Hull and East Yorkshire Hospitals NHS Trust

Quality Report

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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 services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Inadequate
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Hull and East Yorkshire Hospitals NHS trust operates acute services from two main hospitals – Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) – with a minor injuries unit at Beverley Community Hospital and some outpatient services within other community locations. In total, the trust had approximately 1,300 beds and 7,400 staff.

Hull Royal Infirmary houses the main emergency provision for the trust, including accident and emergency services, critical care, acute medical and surgical services as well as the Women and Children's Hospital. The HRI site has over 700 beds. Castle Hill hospital has cardiac and elective surgical facilities, medical research teaching and day surgery facilities (the Daisy Building), ear, nose and throat (ENT) services and breast surgery facilities and outpatients. The CHH site has over 600 beds.

We carried out a follow up inspection of the trust between 19 – 21 May 2015 in response to concerns that had been identified both during a previous comprehensive inspection of Hull and East Yorkshire NHS Trust in February 2014 and highlighted through other information routes.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect critical care services or end of life services at the follow up inspection. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

At the inspection in February 2014 we found the trust was in breach of regulations relating to patient care and welfare, medicines management, staffing, premises, staff support and governance.

Overall we rated the trust as 'requires improvement'. We rated it 'good' for being effective and caring. The trust 'required improvement' in the domains of safe, responsive and well led.

Our key findings were as follows:

- The trust had responded to previous staffing concerns and was actively recruiting to fill posts however there were areas in medicine where nurse staffing levels were impacting on patient care and treatment particularly on the elderly care wards. There were also staffing pressures in the electrocardiography department at Castle Hill Hospital which meant staff were struggling to carry out cardiac diagnostic tests for patients.
- Systems and processes on some wards for the management of medicines and the checking of resuscitation equipment did not comply with trust policy and guidance.
- Most patients across the medicine health group received a good standard of care. However, on the elderly care wards patients were waiting for staff to assist them with their basic needs. Call bells were not in reach of patients in some areas. There was inconsistent use of the red top water jug system to identify patients that required assistance with nutrition and hydration. Care was not always being actively recorded in the patient's records.
- There had been changes to medical pathways of care to improve access and flow however this had not yet resulted in a significant improvement as there continued to be delays in discharge, patient bed moves out of hours and, patients were being cared for on non-specialty or other specialty wards due to inpatient capacity issues.
- There was an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014.
- Most staff had received safeguarding training and could demonstrate an understanding of their role and what action to take if they were concerned about a person.
- At the time of the inspection the trust was a mortality outlier for deaths from septicaemia (except in labour). This had been persistently raised. Actions plans had been put in place however the number of deaths remained raised.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust was 108.3 which was higher than the England average (100) in June 2014. At York hospital for the same period the indicator was 98. The SHMI is the ratio between the actual numbers of patients who die following hospitalisation at the trust and the

Summary of findings

number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 99.2 which was similar to the England ratio (100) of observed deaths and expected deaths.

We saw several areas of good practice including:

- The appointment of an internal anti-bullying Tsar (a doctor) to lead the anti-bullying work. We received many positive comments about the tsar and their approach to the role.
- The opening of the new emergency department represented a substantial improvement in the facilities for the hospital so that emergency care and treatment was provided in a suitable environment.

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

- Address the breaches to the national targets for A & E and referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard to eye services and longest waits.
- Ensure there is a sustainable action plan to improve the reporting performance of histopathologist service.
- Ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the elderly care wards, consultant and nursing cover within A &E; histopathologists, echocardiography team and surgical wards.
- Ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014)
- Ensure that all incidents are investigated in a timely manner, that lessons are learnt and that duty of candour requirements are effectively acted upon and audited.
- Ensure that there is a policy and procedures in place to ensure that there is effective transition for young people to adult services
- Ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.
- Ensure appropriate arrangements are in place to respond to major trauma and incidents within ED.
- Ensure that there is an effective and timely system in place, which operates to respond to, and act on, complaints.
- Ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.
- Take further steps to improve the facilities for children, young people and parents on the 13th floor.
- Take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, and that there is an appropriate "safe bed space" for the use of children and young people with mental health needs. Following the inspection the Trust told us it was implementing an accepted anti-ligature risk assessment.
- Ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.
- Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.
- Ensure that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance
- Review its patient pathways and patient flow through services to ensure:

1. Plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management
2. The seating area on the elderly assessment unit is not used for beds

Summary of findings

3. Plans for dealing with extra capacity are reviewed including the “reverse boarding” policy.
4. Internal patient transfers take place in accordance with trust policy and reduce the number of patient bed moves ‘out of hours’ unless for clinical reasons
5. More timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.

- Ensure use of best practice guidance, such as the “Safer steps to surgery” checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- Ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients.
- Review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres
- Ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation

In addition there were areas where the trust should take action and these are reported at the end of the two individual hospital reports.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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

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

The trust serves a population of approximately 600,000. Life expectancy for those in East Riding of Yorkshire is better than average, but worse than average for those in Hull. Kingston Upon Hull performs significantly worse than average for most measures on the local health profile. East Riding of Yorkshire performs similar to or better than the England average. Hull is one of the most deprived local authorities in the country. East Riding of Yorkshire is in the 2nd IMD quintile (where 1 is the least deprived).

The trust has not yet achieved foundation trust status. The trust's management structure is based on health groups: these include surgery, medicine, family and women's health and clinical support along with the corporate functions.

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

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

At the comprehensive inspection in February 2014 HRI and CHH were found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare), 10 (governance), 13 (medicines), 22 (staffing) and 23 (staff support) for the regulated activities treatment of disease, disorder or injury and diagnostic and screening procedures. Additionally HRI was also found in breach of regulation 15 (premises). Compliance actions had been set for all these breaches and the trust had action plans in place to become compliant by March 2015.

Our inspection team

Chair: Michael Wilson, CEO, Surrey & Sussex Healthcare NHS Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists including medical, A&E and surgical consultants, junior doctors, senior managers, nurses, midwives, allied health professionals, children's nurses and experts by experience who had experience of using services.

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we routinely ask the following five questions of services and the provider:

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

However, as this was a focused inspection we did not look across the whole service provision; we focused on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

The team inspected the following core services at HRI:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Maternity
- Services for children and young people
- Outpatient and diagnostic services

The team inspected the following core services at CHH:

- Surgery
- Outpatient and diagnostic services

We did not inspect the core services critical care or end of life services at either site as they had been rated as "Good" at the February 2014 inspection. Medical care was not inspected at CHH as almost all the services had been transferred from CHH to HRI since the last CQC inspection.

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and the local Healthwatch organisations.

We held a listening event in Hull on the 18 May 2015, where 52 people attended and shared their views and experiences of the trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 19 and 21 May 2015. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

What people who use the trust's services say

Evidence from the Cancer Patient Experience Survey, National Cancer Intelligence Network, 2012/13 and 2013/14 indicated that responses were similar for both years. In 2013/14 there were 27 out of 34 indicators that were similar to 60% of the trusts nationally; one indicator was in the top 20% of trusts and six were in the bottom 20% of trusts. Information from the Patient-led assessments of the Care Environment (PLACE) indicated that for 2014 the trust was the same as the national average for privacy, dignity and well-being and was slightly below from cleanliness and food. It scored 84 compared to 92% nationally for its facilities. There has been a year on year increase in the number of complaints in this trust since 2010/11 with approximately 800 in 2013/14. However, in 2014/15 there was a reduction in the number of complaints received to 769.

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In the 2013 CQC inpatient survey comments received from patients were similar to those of other trusts. The response to CQC A&E Survey 2014 (undertaken before the move to the new facilities) was worse than other Trust's A&E departments for 11 of the 24 questions and about the same for the remaining questions. For the Friends and family test the percentage of people who would recommend the Trust was persistently below the national average for inpatients, 90.6 – 93.4% from December 2013 to October 2014. In November 2014 this improved to 96% and was at 97% in April with a 21% response rate from patients. For A&E the number of patients who would recommend A&E was well below the national average. For example 66% of patients in April 2015 compared with 87.5% nationally and in May 2015 71% of patients and nationally the figure was 88%.

The majority of patients we spoke with said that they were listened to by staff and felt they were treated with privacy and dignity. However some patients and relatives on the elderly care wards felt they did not receive a good standard of care and there was a lack of communication between the nursing staff and patients particularly around discharge planning.

Facts and data about this trust

Hull Royal Infirmary has over 700 beds and in addition to acute medical and surgical services provides accident and emergency (A&E) services. The A&E services were seeing year-on-year increases in attendance, and treated over 131,000 people in 2013/14. The Women and Children's Hospital located at Hull Royal Infirmary houses the maternity and children's services, including neonatology with a 28-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, the HRI 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.

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

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.

Overall the trust has:

Beds approximately 1,300 including:

· General and acute 992

· Maternity 72

· Critical care 44

Staff (whole time equivalent establishment): **7,361.65**

· Medical 1,024.38

· Nursing 3,004.73

· Other 3,332.54

Revenue (2014-15 projection): £522,330

Activity summary (Acute) – 2013/14

· Inpatient admissions 185,676

· Outpatient (total attendances) 617,971

· Accident & Emergency (attendances) 131,308

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Requires improvement** 

Summary

Incidents were reported, however staff confirmed that feedback and learning from incidents required improvement. There were a significant number of incidents that required further investigation and review and we found a backlog of incidents in the Accident & Emergency Department that required validation.

Whilst nurse staffing levels had improved in A&E there were still Consultant staffing shortages although the trust were working on a range of recruitment strategies to fill the remaining vacancies. There were also role specific staffing issues across the trust, for example in electrocardiography and histopathology staff. Maternity staffing had improved since the last inspection from a ratio of one midwife to 35 births to 1:32 births.

There were a significant number of infection control issues across surgical services and in the Accident & Emergency Department at Hull Royal Infirmary. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols. Hand-washing facilities for clinical procedures were inadequate. There was inappropriate access to store rooms, and temporary repairs to flooring in ward and clinical areas. Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections.

There was concern regarding the robustness and safety of the windows on the paediatric wards situated on the 13th floor of the tower block at Hull Royal Infirmary. In addition a number of ligature risks were also identified by the inspection team on these wards which was raised as a concern at the time of the inspection. The Trust provided written assurance that they had checked all the windows in the building and they met the appropriate standards.

Safeguarding systems were in place and staff were aware of these. Safeguarding training for vulnerable adults and children had improved overall however Level 3 Safeguarding training remained below trust target. However, the Trust informed us it was on track for the trajectory of March 2016 and compliant with the Clinical Commissioning Group (CCG) target We had concerns about the implementation of “Patient Watch” as a form of restraint within the policy. This was a form of restraint provided by the Trust’s security service and used with patients who had health related confusion.

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Duty of Candour

- The trust had in place a policy relating to these new requirements.
- Information to be reported under the duty of candour requirements was yet to be fully included in the electronic incident reporting system.
- We saw that information about duty of candour was displayed on the staff intranet.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements.
- The Trust had identified the need for an e-learning package for Being Open and the Duty of
- Candour and was to progress the development of this for staff.
- Application of the duty of candour to incidents generally and the backlog of incidents was not consistent. For example, of six incidents which related to the emergency department, only three of these had evidence indicating the date of a verbal apology given to the patient or relative. A report provided by the trust showed that between December 2014 and April 2015 the medical health group had achieved 33% against the duty of providing an apology and 40% against providing patients with feedback.
- We were told that the trust could only track and trace confirmation of apologies being given by reviewing patients' notes. The governance team was reviewing patient notes for all moderate and serious incidents and a report was to be sent to the operational quality committee.
- Trust data indicated the trust was only 38% compliant with the provision of an apology when a patient had been involved in an incident from when the duty commenced on the 27 November 2014 to the 17 February 2015.

Safeguarding

- We reviewed actions taken since our previous inspection in October 2013 where safeguarding had been a concern. The action plan from this inspection was presented as completed and updated as of May 2015.
- Policies and procedures were in place and the trust had a Safeguarding Board which met monthly to review and manage safeguarding throughout the trust.
- There was a team of safeguarding staff within the trust whose role it was to ensure the Trust's safeguarding practices met current regulations and to provide support and training to staff. There were safeguarding link nurses on wards and departments.

Summary of findings

- The trust worked closely with both the local authority and the police.
- There was a specific suite available for child protection medical examinations.
- There had been significant progress in increased training rates though this was still variable in some areas. For example, in medical care services training figures showed 71% of medical staff had completed safeguarding children and 64% had completed safeguarding vulnerable adults training. Overall trust performance for the vulnerable adults training was 85.2% and for safeguarding children training was 86.5% as of May 2015 against a target of 85%. Staff we spoke with had completed training, or arrangements were made for them to attend.
- We reviewed actions taken since our previous inspection, when we asked the A&E department to ensure that staff were supported to complete Safeguarding Children Level 3 training where appropriate. At the time of the inspection it was reported in the "Named nurse and named midwife report" dated May 2015 that level 3 child safeguarding training was non-compliant across the trust at 66.6% with the majority of non-compliance within the A&E department. However, the Trust informed us it was on track for the trajectory of March 2016 and compliant with the Clinical Commissioning Group (CCG) target.
- Staff we spoke with were aware of their responsibilities and of the appropriate safeguarding pathways to use. We reviewed evidence of appropriate risk assessments being undertaken, including escalation to the safeguarding team when safeguarding concerns were suspected.
- At our inspection in February 2014 we found there were procedures in place for protecting adults and children from abuse within midwifery services. There was also a named midwife for safeguarding however the post was only funded for 15 hours per week. This had been identified as a risk by the head of midwifery and a business case had been made for a full time post. At this inspection we found the named midwife, safeguarding post was full time. The Quality, Safety and Performance report for May 2015, showed 44 staff had been trained to offer safeguarding supervision within midwifery and this would be received four times a year.
- Additionally, the trust had a midwife who had the role of 'Vulnerable Adults, Teenage Pregnancy, and Healthy Lifestyle Midwife,' and staff told us they were able to refer patients to this member of staff.
- We noted that information was not always recorded in A&E about children in the same households as adults with risk

taking behaviours or other vulnerabilities so that they could be brought to the attention of paediatric liaison services. The trust had acknowledged as a gap and actions were being put in place to address this.

- At the time of the inspection there were gaps in the uptake of safeguarding children supervision in paediatric services and within A&E. Work to improve this had not commenced following the withdrawal of the teacher practitioner who was leading on this.
- At our October 2013 inspection we had noted that details of physical intervention and restraint were not recorded in the patient's records nor on the trust's incident reporting system. A restraint policy had been implemented in January 2014 and reviewed in October 2014. Whilst the reporting of incidents had improved from 2013/14 there was evidence from the Safeguarding and Vulnerable
- Adults Restraint Update Report 18 May 2015 which showed there had been 296 episodes of patient watch from April 2014 – March 2015, and only 21 incident reports had been completed for these.
- We had concerns about the implementation of "Patient Watch" as a form of restraint within the policy. This was a form of restraint provided by the Trust's security service and used with patients who had health related confusion. Restricting a patient by authorising bed-watch was used when it is deemed necessary to prevent an individual patient harming themselves, others or property. The policy stated that consent must be obtained, or where this is not possible the Mental Capacity Act Best Interests pathway must be followed and a Deprivation of Liberty authorization, where applicable must be requested and agreed (for cases of 72 hours of more).

Incidents

- There had been five Never Events reported in in this trust between February 2014 and January 2015, one of which was late in being reported and had occurred in the previous financial year. Three of the never events were within spinal surgery since December 2014. The Trust had commissioned a review by the Royal College of Surgeons as a consequence. At the time of the inspection the terms of reference were being agreed and the review had yet to conclude.
- The trust was ranked nationally as the 10th highest reporter of severe harm incidents within its cluster of 29 peer organisations as at the end of March 2014. The rate of incident reporting showed the trust was in the lower levels of reporters nationally.

- Since the last inspection the trust informed us that they had upgraded the electronic incident reporting system and the serious incident reporting policy had been reviewed. Trust data showed staff had reported approximately 850 more incidents in 2014/15 compared to the previous year.
- There had been 86 serious incidents (SIs)/never events declared from 1st April 2014 to January 2015 which was an increase from 36 in 2014/15.
- As of February 2015 there were 1453 incidents reported by staff that had not been investigated within the Trust policy timescales which was an increase of 510 from the position reported in December 2014.
- There was a backlog of incidents that required further review and there were delays in incidents being investigated. External support was being put in place as there were delays in securing clinical staff for panel members to investigate incidents. We saw that incidents were discussed at ward and clinic manager meetings from across the trust to promote shared learning. However there may have been delays in the learning from incidents due to the backlog of incident investigations.
- Most staff said they were aware of the type of incidents to report. We found that incident reports were not being consistently completed in accordance with trust policy. For example, the trust restraint policy indicated that when patient watch by a security guard was initiated an incident report should be completed. Evidence from the Safeguarding and Vulnerable Adults Restraint Update Report 18 May 2015 showed there had been 296 episodes of patient watch since January 2015, 21 incident reports had been completed for these.
- There was a "Learning lessons newsletter" circulated to staff. We saw copies dated March and May 2015. There were also summaries of individual lessons leant on the trust's intranet.

Infection control

- In the A&E department some patient trolleys were not clean. Portering staff told us they cleaned trolley mattresses after each patient's use, but currently there was no designated area in the department to do this. In the majors utility area we found two commodes which were dirty and stained. We were informed that domestic staff visited the department in the morning and evening, and could be contacted at other times (24/7) if required.
- When we visited unannounced in the evening we did not observe staff hand washing. In the paediatric emergency area, we were informed that toys were cleaned but staff did not know how often this was done and no record was kept. In medicine at

Hull Royal Infirmary ward areas appeared clean and we saw that staff regularly washed their hands between patient interventions. Staff were bare below the elbows, in line with trust policy and national guidelines for best hygiene practice.

- There were no methicillin-resistant staphylococcus aureus (MRSA) Bacteraemia infections within medicine over the last 12 months. Nine acute acquired cases of Clostridium difficile had been reported by the trust year to date as at 15 May 2015.
- In surgery there were a number of infection prevention and control issues identified. We saw potential risks of contamination caused by inappropriate storage and ineffective cleaning protocols. Hand-washing facilities for clinical procedures were poor on ward 6 at HRI. We saw inappropriate access to store rooms, and temporary repairs to flooring in ward and clinical areas.
- Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections. Increased health risks to patients will occur if ventilation systems do not achieve and maintain the required standards Health technical memorandum 03-01: specialised ventilation for healthcare premises. The Health Act 2008: code of practice for the prevention and control of healthcare associated infections, sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risks of infection is kept as low as possible.. We saw reports for visual inspections and compliance with performance measures: these reports we saw identified issues such as “rotten plant” and the presence of dirt and rust within the ventilation systems that served the theatres. The environment in the theatre suite was damaged with exposed plaster (at HRI), exposed timber, damaged flooring, loose wall protection and damaged light switches. Environmental damage within the theatre suit hampers effective cleaning procedures and has the potential to increases the risk of surgical site infections to patients.
- We visited a surgical ward which cared for seven surgical specialities. Staff told us that orthopaedic patients on this ward were not “ring-fenced” in accordance with national guidelines (Saving Lives: a delivery programme to reduce Healthcare Associated Infection, including MRSA Screening for Methicillin-resistant Staphylococcus aureus (MRSA) colonisation: A strategy for NHS trusts: a summary of best practice 2006); patients who had undergone joint replacements had been placed in a bay with other surgical patients which did not protect them from cross-infection. We reviewed internal infection, prevention and control (IPC) assessments for March 2015. These indicated that

some theatres were classed as inadequate (below 80%): these theatres were 7, 8 and 12 (73%) and day surgery theatre 3 (65%). Other theatres required improvements (scoring 80-88%) for theatres 3, 4 and 5 (83%), 6, 9 and10 (86%) 14, 15 and 16 (83%), 19, 20 and 21 (81%).

Medicines

- The trust monitored the pharmacy service provided to wards on its clinical pharmacy dashboard.
- This showed that pharmacy staff spent more time on the wards compared to the previous inspection. All wards apart from maternity and gynaecology were visited by a pharmacist; the length of the visit being determined by the ward's speciality.
- Fourteen extra pharmacy staff had recently been recruited and ten new pharmacists were due to be in post by August 2015. The pharmacy team spent an average of 80 hours per day on wards across the trust during March 2015 and further clinical pharmacy ward services were planned for the autumn.
- A junior pharmacist and senior pharmacy technician told us that pharmacists and technicians now spent more time on the wards: They said that most of the work coming to the dispensary was already clinically checked which reduced delays in supplying medicines.
- The percentage of patients whose medicines had been reconciled (checking the patient continues to receive the medicines they were taking before admission, unless changed or stopped for medical reasons) was 80%, and about half of these patients' medicines were reconciled within 24 hours of admission.
- The trust used the 'medication safety thermometer' tool to measure how often patients missed a prescribed dose of medicine. In March less than 1% of patients missed a dose of a 'critical' medicine (where missing one dose put the patient at possible risk of harm) and less than 5% missed doses of other medicines. These figures show that patients received the medicines they needed most of the time.
- The trust's latest audit of medicines that are controlled drugs (CDs) found that daily stock checks were not always completed. When we looked at the CD registers in the emergency department we found eleven incomplete administration records; there was no evidence of the omissions being noted and action being taken. There were some gaps in the records we checked on Acorn ward and PHDU, but the majority of the checks had been completed appropriately. The wastage of controlled drugs was not recorded. Detailed records of the use of CDs are required by law to prevent mishandling or misuse.

- A number of patients had been waiting between one and five hours in the discharge lounge for take home medicines. For example, one patient had been waiting for over 90 minutes yet their discharge had been planned at 10am the previous day. Three patients had been waiting between three and five hours. One medication had been dispensed in a different dose to that prescribed, this was noticed by a nurse in the discharge lounge and was rectified.
- On ward 8 a member of our inspection team was able to enter the treatment room containing medications as it was unlocked. In the same treatment room the drugs fridge had been reported as not working on 18th May 2015, there was no evidence on 21st May 2015 that any action had been taken to rectify this.
- Records showed medicine fridges on some medical wards were not being consistently monitored in line with trust policy to ensure appropriate temperatures were maintained for the safe storage of medicines. The temperature of the medicines fridge in the A&E resuscitation area was not monitored accurately. In A&E majors, we found that medicines fridge temperatures were not checked daily.
- Records showed medication doses were not consistently signed to indicate that the medicine had been given and where medication was not given the reason for doing so was not always recorded using the numeric codes for "omitted or delayed doses" on the drug chart.
- On two medical wards we observed that tablets had been left in a medicine pot on the patient's bedside and nursing staff had not stayed to ensure that the medication had been taken by the appropriate route of administration which was not in line with the trust's medicines policy.

Assessing and responding to patient risk

- Between September 2014 and March 2015 there were 1,842 black breaches in A&E at the trust of which there had been 308 black breaches in February and 423 during March 2015. Black breaches are defined as the time between an ambulance arriving at the hospital to the patient being formally handed over to the emergency department which is longer than 60 minutes.
- Performance information for ambulance turnaround times for the week of our visit in May 2015 indicated that 52% of patients were seen within 15 minutes.
- Data provided by the trust indicated that for April 2015 the arrival to initial clinical assessment/triage was, on average, 10.9 minutes and from arrival to be seen by a doctor was 108.7 minutes.

Summary of findings

- In paediatrics we were concerned regarding the windows and whether these could be opened. We asked for the trust to clarify the situation with regard to window restrictors and the trust confirmed that there were window restrictors in place on all of the windows. The bottom windows on the paediatric ward were also locked at all times.
- There was a specific 'Green Room' for children who required a "safe bed space" where they could be closely and continuously observed. Staff told us this was not fit for purpose. We reviewed the space and noted that it would be difficult to observe a child if the room was in use. At the time of the inspection this room was not being used.
- There were a number of ligature risks identified on the paediatric ward 130 including coat hooks. The Trust has taken advice from CAMHS and told us it will introduce the use of an accepted anti-ligature risk assessment tool as part of the quarterly Health & Safety audits.

Staffing

- At the February 2014 inspection we found that 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.
- At the May 2015 inspection we found some improvements in staffing, however the Trust had been slow to respond to the concerns particularly in A&E. Staffing levels and skill mix did not always meet professional body recommendations.
- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to ensure that staffing establishments reflected the acuity of patients. The newly appointed chief nurse was reviewing staffing levels and how these were reported regularly to the Board.
- The trust had invested in £1.5m to increase medical and A&E nurse staffing and provide some supervisory time for ward sisters/charge nurses. The trust used a number of nationally recognized tools for reviewing acuity and dependency levels of patients. For example the Safer Nursing Care Tool and the Birthrate Plus and NICE guidance for maternity services.
- The average fill rate of registered nurses/midwives for day shifts from December 2014 to March 2015 was marginally above or below 80% with March 2015 being 79.5% at HRI. Levels were marginally worse at CHH with the fill rate being 78.4% in March 2015. These figures had improved to 82.4% in May 2015 at HRI and 83.6% at CHH.

Summary of findings

- Prior to the inspection there was a vacancy rate of approximately 8% (200WTE). A number of these posts had been recruited to. At the time of the inspection about 100 staff had been recruited, the majority of which were waiting for registration with the professional body but were working as HCAs in the interim.
- The trust had an IT staffing safety briefing system in place which was broken down into different zones across the Trust. The system indicated the: number of beds; acuity of patients; dependency of patients (for example the number of patients requiring red trays); required registered nurse staffing levels and actual nurse staffing levels.
- We spot checked three of these daily safety briefings in a three month period and found that most zones were not meeting the Trust's required staffing levels and were rated as amber or red.
- There was a shortage of A&E medical staff which the Trust was aiming to address with a three-year recruitment programme included overseas recruitment. The shortage of consultants had an impact on assessing patients and access to senior medical decision-makers. There were nine of 16 posts filled at the time of the inspection with a plan to recruit into a further two post.
- The A&E department had recently increased the level of nursing staff, both in terms of the planned levels and the actual number of nurses in post. At the time of the inspection not all staff were in place and operational.
- There were areas in medicine where nurse staffing levels were impacting on patient care and treatment particularly on the elderly care wards. Of particular concern were wards 8 and 80 which had low registered staffing fill rates both day and night shifts and had the highest number of adverse quality indicators.
- There were also staffing pressures in the electrocardiography department at Castle Hill Hospital which meant staff were struggling to carry out cardiac diagnostic tests for patients.
- Staff reported an increase in the recruitment of consultant obstetricians and midwives. We found the birth to midwife ratio had increased from 1:35 to 1:32 since our inspection in February 2014 but was not yet in line with the national guidance of 1:28. Patients told us they received 1:1 care from a midwife during labour and consultant and medical care which met their needs.
- In outpatient services there were five out of 13 consultant vacancies in the Histopathology team. Although there was some mitigation in place, this was adversely affecting reporting times.
- A new safety workforce tool was being developed for use across the trust.

- In surgery safety briefings were held twice daily and included discussions about staffing, falls, risks, safeguarding, and the allocation of members of staff to other work areas. Staff felt that this made allocations fairer and agreed with its principle. We attended safety brief meetings and saw that staff were moved from wards to work in other areas because of changing patient acuity and staffing levels.
- The senior management team told us that moving staff caused anguish and was on their 'worry list'. The health group's risk register identified a number of issues including insufficient junior doctor cover, availability of agency staff and difficulties in appointing consultants. It stated that there was insufficient junior/middle grade doctor cover which was potentially compromising patient safety in surgery. The risk had been reviewed and agreed that the risk rating should remain high. A business case had been resubmitted in February 2015 supporting phased recruitment of seven junior doctors for the year.
- There were three paediatric surgeons in post and there was concern regarding the sustainability of their 1:3 on call rota
- Most wards had ward clerks and ward housekeepers in place.

Environment and equipment

- There was a lack of appropriate accommodation for children having oncology treatments; they were nursed within cubicles that did not meet the NICE IOG (Improving Outcomes Guidance); Children who required isolation did not have access to rooms with en-suite facilities on Ward 130. There were no toilet facilities and commodes had to be used which led to a lack of privacy & dignity for Children with Oncology needs. During the inspection work was being undertaken to upgrade the bathroom facilities on ward 130.
- The paediatric wards on the 13th floor appeared cluttered and had lack of storage facilities. We were told the service had plans in place to centralise stores across the 13th floor.
- Cubicles holding four or more cots on the neonatal unit were cramped and was not in accordance with the British association of Perinatal medicine (BAPM) Designing a Neonatal Unit guidance in 2004. This meant there could be problems for staff when providing resuscitation or medical intervention.

Records

- In paediatrics the care records we reviewed had little specific information about the specific child's needs or interactions and made it difficult for staff to provide safe and effective care and treatment to children and young people. Staff made generic

entries in care plans to describe the care being provided, with little specific information tailored to the individual child or their needs. We saw generic entries to record children's interactions, such as 'play', 'family', 'discharge'. This did not provide specific information on the child's needs or interactions at that time. For example, two children with specific care needs did not have appropriate care plans in place.

- The care plan templates were out of date for review, had been photocopied a number of times, and this resulted in the templates being hard to read.

Are services at this trust effective?

Requires improvement

Summary

In May 2015 we inspected A&E, medical care, children and young people's services and outpatient & diagnostic services. These services were rated as good in A&E, requiring improvement in medical care and children & young people's services for delivering effective care.

Policies and pathways were based on NICE and other best practice guidelines. Information from audits showed that the majority of intended outcomes for patients within medical services were being achieved with a more mixed picture within audits of A&E. Fluid balance and food charts were not fully completed by staff on the medical wards. We witnessed multidisciplinary team (MDT) working during our inspection.

Fluid and nutritional charts were not always completed fully and there was inconsistent use of the red top water jug system to identify those patients who required assistance with nutrition and hydration

Evidence based care and treatment

- Within medical services care was planned and delivered in line with evidence based guidance although there was no annual audit or policy for the provision of non-invasive ventilation. Action had been taken in response to national accreditation standards for example in endoscopy.
- The A&E department used National Institute for Health and Care Excellence (NICE), College of Emergency Medicine (CEM) and other recognised clinical guidelines.
- In Children's services a number of policies and leaflets we reviewed were out of date, with the review dates of the policies having already passed with no evidence of review having taken

place. An example of this included the hand hygiene leaflet available for children and visitors. This was due for review in 2010. This meant staff did not have current documents to refer to and there was a risk procedures may not be correct.

Nutrition and hydration

- We saw that steps had been taken in the A&E department to ensure that patients' needs for nutrition and hydration were being addressed. Checks within the initial assessment included the patient's needs for food and drink, their needs for assistance if required, and the need for intravenous fluids. These checks were supported by intentional rounding.
- On some medical wards there was inconsistent use of the red top water jug system to identify patients that required assistance with nutrition and hydration.
- In total we reviewed 19 fluid balance and food charts; none of which were fully completed by staff on the medical wards.

Patient outcomes

- At the time of the inspection the trust was a mortality outlier for deaths from septicaemia (except in labour). This had been persistently raised. Actions plans had been put in place however the number of deaths remained raised.
- The Summary Hospital-level Mortality Indicator (SHMI) for the Trust was 108.3 which was higher than the England average (100) in June 2014. At York hospital for the same period the indicator was 98. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The Hospital Standardised Mortality Ratio (HSMR) was 99.2 which was similar to the England ratio (100) of observed deaths and expected deaths.
- The CQC 2014 national survey of patient experience in the emergency department indicated that the trust scored the same compared to other trusts for questions about arrival at the department, tests undertaken, hospital environment and facilities and leaving the department. However the trust scored worse when compared to other trusts for waiting times, doctors and nurses, care and treatment and overall experience.
- The emergency department contributed to the CEM clinical audit programme and through this measured and benchmarked its performance against other trusts. The trust had a mixed performance in its performance against the CEM audits at the 2014 inspection. We reviewed the CEM 2013 audit

on severe sepsis and septic shock at the May 2015 inspection and it had mixed performance outcomes. For example, it showed red flags for fluids, blood glucose measurement and antibiotics being administered within one hour.

- Information from audits showed that the majority of intended outcomes for patients within medical services were being achieved.
- The 2014 annual RPA's report showed that internal audits of compliance with radiation regulations showed good compliance. The report also highlighted that an external audit undertaken in October 2014 was satisfactory.
- It was also reported that audits throughout 2014 across a number of areas, on patient radiation doses, showed good compliance with local and national diagnostic reference levels. Diagnostic reference levels (DRLs) are used as an aid to optimisation in medical exposures.
- The National Paediatric Diabetes Audit (published October 2014) indicated that there were proportionately fewer children (11.7%) with diabetes that had an HbA1c measurement of < 7.5% which was better than the England average (15.8%). However, the median HbA1c measurement was similar (71%) to the England average (69%). HbA1c is usually done from a fingertip blood test and measures diabetes management over two to three months. The recommended level for children is generally <58mmol/mol (7.5%).
- Emergency readmission rates were higher than the England average for the under 1s, and lower for children aged 1-17.

Multidisciplinary team (MDT) working

- We found there was effective multidisciplinary working within internal hospital teams. Examples included: observation of a comprehensive MDT handover on EAU where all patients were discussed three times a day.
- There were specialist radiologists as core members on multi-disciplinary teams including; lung, brain and CNS, breast, upper GI, cancer of unknown primary, sarcoma, skin, urology, gynaecology, head and neck, colorectal, haematology and pituitary.
- We observed good working relationships between nursing and medical staff.
- In children's services there were issues with accessing dietetic and occupational therapy support.

- Dietetic services were on the risk register. There was a lack of capacity to input into MDTs and an inability to routinely review children on wards. Controls put in place to manage this included the dietetic department trying to recruit locums and dieticians prioritising workloads.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Overall consent was discussed and obtained appropriately in almost all areas we inspected. However, during our visit to the gynaecology outpatient department it was observed that women were undergoing flexible hysteroscopy without being asked for written consent. This was raised as an urgent issue with the Trust and action was taken.
- We observed patients being asked for their consent. For most patients who arrived in the A&E department, interventions required informal or verbal consent.
- Understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included in mandatory training which staff attended on a three-yearly basis.
- Staff we spoke with mainly demonstrated an understanding of the MCA, of their responsibilities and of DoLS procedures, although not all staff we spoke with had experience of using the procedures.

Are services at this trust caring?

Good

We inspected caring for the core services of A&E, medical care, children & young people's services and outpatient & diagnostics. Overall patients were cared for with empathy and with respect to their dignity. However less than optimal staffing levels on the elderly care wards meant patients were waiting for staff to assist them with their basic care needs. Call bells were not in reach of patients in four medical ward areas we visited. Most patients were given emotional support and told us they felt involved in decisions about treatment and care. However some patients and relatives on the elderly care wards felt there was a lack of communication between the nursing staff and patients particularly around discharge planning. The trust had achieved good progress in promoting the privacy and dignity of patients which had been greatly improved with the opening of the new emergency department.

Compassionate care

- Overall we observed positive, kind and caring interactions between staff and patients in A&E, on the medical wards and

clinics. However on four medical wards that we inspected call bells were not in reach of patients. A patient told us about a delay in receiving basic care and we witnessed another example of delayed care.

- Patients mostly told us that, although staff were very busy, the standard of care they had received was good and all their clinical needs had been met. However, staffing levels on the elderly care wards meant patients were waiting for staff to assist them with their basic care needs.
- Friends and Family Test data varied by service. Overall for inpatients the trust had 97% of respondents recommending the trust in both April and May 2015 compared to 95.4% nationally.
- This was an improvement on 2104 figures. In May 2015 figures for the A&E department indicated that from a response rate by patients of 5.6% the percentage of people who would recommend the department had increased to 71% (in previous months it had been as low as 65%) with a national recommendation of 88.3%
- In the Care Quality Commission (CQC) A&E survey 2014 the trust performed about the same as other trusts for four questions related to caring, but it performed worse than other trusts for the remaining four questions. The trust performed about the same for questions related to arrival at A&E, tests (answered by those who had tests only), hospital environment and facilities, and leaving A&E. However, the trust performed worse than other trusts for questions related to waiting times, doctors and nurses (answered by all those who saw a doctor or nurse), care and treatment, and experience overall.
- We reviewed actions taken since our 2014 and January 2015 inspections, when we asked the department to ensure that the privacy and dignity of patients was promoted in the emergency department. Patients had been waiting on trolleys in corridors for significant periods, often without easy access to toilet facilities. This had not significantly improved at our January 2015 inspection. Privacy and dignity of patients had been greatly improved with the opening of the new emergency department in April 2015.
- The trust performed around the same as other trusts in relevant questions in the CQC's Inpatient Survey 2013.
- The cancer patient experience survey results for 2013/2014 for inpatient stays showed the trust was in the top 20% nationally for one of the 34 questions, the bottom 20% for six of the questions with the remainder similar to other trust nationally.
- The Patient-led assessments of the Care Environment (PLACE) for both 2013 and 2014 indicated that the Trust performed

Summary of findings

better than other trusts in 2013 in relation to privacy, dignity and wellbeing with a score of 92% compared with the England average of 88% and the same as the England average of 87% in 2014.

Understanding and involvement of patients and those close to them

- Most patients told us they felt involved in decisions about treatment and care.
- However some patients and relatives on the elderly care wards felt there was a lack of communication between the nursing staff and patients particularly around discharge planning.

Emotional support

- Most patients we spoke with felt they were supported emotionally
- There was a range of clinical nurse specialists at the trust who supported patients, for example, in cardiology, diabetes and neurology. There were also clinical nurse specialists in breast, urology, upper GI, head and neck, sarcoma, skin, palliative care, haematology, lung and lymphedema.
- There was a bereavement service and dedicated bereavement officers who were available to support families needing to return to the hospital following the loss of a loved one.
- Staff in dermatology proactively encouraged patients regarding the importance of regular treatments and offered emotional support when necessary. Patients were contacted by phone if they missed an appointment to check whether everything was alright and to discuss on-going treatment.

Are services at this trust responsive?

Inadequate

Summary

In the services we inspected we found that the Trust was not responsive to patient's needs. We judged

the trust to be inadequate in A&E and medical care and required improvement in children & young peoples' services and outpatients & diagnostics. The trust was failing to meet the national waiting time targets, such as the 18-week referral to treatment time (RTT) target, the A&E target and the achievement of cancer waiting times.

Medical patients were sent from ED to wards where discharges were expected as part of "Reverse boarding" which was in the "Standard operating procedure for escalation within the emergency department". This was not safe practice.

Summary of findings

There was not a robust system for investigating and escalating concerns from PALS/complaints service. We reviewed a selection of complaints during the inspection and found that some should have been escalated as SIs or to safeguarding team. Discharge processes required improvement, especially with external partners.

Service planning and delivery to meet the needs of local people

- The majority of the trust's services were commissioned by two clinical commissioning groups based on the needs of the local populations.
- The trust was also a tertiary centre for some specialist services commissioned through NHS England.
- The newly extended and refurbished emergency department which opened in April 2015 was planned and designed in consultation with patients and staff following feedback received from patients and their relatives about their experiences in the department.
- The trust executive informed us they were aware that the A&E and acute medical service pathways in their present form did not fully meet the needs of patients in the trust's catchment area for urgent and emergency care. The service model was being refined in consultation with commissioners and neighbouring providers of care. This included the reconfiguration of services, introducing the ambulatory care unit, elderly assessment unit, and three medical wards transferring from Castle Hill Hospital to Hull Royal Infirmary.
- There were plans to have a winter pressure escalation plan in place by July 2015. The trust was liaising with community services to support winter planning. However, staff expressed concerns regarding capacity and demand which remained high and had resulted in the winter surge ward being open for much of the time leading up to the inspection.

Meeting people's individual needs

- We reviewed actions taken since our 2014 inspection, when we asked the trust to ensure that staff who were involved in caring for patients living with dementia were suitably trained; to review the mental health support available for children and young people in the emergency department; to review the operation of the self-check in system in the minors area to ensure that patients' symptoms were appropriately recorded and there were no barriers to communication such as the need for an interpreter, and to review the use of patient passports as these were not being completed consistently.

Summary of findings

- The trust had also completed a review of the use of patient passports. Patient passports were completed by other care providers prior to admission. The learning disabilities nurse received details of patients with a learning disability which were discussed at twice daily safety briefings and patients were also highlighted on the ward information board. During patient assessments the learning disability nurse assessed their needs and checked these were met.
- The trust had completed a review of the operation of the self-check-in system and an audit had confirmed that symptoms were correctly recorded. Positive patient feedback had been received. We were not able to confirm how well the system worked where there were language or literacy issues for the patient. Observation of a small number of patients indicated that the ability of people to use the system varied considerably from finding it easy to use to people to those who struggled and then required assistance.
- Interpreter services were available, including an on-line service.
- Physiotherapists had introduced neon wristbands on the elderly care wards to alert staff if patients needed assistance mobilising or required a walking aid.
- The Trust hosted a learning disabilities (LD) liaison nurse. The nurse was notified of admissions by a variety of methods: access to the IT system, direct referrals from the ward staff or, via the community LD teams, particularly in assisting with elective pathways.
- Patients with learning disabilities were assessed using the Trust's screening tools for activities of daily living and their care individualised based on their risk scores and needs. Information gained from the patient, carers, family members and patient communication tools/passport, where relevant, assisted in the care assessment process.
- There was a Commissioning for Quality and Innovation (CQuIN) scheme in place which demonstrated that the commissioner requirements were being met. This included a measure for better identification and support to patients with learning disabilities. Evidence indicated that the target had been met for the first three quarters of 2014/15. Following the inspection the trust told us the target had also been met for quarter four of 2014/15.
- There were 22 mixed sex accommodation breaches as of May 2015.
- The 2014 NHS National Children's Inpatient and Day Case Survey highlighted that the Trust had performed significantly

worse that other units in relation to parents and children not being actively involved in changes to the child's care. The Trust performed about the same as other NHS trust's in other areas of the survey
- Concerns relating to the lack of facilities available for parents and the suitability of facilities on the 13th floor were still outstanding. We found the trust had no timescale as to when phase two of the move for children's services to the Women and Children's Hospital would take place.

Dementia

- There was no dementia strategy for the trust. The trust had a Dementia Programme Board in place to assess, monitor and action the care needs of patients living with dementia.
- The Trust has a live electronic database available to all staff through the Trust staff intranet which allowed staff to identify which patients were diagnosed as living with dementia and where they have been admitted to.
- The Trust also had the Cayder Boards, on all wards across the organisation. Patients were identifiable on this live IT system by a butterfly symbol. The Trust had a dementia lead nurse who worked 2.5 days per week. The nurse was a support to ward staff who could make direct contact for advice. The lead nurse provided a range of training packages for staff regarding the butterfly scheme.
- The trust reported that dementia leads had undertaken work to improve awareness of dementia, training uptake and to provide dementia friendly environments. The number of staff trained had increased from 342 in 2013/14 to 1900 in 2014/15, so that 2242 staff were trained in dementia.
- The environment had been improved on some of the elderly care wards to meet the needs of patients with dementia. There was a reminiscence room on one of the elderly care wards, adapted signage and other dementia-friendly themes.
- Patients were assessed by the mental health team.
- There was a dementia CQuIN in place which demonstrated that the commissioner requirements were being met. This included measures for dementia screening, clinical leadership and supporting carers. The target had been met for the first three quarters of 2014/15.

Access and flow

- Between November 2014 and December 2014 there was a 57% increase in the number of four hour breaches in the A&E department. Since May 2014, the trust has only met the four hour waiting time standard once, and there had been a clearly

declining trend. April 2015 performance data indicated performance against the four hour target of 71.4% and three twelve hour trolley waits. In May 2015 it was 72.7% and the Trust remained a national outlier.

- The new emergency majors department had opened on 22 April 2015. An analysis prepared by the trust of performance data before and after the opening of the department indicated a marginal improvement was achieved in most performance data. Overall, the number of trolley waits exceeding four hours had reduced from 39 per day to 18 per day. However, an average of 88 patients per day breached the four hour target in the period to 30 April 2015. In excess of 50 breaches of the four hour target occurred during one evening of our visit.
- Information from NHS England (Apr'13 – Nov'14) indicated that 60% (10,933) of delayed transfers of care were due to completion of assessment compared to 18.8% nationally, with a further 27% due to patient or family choice compared with 14% nationally.
- Bed occupancy for the trust from quarter one 2013/14 – quarter two 2014/15 was persistently above the national average. The bed occupancy rate was 92.5% which was higher than the national average of 82%.
- At the last inspection we found that patients were experiencing multiple moves between wards and hospitals after 10pm. During this inspection we tracked one patient's admission; they were moved three times during their stay; two of these moves occurring after midnight. Another patient was moved from A&E to EAU after midnight, they sat in a chair for five hours as no bed was available.
- The number of transfers after 10pm had increased from 2,436 in 2013/14 to 2,643 in 2014/15. Data between January and April 2015 showed 779 patients had been internally transferred between 10pm and 8am which was not in line with trust policy for out of hours arrangements for transfer which stated that 'patients should not routinely be internally transferred between 10pm and 8am'. Data indicated that since January 2015 the moves were reducing from 249 in January to 102 in April 2015.
- Transfers across sites had reduced from 279 in January 2015 to 146 in April 2015.
- Medical patients were sent from ED to wards where discharges were expected as part of "Reverse boarding" which was in the "Standard operating procedure for escalation within the emergency department". We were told patients were risk assessed by the ward but a bed may not have been immediately available.

Summary of findings

- Staff on a medical ward said they have had “reverse boarders” waiting on the ward on a trolley or in a chair for a bed in the last two weeks. We were told by senior medical staff that a risk assessment was always done with the ward agreeing to the plan but ward staff told us they disagreed with this and said they were told they were to take extra patients when there was a patient due to be discharged that day. This was not safe practice.
- Senior management within the Trust refuted the “Reverse boarders” policy when we discussed this with them.
- Discharge processes required improvement, especially with external partners. There was a recent development of a discharge hub which was clinically led and included staff from social services.
- We tracked patients within the Trust’s IT processes and it was clear the system was capable of providing intelligent timely information but the “operators “ were not making the links and updating the screens. On the day we reviewed the hospital data the HRI site was reporting approximately 113 delayed discharges and CHH site approximately 43 delays. The social care data showed only circa 60 at HRI and 33 at CHH. Most of the gap in figures was the delay in the hospital staff processes not social care. The rest of the gap was patients who had initially been medically fit for discharge (MFD) but no longer were. There were single numbers of patients who were MDT and there was a gap in social care provision, mainly care packages.
- The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral (November 2014). RTTs were not met within trauma and orthopaedics (82%), urology (84%), ENT (78%), cardiothoracic (76%), neurosurgery (87%), neurosurgery (87%), plastic surgery (89%) and general surgery (86%).
- As of May 2015 the trust was almost meeting the Cancer two-week wait target from GP referrals. It was not achieving the Cancer 62-day wait from urgent GP referrals (77.5% against a target of 85%).
- Data for May 2015 indicated that the Trust was not achieving the 18 week referral to treatment targets: for admitted patients it was at 80% against a target of 90%; for non-admitted patients it was at 91% against a target of 95%; and there had been six patients waiting longer than 52 weeks.
- The average length of stay for elective patients was generally above the England average: cardiothoracic surgery (8.7 days; England average 7.9 days); colorectal surgery (6.3 days; England

average 6 days) and for trauma and orthopaedics (3.4 days; England average 3.5 days). Average length of stay for non-elective patients was above the England average and for some specialities significantly above: upper gastrointestinal surgery (21.1 days; England average 4.4 days); colorectal surgery (13.5 days; England average 4.5 days); and for urology (3.6 days; England average 3 days). Increased lengths of stay increases risk of hospital acquired infections and limits access to beds for other patients.

- National data indicated that during 2014 twenty three patients had their operation cancelled and so were not treated within 28 days; this was lower than the England average.
- However, more recent national data, available up to March 2015, indicated that the proportion of last minute cancellations of operations was increasing. In quarter four 2014/15 there were 526 operations cancelled across the Trust's services at the last minute for non-clinical reasons and 17 patients not treated within 28 days of a last minute elective cancellation.
- To help meet the referral to treatment targets various initiatives had been put in place, such as surgical lists undertaken on Saturdays and Sundays.
- A system was in place to admit patients who required inpatient admission following day surgery.
- Staff told us that during the winter period one ward had been transferred from the surgical health group to the medical health group as part of the winter plan. However, this did not prevent the admission of a number of medical outliers to the other surgical wards. During the inspection we saw two medical outliers in surgical beds.
- Effective use of existing facilities could be improved. Data provided by the trust showed the utilisation of theatres varied between 51.3% and 94.1%. The trust had developed a Theatres Transformation Programme in May 2015 focusing on maximising efficiency.
- We saw an environment next to the day unit that was a purpose built clinic with appropriate facilities and only used for two or three sessions each week. Staff told us this would provide more effective space for pre-assessment clinics.
- A dedicated pre-assessment unit was on site, however we found that pre-assessment was being carried out in three different locations and all had varying clinic times, between 30 and 60 minutes.

- Processes varied between the different pre-assessment areas. Staff reported that there were enough pre-assessment appointments but they were concerned that pre-assessment clinics did not have enough capacity to deal with the backlog of patients.
- No patient group directive was in place for nursing staff to administer treatment within pre- assessment for patients who tested positive for bacteria that required treatment before surgery.
- The existing system added delays for patients as the patients' GPs and anaesthetists had to be contacted prior to administering any treatment.
- The hospital's risk register identified a number of further issues affecting patient flow through the hospital. These included delays in histology results, inadequate CT/MRI slots/scanners, insufficient capacity for intensive care patients, inability to meet demand for follow-up appointments and failure to meet referral-to-treatment (RTT) targets.

Learning from complaints and concerns

- At our 2014 inspection we found staff were not regularly informed as to the outcomes of complaints and lessons learned were not discussed at team meetings. Nor were staff aware how the trust disseminated learning from complaints investigations.
- Trust-wide data showed that similar levels of complaints were received in 2013/14 (781) and 2014/15 (769).
- The average number of days to process closed complaints was 48 days against a Trust target of 40 days. 5.6 % of complaints were re-opened.
- As of February 2015 the Trust had 104 complaints which were open and were dealing with 30 complaints which had been re-opened as the patient was not satisfied with the response. The majority of complaints were within the surgery health group. Work had been done to close complaints and 229 complaints were closed in the third quarter of 2014/15, a 109 of which had been within the surgical health group. However minutes from the surgery health group in January 2015 indicated the number of overdue complaints was increasing.
- The top themes received from complaints related to clinical treatment, admission, transfer and discharge, communication and attitude of staff.
- The board did not have patient stories and there was no clear process for ensuring board level understanding of complaints.
- There was not a robust system for escalating concerns from PALS/complaints service. We reviewed a selection of complaints during the inspection and found that some should

have been escalated as SIs or to safeguarding team. For example a PALS contact had been escalated to complaints and then to the appropriate health group management as a possible serious incident but this had not been actioned by the health group management and was outstanding at the time of the inspection.

- Of the five complaints we reviewed in detail the quality required improvement. Only one indicated that the investigation had been thorough, there was a clear outcome and by raising the complaint the person had made a difference.
- There was information in clinical areas for patients and relatives about how to make a complaint and provide feedback.
- At our May 2015 we asked staff about learning from complaints and the preparation and follow up of action plans from complaint investigations. We found several examples of actions the medical services and A&E department had taken in response to complaints. The introduction of meeting and greeting by a senior nurse of patients who arrived in the majors area, of intentional rounding, and of the serving of regular meals for patients waiting, were examples of steps the department had taken in response to complaints received from patients.
- Clinical leadership has been strengthened within the complaints team and quality measures set for 2015/16.
- A new system started in May 2015 where information from complaints was escalated to the operation quality meeting.
- There was also a weekly report sent to the Health groups' governance boards.
- From March 2015 there were PALS teams based at both HRI and CHH.

Are services at this trust well-led?

Requires improvement

Summary

There was no overall long term vision and strategy for the Trust. There was limited evidence of the "golden thread" of governance. Governance, performance and quality were not well integrated.

Cost improvement plans did not have had quality impact assessments (QIA). Within health groups governance processes were varied; risk registers lacked clear actions or planning for many of the risks to be addressed. The management of incidents within the trust was not robust and there was a backlog of incidents still to be reviewed.

Work had progressed to address the issue of the bullying culture found at our February 2014 inspection.

Summary of findings

Vision and strategy

- The chief executive had been leading the development of a new set of values and a staff charter for the organisation which was launched in April 2015.
- The values were not yet embedded within the Trust. Not all of the executive team were able to describe the vision and values.
- There was no clear long term strategy in place for the trust. Executives we spoke with were unable to talk about what the deliverables of a strategy were for the Trust. They could not articulate what the strategic goals would be or what, when, and how it would be different from existing provision.
- The trust presented CQC with a set of Trust objectives for 2015-16 and quality and safety goals for 2015-16. One of the objectives was to develop a vision and plan for a "Five year forward view".
- We were provided with a five year plan summary for 2014/15-2018/19. The two key stated ambitions were to achieve Foundation Trust status and be in the top quartile for performance when measured against other Foundation Trusts nationally and to be the leading provider of acute health care services in North and East Yorkshire and the northern part of Lincolnshire.
- At the time of the inspection there was no approved patient experience strategy. A draft strategy had recently been produced and was to be linked to the Quality account.
- There was no overarching clinical quality strategy in place. There was the statutory Quality account for 2013/14 which included some clinical priorities going forward into 2014/15
- There was no nursing and midwifery strategy in place. The chief nurse, who was new in post, had within their first month taken a paper to the Board outlining the Board's role and responsibilities for ensuring the correct numbers and types of nurses, midwives and care staff for the organisation.
- Their stated intention was to develop a strategy and to provide the Board with a monthly report on staffing.
- Collaboration with external stakeholders to develop strategic priorities and system changes varied.
- We received comments about a lack of engagement and participation for example in the work stream related to winter planning.
- In Surgery there was no clear long term strategy or vision for the service however staff were able to articulate the health group's

operational plan. Senior managers within the health group commented that the health group's focus was to make decisions affecting the present and medium term and not the longer-term.

Governance, risk management and quality measurement

- Governance structures were not robust. There was a high risk of non-delivery of performance and service change as there was limited evidence of underpinning structures and governance to enable effective delivery.
- There was limited evidence of the "golden thread" of governance. Governance, performance and patient impact were not well integrated. The committee structure was not in line with the accountability structure. Minutes of meetings did not show the level of scrutiny or challenge expected within such an organisation. Health Care groups had previously worked autonomously and in isolation of each other with variation in the approach to governance frameworks. We were told that this was being reviewed to ensure consistent approach to governance.
- The management of incidents within the trust was not robust and there was a backlog of incidents still to be reviewed. The decision making process to declare an incident as an SI required improvement together with the timeliness and quality of the investigations. External support was being put in place as there were delays in securing clinical staff for panel members to investigate incidents. The chief nurse was to start weekly review meetings to help address these issues. A new medical consultant role was to be created for clinical quality and learning from serious incidents.
- We reviewed both Trust-wide and service risk registers. Some risks had been on the risk register for over two years and described in the same way during this time. Not all risks that were assessed as being high risk (scored 15 or over) were on the board's risk register. We did not see evidence that these risks had been discussed at health group level and a decision taken not to escalate.
- The trust was slow to react to the concerns. For example, staffing in A&E where concerns had been escalated and a business case for additional staffing written in the Autumn 2014. A revised case was approved following our January 2015 inspection.
- The trust was forecasting a deficit budget for the current financial year. The financial plan required £20m of cash releasing efficiency schemes (CRES) of both cost efficient and

increased productivity. We were told that none of the cost improvement plans had a quality impact assessments (QIA) which meant the Board could not assure itself how patient care might be affected when changes to services were planned.

- There was a QIA procedure which was required for plans above £100,000. Not putting lower value plans though a QIA process could lead to increases in risk and safe staffing. For example, two quality posts in medicine had been removed the previous year and staff told us this had impacted on incident management.
- To deliver the financial plan a programme management office had very recently been created with an interim lead manager. We requested copies of plans.
- Policies and standard operating procedures were not always aligned with what happened operationally. For example, the reverse boarding policy where conflicting views of the existence/operation of the policy were expressed to us.
- It was not clear who the Board level accountable officer for infection prevention and control was.
- The trust had a named DIPC (Director for infection prevention and control) who was a microbiologist but was not accountable at board level. Whilst there was no national requirement that the DIPC had to be a board member this may have weakened the governance of infection control at Board level.
- Within health groups governance processes were varied for example in the surgical health group the risk register had a number of risks that had been "open" for some time and whilst some controls had been put in place they had not been resolved. There was an Integrated Governance Group meeting held each month, although two of three recent meeting had not been quorate. In children's services a risk register was in place, but this did not include some of the risks we identified during our inspection (for e.g. risks to children with mental health needs). Many risks on the risk register had been present for some time and there was a lack of clear action or planning in place for many of the risks to be addressed.

Leadership of the trust

- There had been many recent changes to the senior leadership within the team: a new CEO had started on the 30 September 2014: a new Chairman in February 2105; a new chief nurse in April 2015. Almost all of the non-executives were new and there were also two vacancies. There was an acting chief operating officer. The medical director left the trust in June 2015.

Summary of findings

- The Trust Development agency had provided senior leadership support from May 2015 with a part- time improvement director to work with the senior team
- The majority of staff we spoke with had a positive view of the new leadership, especially the chief nurse.

Culture within the trust

- Issues of bullying and harassment of staff were identified at the February 2014 CQC inspection.
- These were further confirmed by an Advisory, Conciliation and Arbitration Service (ACAS) report commissioned by the trust in 2014.
- The ACAS report indicated that significant issues had been found. The report was published on the Trust's website. The NHS staff survey result responses concurred with the CQC and ACAS report. Staff were reporting issues around communication, lack of visible management and negative behaviours. The Trust had performed poorly in the 2014 NHS Staff Survey with 22 negative findings, one positive and eight as expected.
- At the May 2015 inspection the executive reported actions it had taken following recent changes in the executive team. Examples included the appointment of an internal anti-bullying Tsar (a doctor) to lead the anti-bullying work. We received many positive comments about the tsar and their approach to the role. The trust had also introduced a number of schemes which focussed on empowering staff.
- The chief executive had made a clear statement to staff that bullying was not acceptable. We saw evidence that allegations of bullying had been followed up in the department and action taken.
- The new staff charter was explicit about what the Trust expected and did not expect of its staff and what staff could expect in return. For example, Staff should be polite at all times, staff should not "bad-mouth colleagues" and the trust would provide staff with the right skills and development.
- Staff were expected to attend PaCT (Professional and Cultural Transformation) workshops as part of the ongoing work to address the cultural issues identified in the staff survey and the ACAS report. The PaCT workshops were part of mandatory training for Band 7 and above trust staff. Over 1,200 staff had completed the training.
- An online reporting tool had been put in place and a staff advisory and liaison helpline so that staff could report any incidents of bullying or harassment.

Summary of findings

- Professional champions were being developed to help colleagues who might be experiencing negative behaviours.
- There was an active joint negotiating consultative committee (JNCC) which had been supportive and involved in the work of ACAS and the action plan developed from it.
- The majority of staff we spoke with told us that the bullying culture had been acknowledged by management and that the culture was improving.

Fit and Proper Persons

- The trust was aware of 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 policy covered identity, right to work, employment history, professional registration and qualification checks.
- We reviewed the personnel files of three directors on the board. One was appointed since the Regulation came into force and two were appointed prior. The files indicated that the relevant checks had been done.
- June 2015 board papers stated that all executive and non-executive directors had been assessed and passed their 'fit and proper person' test.

Public engagement

- The Trust had a membership model in place in preparation for FT status.
- There were regular newsletters informing Trust members, the public and staff about developments at the trust.

Staff engagement

- Following the allegations of bullying in 2014 the Trust has improved its engagement with staff.
- Directors were allocated to wards/services to improve the ward to board engagement. The visibility of directors varied. Staff within A&E commented on the visibility of directors especially the CEO.
- The trust annually recognised the achievements of staff through the Golden Hearts awards.

Innovation, improvement and sustainability

Summary of findings

- The opening of the new emergency department represented a substantial improvement in the facilities for the hospital so that emergency care and treatment was provided in a suitable environment. The newly extended department opened in April 2015 and further phases of work were planned.
- Work had been introduced to improve the experience for dementia patients and further work was planned including changing the menu, introducing open visiting and the use of dining companions.
- The stroke unit had introduced charge nurse and matron clinics for patients and relatives to discuss concerns.
- Physiotherapists had introduced neon wristbands on the elderly care wards to alert staff if patients needed assistance mobilising or required a walking aid.
- Six of the 86 GP surgeries who used the laboratories were trialling a new test requesting system (Cyber lab). The new system would provide the requester and the laboratory with improved clinical safety and more reliable and accurate test requesting and result reporting.
- Pathology had recently appointed an 'innovation adoption manager' who went out to speak with clinical users and ask what ideas or problems pathology can help them with. This had led to good engagement with clinical users. For example, pathology was working with A&E and GPs on their pathways for taking pathology samples.
- Radiology "Backtrack Pioneer Team" undertook a project which improved patient transfers to and from the Radiology Department, created a more pleasant environment for patients by clearing corridor space and creating a working space for the portering team.
- Other examples of innovation in radiology included development of a handover form and contribution to the proposals for the establishment of a pathway for investigation and management of knee problems in primary care.
- The plastics trauma team had developed a one stop service for patients to attend the department and be immediately listed for theatre when appropriate.
- The development of extended roles and the exploration of technical apprenticeships along with the glaucoma monitoring scheme and the introduction of nurse practitioners and virtual clinics were improving the management of increasing demand as well as dealing with historical waiting lists.
- Staff had developed a urology emergency ambulatory care area, where patients could be assessed to determine whether admission or treatment was required.

Summary of findings

- Members of the senior management team told us that they were very proud of the nurse-led services that they had developed in the division, such as the extended roles of nurses to cover consultant shortages.

Overview of ratings

Our ratings for Hull Royal Infirmary

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

Our ratings for Castle Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Not rated	Not rated	Not rated	Requires improvement	Inadequate
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement

Our ratings for Hull and East Yorkshire Hospitals NHS Trust

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

Overview of ratings

Notes

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

2. As this was a follow up inspection to the comprehensive inspection in February 2014 not all services or domains were inspected.

Outstanding practice and areas for improvement

Outstanding practice

The plastics trauma team, based in outpatients, had developed a one stop service for patients to attend the department and be immediately listed for theatre when appropriate.

In relation to Radiology discrepancies we saw that the peer review process was an outstanding example of governance. The peer review meetings focussed on openness and learning and displayed a sensible application of legislation.

Areas for improvement

Action the trust MUST take to improve

- Address the breaches to the national targets for A & E and referral-to-treatment times to protect patients from the risks of delayed treatment and care. It must also continue to take action to address excessive waiting times for new and follow up patients with particular regard to eye services and longest waits.
- Ensure there is a sustainable action plan to improve the reporting performance of histopathologist service.
- Ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the elderly care wards, consultant and nursing cover within A & E; histopathologists, Echocardiography teams and surgical wards;
- Ensure the sustainability of the work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014)
- Ensure that all incidents are investigated in a timely manner, that lessons are learnt and that duty of candour requirements are effectively acted upon and audited.
- Ensure that there is a policy and procedures in place to ensure that there is effective transition for young people to adult services
- Ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy.
- Ensure appropriate arrangements are in place to respond to major trauma and incidents within ED.
- Ensure that there is an effective and timely system in place, which operates to respond to, and act on, complaints.
- Ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.
- Take further steps to improve the facilities for children, young people and parents on the 13th floor.
- Take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, and that there is an appropriate "safe bed space" for the use of children and young people with mental health needs.
- Ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.
- Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.
- Ensure that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance.
- Review its patient pathways and patient flow through services to ensure:

1. The plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management
2. The seating area on the elderly assessment unit is not used for beds

Outstanding practice and areas for improvement

3. plans for dealing with extra capacity are reviewed including the “reverse boarding” policy;
4. internal patient transfers take place in accordance with trust policy and reduce the number of patient bed moves ‘out of hours’ unless for clinical reasons;
5. more timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.

- Ensure use of best practice guidance, such as the “Five steps to safer surgery” checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections.
- Ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients.
- Review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres
- Ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment. Care and treatment was not always provided in a safe way for patients. The provider must: 1. ensure that planning and delivering care always reflects published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice specifically in relation to: breaches to the national targets for A & E; lack of compliance with the guidance issued by the College of Emergency Medicine; breaches to the referral-to-treatment times with particular regard to eye services and longest waits. Regulation 12(1) 2. review all incidents in a timely manner and ensure shared learning Regulation 12(2)(b) 3. take actions to protect children and young people from the risk of self-harm and/or injury by ensuring that on the 13th floor the ligature and anchor points on the ward are addressed, Regulation 12(2)(a) 4. put in place policies and procedures to ensure that there is effective transition for young people to adult services Regulation 12(2)(i) 5. Ensure appropriate arrangements are in place to respond to major trauma and incidents within ED. Regulation 12(1)

This section is primarily information for the provider

Requirement notices

6. Ensure that there are robust processes in place for the checking of equipment particularly resuscitation equipment on the medical wards.

Regulation 12(2)(e)

7. Take further steps to improve the facilities for children, young people and parents on the 13th floor of HRI.

Regulation 12(2)(d)

8. Ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines on the medical wards. In addition the Trust must ensure that controlled drugs are stored appropriately and that records of the management of controlled drugs are accurately maintained and audited within A & E and children's services.

Regulation 12(2)(g)

9. Review the results of IPC audits across ED, all wards and theatres and identify and instigate appropriate actions including addressing the flooring and walls within theatres

Regulation 12(2)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. The provider must: 1. ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels; particularly on the:

This section is primarily information for the provider

Requirement notices

- elderly care wards,
- consultant and nursing cover within A & E,
- histopathologists,
- echocardiography teams and
- surgical wards.

Regulation 18(1)

2. ensure that appropriate support is in place to develop staff specifically sustaining the Trust's work to address the concerns raised regarding the bullying culture and the outcomes from the NHS staff survey data (2014)

Regulation 18(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and ensure compliance with the regulations. The provider must: 1. Ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation. Regulation 17(1) & (2) 2. Ensure the use of best practice guidance, such as the "Five steps to safer surgery" checklist and Interventional Radiological checklists for appropriate procedures in all outpatient and diagnostic imaging settings and audit their use to include completion of all sections. Regulation 17 (2) (b)

This section is primarily information for the provider

Requirement notices

	3. Ensure there is a sustainable action plan to improve the reporting performance of histopathology service. Regulation 17(2)(a) 4. Ensure incidents and duty of candour requirements are effectively acted upon and audited Regulation 17(2)(a) 5. Ensure there is the development of a long term clinical strategy for the surgery health group which meets the clinical needs of patients and which is in line with the trust's overarching strategy. Regulation 17(1) & (2)(a) 6. Review its patient pathways and patient flow through services to ensure: · The plans for the acute medical pathways from ED to discharge are effectively implemented including pro-active bed management · The seating area on the elderly assessment unit is not used for beds · Plans for dealing with extra capacity are reviewed including the "reverse boarding" policy. · internal patient transfers take place in accordance with trust policy and reduce the number · of patient bed moves 'out of hours' unless for clinical reasons · more timely discharges of patients, including working collaboratively with social care and community providers to improve the discharge system.
Regulated activity	**Regulation**
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints.

This section is primarily information for the provider

Requirement notices

Complaints received were not all investigated and acted upon in a timely or appropriate way. The provider must:

1. Ensure that there is an effective and timely system in place, which operates to respond to, and act on, complaints.

Regulation 16(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect. Patients were not always treated with dignity and respect. The provider must: 1. The provider must ensure that patients' privacy and dignity is maintained when being cared for specifically that call bells are within reach of the patient at all times, especially on the medical wards and regular audits must be completed to monitor compliance. Regulation 10(1)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs. The nutritional and hydration needs of patients were not always met. The provider must:

This section is primarily information for the provider

Requirement notices

1. Ensure that patients' nutrition and hydration is maintained in a timely manner; including the effective use of the 'red top' water jug system across all medical wards and the accurate recording of fluid balance and food charts for patients.

Regulation 14(1), (4)(a) & (4)(d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Need for consent. Care and treatment of service users was not always provided with the consent of the relevant person. The provider must: 1. Ensure that appropriate procedures are in place to obtain consent for hysteroscopies within outpatients. Regulation 11(1)