Hull and East Yorkshire Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Requires improvement
Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Good
Are acute services at this trust caring?	Good
Are acute services at this trust responsive?	Requires improvement
Are acute services at this trust well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

Hull and East Yorkshire Hospitals NHS Trust serves a population of 660,000 and provides a range of acute and elective services to the residents of Hull and East Riding of Yorkshire. It is designated as a Major Trauma Centre. The trust employs approximately 8,000 staff. The trust operates acute services from two main hospitals – Hull Royal Infirmary and Castle Hill – with a minor injury unit based at Beverley Community Hospital. Accident and emergency services, women's and children's services are located at Hull Royal Infirmary with mainly elective services, including cardiology, ear, nose and throat and oncology provided at Castle Hill Hospital.

We found that the trust had a clear vision and organisational development was taking place, involving a range of stakeholders, including patients and staff. New initiatives to engage and empower staff to drive improvement within the trust had been introduced. There were systems and procedures in place to identify and monitor risk. The incident reporting system had recently been strengthened. However, we found that not all incidents were being reported and learning from these was not consistently shared across the trust.

The trust was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing numbers of admissions, particularly patients referred to the hospital as an emergency. The shortage of nursing and medical staff, particularly junior doctors, was impacting on the care patients received, leading to delays in assessment and treatment. Staffing levels and skill mix did not always meet professional body recommendations. The trust board was taking action and had agreed to invest in recruiting more nursing staff, and was in the process of recruiting into medical posts.

The accident and emergency department did not have the capacity in terms of facilities and staffing to deal with the numbers of patients attending. There was a lack of appropriate senior clinicians and the children's accident and emergency department could not provide a dedicated 24-hour service. A refurbishment programme was due to be completed by October 2014, which will increase the size and capacity of the department. However, in the meantime patients faced long waits, including on trolleys in corridors.

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

The minor injuries unit at Beverley Community Hospital provided a good service and patients were satisfied with their care and treatment.

The trust scored above the national average for the friends and family test. In the Care Quality Commission's 2012 Adult Inpatient Survey the trust performed about the same overall as other trusts, although it was worse than other trusts for questions on accident and emergency services. Local surveys and patient feedback showed that, generally, patients received good care, particularly in the critical care units. However, patients reported poor experiences of delays in diagnosis, access to treatment, poor communication and difficulties in obtaining outpatient department appointments.

The trust was improving the way it engaged with people, and was in the process of changing the culture within the trust to be more outward-facing. However, despite the new initiatives and strategies, many staff did not feel engaged, particularly with the senior management team. Learning was not routinely shared between health groups and divisions. Some staff across the trust with whom we spoke reported that they felt pressure to meet performance targets and spoke of a bullying culture in some areas.

We found the trust in breach of Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 15 (premises), 22 (staffing) and 23 (staff support) for the regulated activities of 'treatment of disease, disorder or injury' and 'diagnostic and screening procedures'.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The trust had recently reviewed its incident reporting system, having identified that not all incidents were appropriately categorised. The trust strengthened its reporting and investigation processes as a result. There were clear governance arrangements in place to assess, monitor and report risks to the trust board. However, we found staff did not always report incidents due to a lack of time. Feedback was variable depending on the speciality and learning from other services was not routinely shared.

Nursing and medical staff shortages were experienced across all areas of the trust and meant that the necessary experience and skills mix did not always meet national guidance and recommendations. The lack of junior doctors was a particular concern and they reported that they were regularly being asked to cover a range of specialties, sometimes when they had yet to complete the necessary competencies. Not all staff had completed their mandatory training. Junior doctors reported that departmental teaching was limited in some areas.

There was limited pharmacist oversight in some areas in the trust, which impacted on patients' medications being reconciled when they were admitted.

There were systems to manage and monitor the prevention and control of infection. All areas visited were clean. The trust was working to locally agreed targets for infection control and had action plans in place to address any shortfalls in identified practice.

There were good safety checklists in place.

Are services effective?

Good

The trust had taken part in national clinical audits. This allowed services within each hospital to benchmark their performance against that of other hospitals and over time, so that improvements could be made.

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

Patients received care in line with best practice and national guidance. There was ongoing monitoring of care bundles.

There was effective multidisciplinary working within teams and across the hospitals. For instance, the critical care outreach team and palliative care team supported staff with advice and specialist expertise, which was highly valued by staff.

Summary of findings

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

In the maternity services, care and treatment was planned and delivered in a way to ensure women's safety and welfare. Risk assessment tools were used to ensure the timely referral of women developing critical illness during or after pregnancy. Children's services were effective, with examples of evidence-based care pathways kept under review and positive multidisciplinary working within the departments and externally.

Are services caring?

Good

Analysis of surveys and patient feedback showed that patients had generally experienced good care. Patients told us that the staff were caring and compassionate. We observed examples of good practice of staff safeguarding patients' privacy and dignity.

In addition, the trust's own quality policy ("Setting the Standard"), ensured that ward managers received feedback on their ward's progress against the trust's 12 quality standards. Operating theatre staff were observed to be kind and caring to patients, promoting their privacy and dignity throughout their time in theatre. On the critical care unit patients and families said the care was exceptional. Family members told us that staff had kept them fully informed regarding the progress of their family member.

Patients told us they had been involved in decisions about their care and treatment.

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

Are services responsive to people's needs?

Requires improvement

The trust was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing number of patients, particularly emergency attendees and admissions. The shortage of nursing and medical staff, particularly junior doctors was impacting on the care patients received, leading to delays in assessment and treatment. Many patients found that they were moved, sometimes more than once, within the hospital and between hospitals, often through the night.

The trust had introduced a dementia strategy, which included the Butterfly Scheme, which enabled staff to be alerted to a person's specific needs who may be vulnerable because of dementia. This had been positively received but not all staff had received training in it.

Summary of findings

At times, the A&E department and the acute assessment unit did not have the capacity in terms of facilities and staffing to deal with the number of attendances. Patients had long waits for treatment and some were on trolleys in corridors for significant periods. The children's accident and emergency department closed at midnight, except for the waiting area, which meant that children were then cared for in an adult environment. Children's nurses were made available from the children's services when needed.

The critical care units were able to meet the needs of patients and staff told us that discharge was rarely delayed. There was good integrated working between the children's centre and midwifery team, which had led to women accessing antenatal services earlier. A discharge hub had been introduced, whereby hospital staff worked with commissioners. Indications were that this was improving the discharge process, although there were still concerns over delays in discharging in some areas.

There was a responsive and accessible service for the management and care of critically ill children. However, we found that at the time of the inspection, the paediatric service was undergoing a period of service transformation. As a result, whilst access to parental accommodation was available, it was not yet at optimum levels and parents were not always able to sleep next to their child or had been given inadequate sleeping facilities such as uncomfortable chairs. Therefore, we found a limited ability to provide holistic, family centred care.

Clinic cancellation figures for both hospital cancellation and patient non-attendance had been consistent at approximately 20% each month across both hospitals in the trust. Backlogs had built up with some specialities. There were insufficient slots for people in the NHS Choose and Book electronic appointment system, which was causing delays and a failure to meet national referral-to-treatment time targets.

Are services well-led?

Requires improvement

The trust's vision aimed to increase engagement and empower staff to achieve, "greater things". A key priority was the increased involvement of staff, the public and the wider community in organisational development. However, some initiatives had only recently been introduced and many staff reported that they did not feel engaged.

There was a mixed response regarding leadership in some divisions, some staff were proud of working for the trust: they felt supported and well informed. However, some reported that they felt under huge pressure to work additional hours and meet performance targets. Some staff spoke of a bullying culture in some areas, and that meeting targets was a priority for some managers over patient care.

Governance and reporting mechanisms were in place to identify and manage risk, but not all actions taken to mitigate or eliminate them were effective. The accident and emergency department, the acute assessment unit, the lack of

Summary of findings

junior doctors and cancelled appointments were just some of the risks identified. Despite the opening of additional beds as part of the winter plan, patient flow through the hospital was not always effective, particularly when there was a peak in admissions, leading to multiple patient moves, risking a disruption to the continuity of care and delays in access to assessment and treatment.

Following a recent review of incidents, reporting processes had been strengthened. However, we found there was a delay in reporting some incidents and many staff told us that they did not have the time to report. Some staff had received no or limited feedback to reports made. Many staff told us that there was little shared learning across divisions.

Summary of findings

What people who use the trust's services say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they had received. In October 2013, the trust scored above the England average for inpatient tests, with 94.8% of patients asked saying they would be 'likely' or 'extremely likely' to recommend the ward they stayed on to family and friends. The trust's scores for A&E were significantly above the England average at 93.5%, although the response rate was lower.

Analysis of data from the CQC's Adult Inpatient Survey (2012) showed that the trust scored about the same as other trusts in nine out of 10 areas of questioning. However, the trust performed worse than others for A&E. Although, for specific questions related to privacy, and information provided about the condition and treatment, the responses were still within the statistically acceptable range in comparison to others.

The Cancer Patient Experience Survey 2012/13 showed the trust performed better than other trusts nationally for four questions: giving information on financial support; prescriptions; medical access to notes; and documentation. However, the trust performed worse than other trusts nationally for another four questions related to communication to patients and the lack of staff.

Healthwatch Kingston upon Hull and Healthwatch East Riding of Yorkshire shared the results of their surveys of people's views of the care they received in the trust's hospitals, collected January 2014. There were 295 comments received on services at Hull Royal Infirmary. The most commented area was on A&E services. The results showed that 71% felt they were treated with kindness and respect, 73% felt services were safe, 66% felt their treatment met their needs and 64% rated the hospital as 'outstanding' or 'good'. However, a third of people felt the services required improvement, with A&E requiring the most improvement. Just over half (56%) of people responding felt they were safe in A&E and 59% of people felt treatment met their needs. There were 73 comments received on Castle Hill Hospital. The results showed that 86% felt they were treated with kindness and respect, 90% felt services were safe, 89% felt their treatment met their needs and 71% rated the hospital as 'outstanding' or 'good'.

Areas for improvement

Action the trust MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified and skilled and experienced staff, particularly at night and weekends.
- Ensure that staff are suitably supported, complete mandatory training, and are enabled to access post registration qualifications, for example, post qualification in critical care.
- Ensure that junior doctors are appropriately supervised and not taking on roles and responsibilities for which they have yet to complete competencies in.
- Ensure that there are suitable arrangements for on call, and junior doctors are not responsible for multiple pagers across different areas.
- Review and address why staff feel that they are experiencing bullying and feel pressure to undertake additional hours and put meeting targets above patient care.
- Review incident reporting to ensure that staff report incidents appropriately and in a timely manner.
- Ensure that staff receive feedback from incidents reported, including never events and complaints.
- Ensure lessons learned are disseminated across divisions.
- Ensure that children are assessed and treated in an appropriate environment in line with national guidance on suitable environments for the care and treatment of children.
- Review the patient pathway into the hospital, particularly the accident and emergency department, to ensure that patients are assessed and treated appropriately to meet their needs.

Summary of findings

- Ensure patients have access to hospital appointments and cancellation of outpatient clinics is kept to a minimum.
- Review the patient flow within and across hospital sites to ensure that patients are not experiencing multiple moves including through the night.
- Ensure patients' assessment and treatment is based on best practice guidelines and delivered at the right time to meet those needs.
- Ensure patients receive appropriate fluid and nutrition to meet their needs, we found patients particularly in A&E and AAU were going without drinks and food for several hours.
- Ensure that there are suitable arrangements in place for pharmacy provision across all areas to provide clinical overview and reconciliation of patient medications.
- Provide family friendly facilities for parents on Ward 130 and the high dependency unit to enable parents to support their children.
- Ensure that the environment is safe within the children's and young people's services by ensuring that clinical rooms have only appropriate equipment and that waste bins are appropriately stored.

Action the trust SHOULD take to improve

- Consider reviewing the criteria for ambulance attendance at A&E, to ensure that patients are admitted to the most appropriate place to meet their needs.
- Review the cleaning arrangements in A&E to ensure that there are sufficient staff at all times to keep areas clean following patient treatment.
- Review the location and access to defibrillator equipment in the major area of A&E.
- Review the mental health support available for children and young people in the A&E.
- Review and improve the communication among clinicians including handover arrangements in A&E.
- Ensure that the privacy and dignity of patients is safeguarded and promoted in the A&E and the AAU; patients were waiting on trolleys in corridors for significant periods often without easy access to toilet facilities.
- Review arrangements in A&E to ensure that there is a senior clinician with an overall overview of the A&E department and the interface with AAU.
- Review GP referrals into the AAU and develop performance and assurance measures to ensure that failings can be addressed.
- Review the Clarity self-check in system in the accident and emergency Minors department to ensure that patients' symptoms are appropriately recorded and there are no barriers to communication such as the need for an interpreter.
- Ensure that only staff employed for caring duties, including dealing with patients exhibiting challenging behaviour due to mental health illness or dementia, support patients.
- Review the use of patient passports as these were not consistently being completed.
- Develop the auditing of the WHO checklist to include the completion of all sections.
- Review the information captured on the risk registers so that dates of inclusion are included.
- Provide more sensory play equipment for children with special needs in children's outpatients.
- Identify a board level lead for the outpatients department.
- Ensure that staff who are involved with the care of patients living with dementia are suitably trained, for example portering staff.

Good practice

Our inspection team highlighted the following areas of good practice:

- The trust had introduced Pioneer teams, which empowered staff to develop innovative solutions to drive improvement.
- The end of life team had developed a package of care to ensure that relatives and carers received the necessary support at the end of their relative/friend's life, which included access to parking and a pack of toiletries.

Summary of findings

- The outpatients team had developed a means of identifying when a patient had special needs so they could plan their care appropriately before they arrived in the department.
- The trust has introduced 'Link Listeners', which gives representatives of staff access to the executive team.

Hull and East Yorkshire Hospitals NHS Trust

Detailed findings

Hospitals we looked at:
Hull Royal Infirmary, Castle Hill Hospital, The Minor Injuries Unit – Beverley Community Hospital

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Programme Director NHS Leadership Academy

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

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

Background to Hull and East Yorkshire Hospitals NHS Trust

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 serves a population of 660,000 and provides a range of acute and elective services to the residents of Hull and East Riding of Yorkshire as well as a number of specialist services to North Yorkshire, North and North East Lincolnshire. The trust is designated as a Major Trauma Centre and is part of the Northern Lincolnshire Major Trauma Network. The trust provides a number of tertiary services for a population of 1.2 million. The trust has approximately 1,384 beds and employs approximately 8,000 staff.

The trust operates acute services from two main hospitals – Hull Royal Infirmary and Castle Hill. Accident and emergency services, women's and children's services are located at Hull Royal Infirmary with mainly elective services, including cardiology, ear, nose and throat (ENT) and oncology provided at Castle Hill Hospital. The trust provides a minor injuries unit at Beverley Community Hospital.

The community and oncology services provided by the trust were not part of this review.

The Women's and Children's Hospital located at Hull Royal Infirmary houses the maternity and children's services

Detailed findings

including a high dependency unit and a 28 cot neonatal intensive care unit. The obstetrics department provides maternity services to women of Hull and East Yorkshire, with approximately 6,000 babies born each year. The 54 bed children's service treats around 15,000 children annually and 53,000 children's outpatients. The trust is accredited as an Endometriosis Centre in the North East of England.

The accident and emergency services department opened in 1967 and was designed for a capacity of 60,000 patients. There had been a year on year increase to over 131,000 patients in the last year. The trust had recently refurbished the Minors area and the children's A&E, and were due to complete the refurbishment of the Majors area, thereby doubling its capacity. The trust operated a minor injuries unit at Beverley Community Hospital.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits on 3, 4, and 5 February and two unannounced visits on 10 and 11 February 2014.

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We spoke with 259 patients and relatives, 199 staff in wards and departments. We interviewed and held focus groups with about 120 staff across all roles and grades. We also checked 91 records across hospital sites.

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

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

Requires improvement

Are services safe?

Summary of findings

The trust had recently reviewed its incident reporting system, having identified that not all incidents were appropriately categorised. The trust strengthened its reporting and investigation processes as a result. There were clear governance arrangements in place to assess, monitor and report risk to the trust board. However, we found staff did not always report incidents due to a lack of time. Feedback was variable depending on the speciality and learning from other services was not routinely shared. This meant the trust could not be assured that there was robust information on incidents reported to inform decisions made about risk and actions to take.

Nursing and medical staff shortages were experienced across all areas of the trust and meant that the necessary experience and skills mix did not always meet national guidance and recommendations. The lack of junior doctors was a particular concern and they reported that they were regularly being asked to cover a range of specialties, sometimes when they had yet to complete the necessary competencies. Not all staff had completed their mandatory training.

At times, the A&E department and the admissions assessment unit did not have the capacity in terms of facilities and staffing to deal with the number of attendances. Patients had long waits for treatment and some were on trolleys in corridors for significant periods. The children's accident and emergency department closed at midnight, except for the waiting area, which meant that children were then cared for in an adult environment.

We found that staff had to access defibrillator equipment for the majors areas from the resuscitation areas as there was no designated machine in majors. We were concerned that this could lead to delays in access should there be a demand in both areas at the same time during high peaks in attendances.

The trust was taking steps to address the capacity issues in the A&E department and had completed part of a refurbishment programme, which had improved facilities in the Minors area and the children's A&E. The Majors areas was due to be completed in October 2014, which would double the capacity available. The trust had agreed further investment in recruiting nursing staff and had introduced a number of measures to identify and address areas of risk such as daily patient safety briefings.

There were systems to manage and monitor the prevention and control of infection. All areas visited were clean. The trust was working to locally agreed targets for infection control and had action plans in place to address any shortfalls in identified practice.

There were good safety checklists in place.

Our findings

Safety and performance

Staffing levels

The trust was facing significant challenges over shortages of nursing and medical staff and insufficient capacity to deal with the increasing number of admissions, particularly patients referred to the hospital as an emergency. The shortage of nursing and medical staff, particularly junior doctors, was impacting on the care patients received, leading to delays in assessment and treatment.

Staff shortages recorded on the risk register included (but were not restricted to):

- Junior doctor shortages in the Queen's centre for oncology and haematology.
- Nurse staffing on children's wards.
- Maternity – midwives working above recommended ratios of midwives to patients.
- Junior doctors in obstetrics.
- Insufficient senior house officers to cover neurosurgery patients overnight – unsustainable spinal rota 1:4 rota.
- Cardiac theatres – shortage of theatre staff.
- Senior clinicians in the adult and children's accident emergency department.
- Children's nurse shortages in the children's accident emergency department.

The shortages resulted in the high use of locum staff, junior doctors carrying more than one pager and sometimes working outside their competencies, poor access to junior doctor training, increased medical on call and the inability to always meet national and professional guidance.

Requires improvement

Are services safe?

The trust used the Safer Nursing Tool to assess the level of nursing care it required. In October 2013, the trust carried out an acuity and dependency audit and identified that elderly medicine was very understaffed across the trust. (Acuity measures how ill a patient is and helps to decide the appropriate level of nursing/medical care required). The board was alerted to a significant risk in relation to medical staffing in the Medicine Health Group in September 2013 (Compliance and Risk Committee, October 2013). Wards were not always meeting Royal College of Nursing recommendations of 65:35 skills mix of registered nurses to health care assistants on duty on a day shift. The wards were experiencing nurse vacancies – for example, in November 2013 there were 101.99 whole time equivalent vacant posts (6.65% of ward nursing establishment). Staffing levels had been affected by maternity leave at 11% across wards and some areas were experiencing 11% sickness absence. Some staff with whom we spoke reported stress and feeling under pressure to work additional hours and outside their competencies.

Staff across wards and departments at Hull Royal Infirmary and Castle Hill Hospital raised concerns about staffing levels. Staff were particularly concerned about the lack of senior medical staff on duty at night and weekends.

The trust had taken steps to reduce the risk to patients by reviewing rotas, increasing some clinical posts, such as increasing the recruitment of consultant obstetrician posts, increasing locum use and had introduced daily patient safety briefings. Senior managers and ward representatives met three times a day to undertake acuity assessments and identify where risks were that day and to redeploy staff to where they were most needed. We were told that £500,000 had been invested in managing the winter pressures in the trust and that some of this had been invested in staffing. The trust had reviewed staffing levels and agreed, but not yet put into action, a further investment of £450,000 to increase nursing staff numbers, with a further investment to be decided in preparation to meet the National Quality Board expectations, including ward managers being supernumery. Ongoing recruitment was taking place of both nursing and medical staff.

Mortality outliers

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

This was the 19th mortality outlier at this trust since 2011. Seven mortality outliers (Coronary Artery Bypass Graft – other (April 2011, January 2012 and September 2013), Peripheral and visceral atherosclerosis (September 2011 and June 2012), Therapeutic endoscopic procedures on biliary tract (November 2011) and Acute Myocardial infarction (September 2011) have been reviewed. The trust provided information to the Care Quality Commission following reviews of the data and put actions plans in place to address any issues identified.

Cleanliness and infection prevention and control

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

Infection rates (August 2012 to July 2013) were within acceptable ranges for methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) and Clostridium difficile (C. difficile), for trusts of a similar size. The trust had reported cases of C. difficile in all three quarters and two cases of MRSA (the locally agreed target with the commissioning group was 0), and therefore breached the target for MRSA.

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

Requires improvement

Are services safe?

Safety checks

In the operating theatres we observed safe surgical checks in place, which included the use of the World Health Organisation (WHO) surgical safety checklist. Recent audits of the WHO checklist indicated that the trust scored 100% but this did not include auditing of all sections of the checklist. Completion of the checklist minimises the risk of avoidable errors to patients.

Learning and improvement

Incident reporting

An analysis of incident reporting for Hull and East Yorkshire Hospitals NHS Trust showed the trust was reporting fewer patient safety incidents than other trusts of a similar size (National Reporting and Learning System July 2012 to June 2013). The trust had undertaken a review of 71 critical incidents and found that 26 needed to be re-categorised as more serious. Medical specialties reported 35% of 389 incidents, which resulted in moderate harm, 39 of which were attributed to the care of older people. Staff did not always report incidents due to a lack of time to complete the documentation. This meant that the trust board could not be assured that data used on incident reporting accurately reflected the numbers occurring, and so take these into account in addressing risk. Learning from incidents was variable across different areas. In some areas it was reported as good and was embedded into staff handovers and ward meetings. However, many staff told us that they rarely received feedback. Where learning took place, this was done within the speciality and not shared across health groups and divisions where there were wider lessons to be learned.

Records

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

We looked at 91 patient records and found that in the main, they were completed and up to date. However, in a small number of those sampled we found some gaps and omissions, for example, for records such as food and fluid balance. In one patient's record, food and fluid charts had not been fully completed for seven days. Staff assessed patients' vulnerability to developing pressure sores, and there were care plans for those who were at risk. The care bundle for two patients, who had been identified in need of two-hourly repositioning, had gaps in their records. Staff could not be assured that patients were being repositioned every two hours in accordance with their risk assessment and care plan as records were not accurate.

Equipment

We found that there was no designated defibrillation equipment within the majors area. Staff accessed this equipment from the resuscitation areas when needed. We found on wards visited that records of daily checks of the resuscitation trolley had taken place. We observed that there was pressure-relieving equipment available for use on the wards and staff confirmed it was available when needed to help reduce patients' risk of pressure sores. There were systems in place to identify when equipment was in short supply or required replacement, some items such as the lack of bariatric equipment and operating theatre tables had been recorded on the risk register. We noted that some of the equipment was in the process of being replaced.

A&E

There were times when the A&E department could not cope with the volume of patients attending. As a consequence, patient safety and the quality of care was compromised. The department had not originally been designed to meet the needs of the high volume of patients attending and, when busy, regularly had patients waiting in corridors because there were no cubicles left for them to wait in. The risk register recorded there was a high risk that patients may be discharged from A&E without senior medical oversight due to the lack of appropriately qualified clinicians. To alleviate this, the trust had introduced 24-hour middle grade medical cover, with a consultant in charge from 8am until midnight. Staff worked hard and were committed to the care and welfare of patients, but struggled to respond to patients' needs. The patient flow through the department and on to wards increased pressure on staff as medical and surgical patients,

including those referred to by their GP, were often sent to A&E first rather than directly to the wards. Once the initial assessment had taken place there were long waits to be seen by medical staff.

Concerns had been raised about the length of time patients were waiting for mental health assessments and that there were inappropriate arrangements for the care of teenagers. We were told by staff that patients who were unsafe to leave the department sometimes faced long waits as the psychiatric service was provided by a different trust. We contacted Humber NHS Foundation Trust who said, "The Humber NHS Foundation Trust operates a Psychotic Liaison Department within Hull and East Yorkshire Hospitals, this includes a rapid response to A&E. Hours of operating are 8am to 8pm Monday to Friday. From 5pm to 9am weekdays and 24 hours on a Saturday and Sunday referrals are received by the Crisis Team. On occasion if the Crisis Team is busy within the Community there may be a response of three hours or more. As you will appreciate patients in A & E are in a safe environment and therefore do not take priority over people in their own homes. We do have regular dialogue with the A&E Department when such occasions arise and always try to meet the four hour deadline."

In addition, there was a concern that patients were able to leave, when very ill and vulnerable as the A&E and particularly the AAU were open, busy, and accessible. This was recorded on the trust's risk register, as part of the concerns around the inadequate facilities in the AAU.

The children's A&E services could not be provided over 24 hours due to the lack of appropriately trained staff between midnight and 8.30am. This meant that children were cared for in an adult environment. The children's waiting room remained open and the resuscitation area was available when needed as appropriate staff were provided from other areas in the hospital.

The trust had recently refurbished the Minors area and the children's A&E, which had improved the facilities and experience of patients. Work was in progress to compete a refurbishment of the Majors area by August 2014, which should double the capacity of the department. However, we were concerned that the arrangements in the meantime were insufficient to ensure that patients were safe and that their treatment needs were met.

Medication

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

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

Monitoring safety and responding to risk

Safety Thermometer

In line with other health groups across the trust, the medical wards were using the NHS Safety Thermometer to manage patient risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections. This is a

tool designed to be used by frontline staff to measure a snapshot of harms and 'harm-free' care once a month. We observed the outcomes, including information on harm-free care days displayed on ward noticeboards.

Analysis of the trust's safety thermometer results showed that the proportion of patients with new pressure ulcers and rates of patient falls with harm had been below the national average between November 2012 and November 2013. There had been a fluctuating pattern above and below average on harms due to venous thromboembolism (VTE or blood clots) and incidents of urinary tract infections. The results for patients with a urinary tract infection who had a urinary catheter were regularly above the national average.

In October 2013 the trust's Safety Thermometer Newsletter identified that 97% of patients had received no new harm since their admission to hospital.

Mandatory training

Not all services had achieved the trust's target of 85% completion of mandatory training. The average across the trust was 85.9%. However the children's division had achieved 72%, the trauma and orthopaedic division 62%, general surgery division 42% and general medicine 52.05%. There were variations in attendance across wards and departments, for instance for the AAU, attendance was 76.4%; Ward 10 achieved 52.2%; ESSU was 64.5% and Ward 70 was 72.2% (Staffing Metrics for November 2013, January 2014). Staff reported that access to mandatory training was problematic; staff could not always be released to access training. Junior doctors told us they did not always receive training due to staffing pressures. Staff had attended safeguarding training but not all staff who were required to have Level 3 training had achieved this for children's safeguarding.

Anticipation and planning

In response to concerns that staff may not recognise the deteriorating patient, the national early warning score (NEWS) had been introduced (corporate risk register, January 2014). Deteriorating scores were escalated to a critical care outreach team. Training for recognising the signs of a deteriorating patient had been introduced and intentional rounding had been implemented on some areas. However, we had concerns that due to staff shortages and high numbers of patients waiting for assessment and treatment, particularly in the corridors next to A&E, that there was a risk that staff would not always identify when a patient's condition was deteriorating and they needed treatment.

Internal and external transfer of patients

Patients told us of being moved on multiple occasions within the hospitals and across sites, often through the night. The trust was aware of the situation, and a review had taken place in December 2013 of the number of patients transferred out of the acute assessment unit (AAU) after 10pm. The review found a total of 583 patients were transferred between 10pm and 6am. Of these, 196 patients had been moved between 10am and midnight and 387 between midnight and 6am. This information was not validated and the trust was implementing a system to capture information on transfers within the trust (Corporate Performance Report, Quality and Safety, January 2014). This meant that patients were experiencing disruption of their care by being moved through the night, sometimes to another site, which could have a detrimental impact, particularly on the frail and elderly. This problem was recorded as high risk on the trust's risk register as patients were often not fit for discharge, due to their complex medical conditions, which increased the workload for the receiving ward staff causing ward rounds to be extended and delayed decision making around treatment plans.

Good

Are Services Effective?

(for example, treatment is effective)

Summary of findings

The trust had taken part in national clinical audits. This allowed services within each hospital to benchmark their performance against that of other hospitals and over time, so that improvements could be made.

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

Patients received care in line with best practice and national guidance. There was ongoing monitoring of care bundles.

There was effective multidisciplinary working within teams and across the hospitals, for instance, the critical care outreach team and palliative care team supported staff with advice and specialist expertise, which was highly valued by staff.

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

In the maternity services care and treatment was planned and delivered in a way to ensure women's safety and welfare. Risk assessment tools were used to ensure the timely referral of women developing critical illness during or after pregnancy. Children's services were effective, with examples of evidence-based care pathways kept under review and positive multidisciplinary working within the departments and externally.

Our findings

Using evidence-based guidance

The trust was using national and best practice guidelines to care for and treat patients. The trust was participating in national clinical audits such as the emergency use of oxygen, non-invasive ventilation, and chronic pain. Action plans were developed for any improvements required. For example, the trust employed a lead nurse as a result of completing the National Audit of Dementia in General Hospitals for 2012-2013, to improve training, monitoring and management of dementia in the trust (Dementia services: Progress Report 2013).

The trust participated in the Commissioning for Quality and Innovation (CQUIN) payment framework, developed nationally and locally by commissioners to reward excellence by linking a proportion of a providers' income to the achievement of local quality improvement goals. The trust had signed up to CQUIN for improvements in the safety thermometer, VTE and dementia. The trust was on target for full achievement of the CQUIN objectives by March 2014.

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

The trust had a stroke protocol designed to ensure that people identified as possible stroke victims followed a specific care pathway and accessed the appropriate services as quickly as possible. This was overseen by a stroke coordinator. The trust provided stroke Level 1 services and was meeting the national target for 90% of patients spending the majority of their time in a stroke unit. The trust scored 100% for patients who received a brain scan within 24 hours of admission, and access to physiotherapist, speech and language therapy within 72 hours.

Maternity services were compliant with all five standards of the CNST Maternity Standards Level 1. The unit performed within expectations with regards to their maternity indicators. These include measures such as number of elective caesarean sections, number of emergency caesarean sections and maternal or neonatal

Good

Are Services Effective?

(for example, treatment is effective)

readmissions. Their normal delivery rate was 67.6%, which was higher than the national average (60.9%). In addition their emergency caesarean section rate was lower than the national average at 12.9% compared with 14.5%.

The critical care service risk-rated themselves against the Intensive Care Society core standards for intensive care units, which was published in November 2013. Clinical audits were carried out regularly and results feedback to the teams during handover. The trust scored similar to expected in all areas of the General Medical Council National Training Survey 2013 with a better than expected response in workload.

Performance, monitoring and improvement of outcomes

The trust introduced a new initiative, 'Pioneer Teams', in October 2012 to empower staff to focus on improving care or efficiency. For example, the hip fracture pioneer team focused on creating a more efficient service for patients and improving rates of recovery. The outcomes from this were the length of hospital stay had reduced from an average of 18 days in October 2012 to 14.3 days in January 2013. A 53% reduction in slips, trips and falls among this patient group and a 40% reduction in the number of pressure sores was reported.

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

Staff, equipment and facilities

The shortage of medical staff from August 2013 was listed as a high risk on the trust's risk register, with an expected peak in January 2014 due to a lack of recruitment and maternity leave. The shortage of clinicians was impacting on the trust's ability to meet national targets for referral to treatment times.

Multidisciplinary working and support

There was good multidisciplinary team working within teams and across other divisions. Multidisciplinary team meetings took place with partners in community and social care for assessment, treatment and discharge. The multidisciplinary team on the Level 1 stroke unit had stroke physicians and neurologists providing 24-hours, seven days a week acute thrombolysis service, with assistance from stroke coordinators. Multidisciplinary ward rounds were observed to take place and patients confirmed that they saw a doctor at least once a day on a ward round. The trust had begun to provide a seven-day physiotherapy and occupational therapy service. There was a dedicated rehabilitation ward working towards designation as a specialist rehabilitation unit from the UK Rehabilitation Outcomes Collaborative. Further development of consultant-led, in-reach service to Hull Royal Infirmary was to be developed.

Good

Are services caring?

Summary of findings

Analysis of surveys and patient feedback showed that patients had generally experienced good care. Patients told us that the staff were caring and compassionate. We observed that staff were polite to patients, explaining what they were going to do and why. Screen curtains were closed when attending to individuals' personal needs, and privacy and dignity were respected.

Each ward monitored the NHS Friends and Family Test as part of setting the standards outcomes. Ward managers received feedback on their ward's progress against 12 standards. Operating theatre staff were observed to be kind and caring to patients, promoting their privacy and dignity throughout their time in theatre.

On the critical care unit, all the patients and the families said the care was exceptional. We were told by family members that staff had kept them fully informed regarding the progress of their family member.

Patients told us they had been involved in decisions about their care and treatment.

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

Our findings

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they had received. In October 2013, the trust scored above the England average for inpatient tests, with 94.8% of patients asked saying they would be 'likely' or 'extremely likely' to recommend the ward they stayed on to family and friends. The trust's scores for A&E were significantly above the England average at 93.5%, although the response rate was lower.

Analysis of data from the CQC's Adult Inpatient Survey (2012) showed that the trust scored about the same as other trusts in nine out of 10 areas of questioning. However, the trust performed worse than others for A&E. Although, for specific questions related to privacy, and information provided about the condition and treatment, the responses were still within the statistically acceptable range in comparison to others.

The Cancer Patient Experience Survey 2012/13 showed the trust performed better than other trusts nationally for four questions: giving information on financial support; prescriptions; medical access to notes; and documentation. However, the trust performed worse than other trusts nationally for another four questions related to communication to patients and the lack of staff.

Compassion, dignity and empathy

Patients were particularly positive about the care on the critical care units, and described staff as kind, caring and thoughtful. We observed staff speaking to patients and their family in a polite, considerate manner and observed them treating patients with dignity and respect.

Involvement in care and decision making

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

Trust and communication

Analysis of local survey information such as that provided from Healthwatch and views expressed at the listening events showed that generally patients were positive about the care and treatment at the hospitals. However, some patients expressed concerns about communication, the attitude of some staff and lack of information. People at the speakout listening event raised concerns around lack of policies on disability and that services were not always joined up.

Involvement in care and decision making

Many patients reported that they were involved in decisions about their treatment, and were asked for their consent prior to a procedure being undertaken. We saw examples of consultation within the records reviewed.

Good

Are services caring?

Trust and communication

There was mixed feedback from some patients and families about communication. Some patients told us that they were fully informed at all times and given information about their condition and treatment. However, information from the listening events and local surveys showed that some people found communication poor.

Emotional support

The palliative care team promoted emotional support for patients and offered advice and information to enable patients and their families to access appropriate services. There was access to multi-faith services and chaplains supported patients throughout the trust.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The trust was facing significant challenges due to the shortage of staff and insufficient capacity to deal with the increasing number of patients, particularly emergency attendees and admissions. The shortage of nursing and medical staff, particularly junior doctors was impacting on the care patients received, leading to delays in assessment and treatment. Many patients found that they were moved, sometimes more than once, within the hospital and between hospitals, often through the night.

The trust had introduced a dementia strategy, which included the Butterfly Scheme, which enabled staff to be alerted to a person's specific needs who may be vulnerable due to dementia. This had been positively received but not all staff had received training in it.

The critical care units were able to meet the needs of patients and staff told us that discharge was rarely delayed. There was good integrated working between the children's centre and midwifery team, which had led to women accessing antenatal services earlier. A discharge hub had been introduced, whereby hospital staff worked with commissioners; indications were that this was improving the discharge process, although there were still concerns over delays in discharging in some areas.

There was a responsive and accessible service for the management and care of critically ill children. However, we found a limited ability to provide holistic, family-centred care. There were poor quality facilities available for parents and families in three areas. Parents were not always able to sleep next to their child or had been given inadequate sleeping facilities such as uncomfortable chairs.

We heard mixed response about booking appointments: some found the booking system efficient while others had experienced delays and difficulties securing an appointment. There were insufficient slots for people in the NHS Choose and Book electronic appointment system, which was causing delays and a failure to meet national referral-to-treatment time targets.

Our findings

Meeting people's needs

Although staff worked hard to meet patients' needs, this was a struggle at times due to the lack of appropriately skilled and experienced staff. The number of cancelled operations was similar to expected but the impact of staff shortages was felt across a range of services and meant that the trust was not meeting national targets in some areas. The trust failed to meet the following targets:

Incomplete referral to treatment target of 92%, it achieved 89.92%.

Patients waiting for treatment less than 18 weeks in surgery (mainly due to the build-up of a backlog).

We were told that there had been between a 6 to 8% increase in referrals and for some highly specialised services was as much as 20 to 60%. The trust was taking action to address the situation such as putting on additional clinic and operation sessions, increasing medical staffing support and reviewing the skills available in the workforce to make best use of staff. For example, changes had been made to extend the scope of senior physiotherapy practitioners to run a neurosurgical clinic. This had improved the New to Follow Up ratios, which meant patients were getting seen quicker and followed up sooner following treatment.

Vulnerable patients and capacity

We found staff were aware of the Mental Capacity Act 2005 and the need for best interest decisions, when patients did not have the capacity to make a decision for themselves. Staff had attended safeguarding training and were aware of how to escalate concerns. The trust had introduced a dementia strategy and a range of measures to identify when patients were vulnerable such as the 'Butterfly Scheme'. However, we found that security guards were being called to support staff when patients were exhibiting challenging behaviour and they were not trained in dealing with vulnerable people, which put the patients at risk of not being cared for appropriately.

Access to services

Analysis of patient survey data and information given at the listening events showed that patients were not always able to access appointments in a timely manner, or their appointments were moved or cancelled. We were told by the trust that there were insufficient appointment slots in

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

the Choose and Book appointment booking system to meet patients' needs. This had been recorded as a red risk on the trust's risk register (red being the highest score). The majority of concerns raised by Healthwatch were around cancelled appointments.

Facilities

The trust faced significant challenges in the Majors area of A&E, the AAU, and children's services, which did not meet national guidance. The trust was in the process of upgrading areas such as A&E, and had plans to develop others such as the children's areas, which were in the process of relocating to the Women' and Children's Hospital. We found at Hull Royal Infirmary in outpatients that the chest clinic was cramped and other clinics felt hot, and the shortage of space at times compromised patients' privacy and dignity, when patients were being weighed and providing samples of tests.

Family centred care

We found a limited ability to provide holistic, family-centred care in three areas in the children's service due to the poor quality of facilities available for parents and families. Parents were not always able to sleep next to their child or had been given inadequate sleeping facilities such as uncomfortable chairs.

Leaving hospital

The trust had introduced a discharge hub with the aid of external partners. Discharge was planned at admission in most cases. However, the trust was not on track to meet the target relating to avoidable delays in transfers and discharges. Only the women's and children's division was achieving the target for immediate discharge letters within 24 hours of discharge.

Learning from experiences, concerns and complaints

The executive team was reviewing information on performance across areas including the outcome to the Family and Friends Test. From this they had developed a list of directors' concerns. At the Hull Royal Infirmary concerns in areas identified included Ward 10, 90, 60 and at Castle Hill Hospital, Ward 21 and 16.

The number of complaints had increased higher than the trust's own target of 92%; 69% related to treatment: trauma and orthopaedics had the second highest number of complaints from April to October 2013 (trust data, April to October 2013).

Commissioners reported that there had been improvements in the way the trust identified themes and trends, and that action was being taken as a result.

The Patient Advice and Liaison services (PALs) activity had increased, but resources had not increased in the health groups to deal with this. The patient experience team monitored concerns through the patient experience forum. The women's and surgical service had seen an increase in complaints and referral to the PALs. The main concerns raised with PALs in 2012 to 2013 was about staff attitude, misunderstanding, and communication information. As a result the trust introduced customer care training, increased face to face meetings. If they struggled to meet the 25-day response time, they would negotiate longer. The trust had also introduced the patient experience forum in November 2013, with a caring dashboard.

From 1 April 2013 to 31 October 13, 416 complaints (lower than the previous average of 59 per month) showed an upward trend in complaints about clinical services, A&E, orthopaedics and trauma, AAU. There was a reduction in complaints in obstetrics and elderly medicine. The trust response times for three days had been 92% since April 2013, which was a decrease of 9%.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust's vision aimed to increase engagement and empower staff to achieve, "greater things". A key priority was the increased involvement of staff, the public and the wider community in organisational development. However, some initiatives had only been introduced between October and December 2013 and many staff reported that they did not feel engaged.

There was a mixed response regarding leadership in some divisions, some staff were proud of working for the trust: they felt supported and well informed. However, some staff reported that they felt under huge pressure to work additional hours and meet performance targets. Some staff spoke of a bullying culture in some areas, and that meeting targets was a priority for some managers over patient care.

Governance and reporting mechanisms were in place to identify and manage risk, but not all actions taken to mitigate or eliminate them were effective. The accident and emergency department, the acute assessment unit, the lack of junior doctors and cancelled appointments were just some of the risks identified. Despite the opening of additional beds as part of the winter plan, patient flow through the hospital was not always effective, particularly when there was a peak in admissions, leading to multiple patient moves, risking a disruption to the continuity of care and delays in access to assessment and treatment.

Following a recent review of incidents, reporting processes had been strengthened. However, we found there was a delay in reporting some incidents and many staff told us that they did not have the time to report. Some staff had received no or limited feedback to reports made. Many staff told us that there was little shared learning across divisions.

Our findings

Our findings

In 2011, the trust commenced a five-year plan to redevelop its organisational vision and values. Through the introduction of two programmes: HEY! It's in Our Hands; and the Great Staff Vision, the trust aimed to increase engagement and empower staff to achieve "greater things". A key priority was greater involvement of staff, the public and the wider community. However, initiatives had only recently been introduced to engage staff and the public in service development. These included the development of patient forums and panels.

Following the NHS Staff Survey results in 2012, which placed the trust at the bottom 20% nationally for 14 of the 28 indicators, the trust introduced the following new initiatives:

Link listeners – whereby staff representatives had direct access to executives.

A series of trust-wide 'Big Conversations' with staff; 700 attended the first event.

Pulse check – a staff survey to gauge staff views on a more regular basis to inform planning.

Pioneer teams – empowering staff to develop new initiatives, to date 31 teams had been supported.

Top five commitments programmes communicated to staff.

Golden Hearts scheme – to celebrate and recognise staff excellence.

Moments of magic – where staff nominated and celebrated colleagues' good practice.

Introduction of an executive leadership programme.

The trust was improving the way it engaged with people, and was in the process of changing the culture within the trust to be more outward-facing. External stakeholders reported that there was improved partnership working with the trust. Leadership of the health groups had been developed to create a triumvirate arrangement of a lead clinician, nurse and senior manager. This allowed for greater engagement across the different roles and closer working relationships. However, despite the new initiatives and strategies, many staff reported that they did not feel engaged. Across the trust many staff reported that there was little communication and silo working within divisions and across the main hospital sites. Some staff felt under intense pressure to cover gaps in rotas, and gave examples of when they felt bullied and harassed by senior management. Some staff felt disempowered and anxious about raising concerns and spoke of a bullying culture in the accident and emergency department and across some surgical specialities, and that meeting targets was a priority

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

for some managers over patient care. Junior doctors were under particular pressure to cover shifts, carried multiple pagers and acted up into more senior roles, even when they had not yet completed the competencies. This left them feeling stressed and unsupported.

The trust had become one of the 35 acute trusts to introduce the transparency programme developed by NHS England and this involved the trust publishing data on patients' harm, staff experience and ward staffing levels. There were systems in place for assessing, monitoring and addressing risk, with lines of reporting to the trust board. The management of risk was evident at every level – from patient risk assessment, team reporting through the division, to the maintenance of the corporate risk register.

All levels of staff with whom we spoke, from the top down, understood their responsibilities with regard to risk in the organisation. Following a recent review of incidents, risk management arrangements had been strengthened. However, many staff told us that they did not have the time to report incidents, and were discouraged from reporting as they had not received feedback. We found there was a delay in reporting some incidents. Therefore, the lack of sharing of lessons learnt meant that this information could not be taken into account for future learning and improved practice.

We were aware of two never events prior to the inspection, one involved a retained swab and one was due to wrong site surgery. However, we were informed of a third at the time of the inspection This involved wrong site surgery.

The trust was in the process of reviewing the acute and elderly medicine service provision to develop future models of care and working with local commissioners and providers to develop more integrated care pathways. The trust's winter plan was considered a high priority and aimed at developing clinical pathways to achieve 'Right place, Right time' strategy for patients. The lack of junior doctors was on the trust's risk register, and following the Deanery Quality Assurance visit in July 2013, the trust had developed an action plan to address concerns raised, but we found that junior doctors still reported that access to local teaching and hand over was problematic in some areas. Recruitment continued to take place to fill gaps in rotas and work was underway to expand consultant cover.

Governance and reporting mechanisms were in place to identify and manage risk, but not all actions taken to mitigate or eliminate them were effective. The accident and emergency department, the admission assessment unit, the lack of junior doctors and cancelled appointments were just some of the risks identified. However, staff and patients told us how there continued to be long waits for treatment and staff were working additional hours or beyond their skill base. Despite the opening of additional beds as part of the winter plan, patient flow through the hospital was not always effective, particularly when there was a peak in admissions, leading to multiple patient moves, risking a disruption to the continuity of care and delays in access to assessment and treatment. Staff were not able to access training, including mandatory training due to the staff shortages.

There was a disconnect between what the reporting system was communicating to the senior management team and trust board and what many staff were feeling at ward and department level. The significant challenges with inadequate emergency provision, ineffective patient flow systems and shortage of key personnel, left patients and staff at risk. The trust needs to do more to better understand the impact of these challenges on the quality and safety of patients and the welfare of its staff group.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety. Patients experienced multiple moves around the hospital and across sites putting them at risk of delayed assessment and inconsistent treatment. Delayed access to diagnosis and treatment was experienced in the A&E and the AAU. Patients were waiting significant lengths of time on trolleys in corridors, causing delays in assessment and treatment putting their welfare and safety at risk.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) Care was not always planned and delivered to meet the service user's individual needs or ensure their welfare and safety. Patients experienced multiple moves around the hospital and across sites putting them at risk of delayed assessment and inconsistent treatment. Delayed access to diagnosis and treatment was experienced in the A&E and the AAU. Patients were waiting significant lengths of time on trolleys in corridors, causing delays in assessment and treatment putting their welfare and safety at risk.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and 'Suitability of Premises'. Children cared for on Acorn Ward could not be appropriately monitored and observed. The facilities on Ward 130, Acorn Ward and the high dependency unit did not provide suitable facilities for the carrying on of the regulated activities

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This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 'Staffing'. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital for the purpose of carrying on these regulated acitvities There were significant shortage of junior doctors, who working across multiple patient groups, without appropriate supervision, sometimes outside their competency. There was a significant shortage of nursing staff across acute elderly medical wards and surgical specialities, including theatres. There was insufficient medical staff in maternity services. There was significant shortages of appropriately qualified medical and nursing staff in children's services including the children's A&E.
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Compliance actions

There was significant shortages of appropriately qualified medical and nursing staff in children's services including the children's A&E.

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

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