clinical harm review group. All incidents across the trust were reviewed with the specific health groups; however, there were no systems in place at the time of inspection to share incidents collectively across the outpatient’s service as a whole.

We asked managers about the risk register and we were told these were managed within the specialities. There was an electronic risk register on the electronic incident reporting system; however this was not always used. However risks were identified within the specific health group risk registers.

We reviewed the trust risk register and saw that there was a risk specific to Ophthalmology. This was added to the register in November 2013 and shows a high risk of patients delayed resulting in loss of eyesight due to lack of capacity for follow up. This risk was reviewed in January 2018.

Locally in Castle Hill Hospital outpatients, we were told current risks included managing the number of patients in the departments daily, staffing and workload in outpatients. These were not documented on any risk registers for outpatients.

We asked senior managers about the main risks to the services and were told follow up appointments, for example, cardiology and ophthalmology and the environment were the main risks to the services Outpatients did not have a risk register but we saw these risks were identified within the specific health groups risk registers.

Senior managers told us there was a weekly performance meeting where the service would monitor follow up appointment backlogs for example. The hospital improvement team had plans to undertake some work in outpatients.

Outpatients had a monthly dashboard to assist managers in monitoring performance against key performance indicators across outpatient’s services.

The trust had a clinical harm review group. All incidents across the trust were reviewed with the specific health groups; however there were no systems in place at the time of inspection to share incidents collectively across the outpatient’s service as a whole.

**Information management**

Staff had access to the required systems across outpatients. Information was available on the trust intranet and staff received information for example from team briefs.

Staff had access to computers in outpatient departments; however we did see three computers unattended in orthopaedic outpatients during our visit. Staff had access to computers in different areas of the main outpatients and staff told us there was always staff close by the computers.

The trust told us there had been no recent data breaches. The trust provided an information governance policy which was in date and due for review in March 2019.

**Engagement**

Plastics outpatients had weekly team huddles, which staff attended, and minutes were available. Team meeting minutes on display in the plastics outpatient manager office from 23 February 2018 showed infection, prevention and control and tissue viability was part of the meeting. There were six to eight weekly departmental meetings.

Orthopaedic outpatients had a staff meeting in December 2017, however there were no minutes available for us to review for this meeting.

Oncology and haematology outpatients took part in the ‘you said we did’ events.
Trust team briefs were sent to staff monthly.

We saw within the outpatient governance committee meeting minutes that patient representation was also included.

We saw that the last outpatient survey was in 2011.

**Learning, continuous improvement and innovation**

Some areas, for example the plastics outpatient department received medication safety alerts. There had previously been an outpatient transformation plan ongoing and we were told for example, this has considered clinic room utilisation in outpatients.

Several pieces of work had been undertaken by the head of outpatients including the staff mapping exercise across surgical and neurosurgery outpatients. This was completed by department nursing sisters.

The trust told us that virtual clinics were in process of being established in orthopaedics. Care plans for wounds, splints and casts were being designed as capture data forms, which would be stored in paper less clinics.

Further work following the staff mapping exercise to understand the outpatient nurses role, skill mix and leadership to review training requirements.

A paper light system was in place within chemotherapy.

The services had plans to implement the quality boards which were used around the trust in outpatients; however these were not in use during our inspection. These boards would include information relating to quality for outpatient areas for patients, visitors and staff.