The Mid Yorkshire Hospitals NHS Trust

Dewsbury and District Hospital

Quality Report

Halifax Road
Dewsbury
WF13 4HS
Tel: 0844 811 8110
Website: www.midyorks.nhs.uk

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	**Requires improvement**
Medical care (including older people's care)	**Requires improvement**
Surgery	**Good**
Critical care	**Requires improvement**
Maternity and gynaecology	**Good**
Services for children and young people	**Good**
End of life care	**Good**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

The Mid Yorkshire Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust serves two local populations; Wakefield which has a population of 355,000 people and North Kirklees with a population of 185,000 people. The trust operates acute services from three main hospitals – Pinderfields Hospital, Dewsbury and District Hospital and Pontefract Hospital. At Dewsbury, the trust had approximately 233 general and acute beds, four beds in Maternity and 8 in Critical care. The trust also employed 7,948 staff of which 1,517 were based at Dewsbury and included 126 medical staff 622 nursing staff.

We carried out a comprehensive inspection of the trust between 16-19 May 2017. This included unannounced visits to the trust on 11, 22 May and 5 June 2017. The inspection took place as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust and to follow up on progress from our previous comprehensive inspection in July 2014, a focused inspections in June 2015, and unannounced focused inspection in August and September 2015. 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.

At the inspection in July 2014 we found the trust was in breach of regulations relating to care and welfare of people, assessing and monitoring the quality of the service, cleanliness and infection control, safety, availability and suitability of equipment, consent to care and treatment and staffing. We issued two warning notices in relation to safeguarding people who use services from abuse and management of medicines.

At the inspection in July 2015 and our follow up unannounced inspections, we found that the trust was in breach of regulations relating to safe care and treatment of patients, addressing patients nutritional needs, safe staffing, and governance. We issued requirement notices to the trust in respect of these breaches.

Our key findings from our inspection in May 2017 are as follows:

- Nurse and medical staffing numbers were a concern. Staffing levels did not meet national guidance in a number of areas. Planned staffing levels were not achieved on any of the medical wards we visited during our inspection. We found examples of patient safety being compromised as a direct result of low staffing numbers. This included a failure to escalate deteriorating patients in line with trust and national guidance and a lack of understanding and implementation of sepsis protocols.
- Access and flow within the hospital was a challenge with a number of medical outliers on wards, and a large number of patient moves occurring after 10.00pm. We found that as nursing staff were working under such pressure in medicine, they were not always able to give the level of care to their patients that they would have liked. We also found that nursing care plans did not reflect the individual needs of their patients, and not all patients felt involved in their care.
- Not all staff had completed mandatory training and the trust was not meeting its target of 95% for all modules of mandatory training. Not all staff had completed the appropriate level of safeguarding training. Many services had not met the target rates for staff undergoing appraisals.
- The completion of nursing documentation was inconsistent and did not always follow best practice guidance. We saw that patients whose condition had deteriorated were not always escalated appropriately. We found trust policies with regards to infection prevention and control were not always being followed. The trust had exceeded their target for the number of cases of clostridium difficile.

Summary of findings

- We were not assured that learning from incidents was being shared with staff. There was also a backlog of incidents awaiting investigation. This meant there were potential risks which had not been investigated, and learning undertaken. Information was not shared consistently. Consequently learning from incidents was not embedded with all staff. Staff we spoke to were not all familiar with the duty of candour and when it was implemented.
- The trust showed poor performance in a number of national patient outcome data audits. The trust also had six active mortality outliers in which the division of medicine were involved.
- There were issues regarding referral to treatment indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment. Managers told us clinical validation had occurred on some waiting lists, for example in areas of ophthalmology. However, this had not occurred on all backlogs or waiting lists for appointments across the trust. Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- We were concerned over the lack of oversight of endoscopy services despite a recovery plan being in place. There were large numbers of patients attending the endoscopy unit having their procedure cancelled on the day. Data also showed an increasing trend of patients waiting for diagnostic testing within endoscopy, of which 493 had breached the six-week threshold.
- There was a lack of assurance that staff were competent to use medical devices and equipment. There was also little assurance that electronic equipment had an annual safety check.
- There was a lack of internal audit and scrutiny in some services and limited assurance that all services were adequately measuring quality and patient outcomes. Some risk registers contained risks with review dates in the past. This led to concern that the risk registers were not always appropriately scrutinised.
- There was no specific mental health assessment room in the emergency department. This did not meet not meet the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983. Staff were not aware of the NHS Protect guidance on distressed patients.
- Families who had been discussed at the multi-agency risk assessment panel (MARAC) were not flagged on the electronic system so could not be identified as being at risk of domestic abuse.
- The critical care service was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) standards in a number of areas. The unit used cameras to monitor patients in the side rooms. The use of the cameras was not in line with trust policy or national guidance.

However;

- Nursing staff showed care and compassion towards patients. Patients and relatives were supported, treated with dignity and respect, and were involved in their care. We did receive positive feedback from some patients and recognition of how hard the nursing staff were working. Staff were also able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- There had been a significant piece of work undertaken to reduce the incident of falls. This had been very successful with the number of falls resulting in severe harm or death reducing by 72%. Falls bands were visible on patients.
- Staff understood their responsibilities to raise concerns and report incidents. When an incident occurred it would be recorded on an electronic system for reporting incidents. We saw evidence that Root Cause Analyses (RCA) of serious incidents were comprehensive
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out. We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.

Summary of findings

- Policies and guidelines were evidence based and easy for staff to access. We saw many examples of good multidisciplinary working across different areas. We observed good interaction and communication between doctors, nurses and medical crews. Service planning was collaborative and focused around the needs of patients. There was sympathetic engagement with staff and patients around the reconfiguration of some services.
- Managers were able to describe their focus on addressing issues with the referral to treatment indicators and reducing waiting times. There were referral to treatment recovery plans in place for various specialties. The Did Not Attend (DNA) rate was lower than the England average.
- The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care. The average length of stay for elective and non-elective medical patients was below the England average.
- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient including hospital staff, community staff and most GPs. They also had access to EPaCCS (Electronic Palliative Care Coordination System), which enabled the recording and sharing of people's care preferences and key details about end of life care.
- Staff reported a positive change in culture with the new management team and felt more engaged. Leadership at each level was visible, staff had confidence in the leadership. Staff spoke of an open culture. Management could describe the risks to the services and the ways they were mitigating these risks.

We saw several areas of outstanding practice including:

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The trust had a new electronic process with remote monitoring to alert staff to fridge temperatures being below recommended levels to store drugs.
- Panic buttons had been installed for staff to use in the emergency department if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department.
- We saw evidence of the risk assessment in patients` notes and falls bands were visible on patients. This enabled all staff in the hospital to identify patients at risk of fall no matter where they were in the hospital.

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

Importantly, the trust must:

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.
- Ensure that there is effective escalation and monitoring of deteriorating patients.
- Ensure that there is effective assessment of the risk of patients falling.
- Ensure that the privacy and dignity of patients being nursed in bays where extra capacity beds are present is not compromised.
- Ensure that there is effective monitoring and assessment of patient's nutritional and hydration needs to ensure these needs are met.
- Ensure that there is a robust assessment of patients' mental capacity in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Ensure that mandatory training levels are meeting the trust standard.

In addition the trust should;

Summary of findings

- Ensure appropriate precautions are taken for patients requiring isolation and that the need for isolation is regularly reviewed and communicated to all staff.
- Ensure reported incidents are investigated in a robust and timely manner and the current backlog of outstanding incidents are managed safely and concluded.
- Ensure staff are informed of lessons learnt from patient harms and patient safety incidents.
- Ensure work is undertaken to reduce the number of patients requiring endoscopies being cancelled on the day of their procedure.
- Ensure staff in maternity services are trained and competent in obstetric emergencies, to include a programme of skills and drills held in all clinical areas.
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians.
- Ensure the end of life time provide regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients.
- Ensure VTE risk assessments are completed and the target of 95% is achieved.
- Ensure that records are completed fully and that records are stored securely.
- Ensure care plans are individualised and reflect the needs of their patients.
- Continue to address issues of non-compliance with referral to treatment indicators and the backlog of patients waiting for appointments.
- Ensure that families who had been discussed at the multi-agency risk assessment panel. (MARAC) are flagged on the electronic system so they can be identified as being at risk of domestic abuse.
- Ensure that there is a specific mental health assessment room that meets the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983.
- Ensure staff are aware of the NHS Protect guidance on distressed patients to ensure that patients with mental health problems would be treated appropriately.
- Ensure a risk assessment is undertaken with regards to access to the staircase via the fire exit on ward 2.
- Consider relocating the resuscitation trolley on ward 4 to ensure it can be easily access in an emergency.
- Ensure that staff are following the medicines management policy and that fridge and room temperatures are appropriately recorded.
- Improve the rate of missed medicines doses.
- Ensure the use of cameras in critical care is reviewed and in line with trust policy and national guidance.
- Ensure that children are recovered from day case surgery in a child friendly environment.
- Ensure there are systems in place for the recording of transfer bag checks.
- Ensure work to improve the completion of consent forms in line with trust expectations.
- Review the risk registers and remove or archive any risks that no longer apply.
- Increase local audit activity to encourage continuous improvement.
- Ensure it continues to address capacity and demand across all outpatient services.

Summary of findings

- Consider ways of ensuring team meetings in main outpatients are regular and consistent.
- Consider ways of ensuring environmental compliance issues with carpets in departments.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Not all staff had completed mandatory training and the trust was not meeting its target for all modules of mandatory training. Not all staff had completed the appropriate level of children's safeguarding training. The completion of nursing documentation was inconsistent and did not follow best practice guidance. Pain scores were inconsistently recorded in adult and children's written records. We saw that patients whose condition had deteriorated were not always escalated appropriately. Families who had been discussed at the multi-agency risk assessment panel (MARAC) were not flagged on the electronic system so could not be identified as being at risk of domestic abuse. There was no specific mental health assessment room in the department. This did not meet not meet the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983. Staff were not aware of the NHS Protect guidance on distressed patients. Staff told us the lack of a palliative care team out of hours had created difficulties in obtaining hospice beds and arranging transfer However: We saw evidence of the risk assessment in patients` notes and falls bands were visible on patients. Panic buttons had been installed for staff to use if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department. The paediatric area was relatively new. It was very clean and well equipped with well- planned processes. There were four cubicles, one private consultant room and two Triage rooms. The facility opened in March and is open 24 hours per day. We observed good interaction and communication between doctors, nurses and medical crews.

Summary of findings

Nursing staff showed care and compassion towards patients. We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.
The Admission Avoidance team and The Hospital Avoidance team (HATS) demonstrated the department not only engaged in multidisciplinary working but also multi-agency working. Staff told us the senior managers were visible and approachable.

Medical care (including older people's care) — **Requires improvement**

Nurse and medical staffing numbers were a concern. Planned staffing levels were not achieved on any of the medical wards we visited during our inspection. Medical staffing reported 21 consultant vacancies was heavily reliant on the use of locums to fill gaps in rotas. Access and flow within the hospital was a challenge with a number of medical outliers on wards, and a large number of patient moves occurring after 10.00pm.
We found examples of patient safety being compromised as a direct result of low staffing numbers. This included a failure to escalate deteriorating patients in line with trust and national guidance and a lack of understanding and implementation of sepsis protocols. We found that as nursing staff were working under such pressure, they were not always able to give the level of care to their patients that they would have liked. We also found that nursing care plans did not reflect the individual needs of their patients, and not all patients felt involved in their care.
Mandatory training and appraisal figures were below the trust target in the division of medicine. There had been a deterioration in training rates since the last inspection. Safeguarding and resuscitation training compliance were a particular concern. We found poor completion of documentation, particularly in relation to risk assessments relating to falls and monitoring of nutrition and hydration. This had been highlighted at the previous inspection.
Issues in relation to the monitoring and assessment of patient's nutrition and hydration needs had been identified at the previous inspection. A project plan had been put in place to address the issues in April 2016; however there was a lack of progress against

Summary of findings

this. We found poor documentation in relation to nutrition and hydration, with only 28% of the records we reviewed being fully completed. We lacked assurance that all patients were receiving pain relief in a timely way and we did not find care plans for pain management in place.

We found trust policies with regards to infection prevention and control were not being followed. We found commodes that were heavily stained and bathroom areas for patients that were not visibly clean. The trust had exceeded their target for the number of cases of clostridium difficile. We found that trust guidance was not being followed with regards to isolation of patients with an infection.

We were not assured that learning from incidents was being shared with staff. There was also a backlog of incidents awaiting investigation. This meant there were potential risks which had not been investigated, and learning undertaken. Information was not shared consistently. Consequently learning from incidents was not embedded with all staff.

The trust showed poor performance in a number of national patient outcome data audits. The trust also had six active mortality outliers in which the division of medicine were involved.

We were concerned over the lack of oversight of endoscopy services despite a recovery plan being in place. There were large numbers of patients attending the endoscopy unit having their procedure cancelled on the day. Data also showed an increasing trend of patients waiting for diagnostic testing within endoscopy, of which 493 had breached the six-week threshold.

We were concerned that the number of new appointments at local leadership level were not able to fulfil their roles as they were working clinically for much of the time. Directorate meetings were variable in their structure and content meaning information was not shared consistently. Consequently learning from incidents was not embedded with all staff.

However:

We did receive positive feedback from some patients and recognition of how hard the nursing staff were working. There had been a significant piece of work undertaken to reduce the incident of

falls. This had been very successful with the number of falls resulting in severe harm or death reducing by 72%. Service planning was collaborative and focused around the needs of patients.
Policies and guidelines were evidence based and easy for staff to access. We saw many examples of good multidisciplinary working across different areas. Overall there was good evidence of seven day working clinical standards being met with some areas above regional averages.
The average length of stay for elective and non-elective medical patients was below the England average. Staff reported a positive change in culture with the new management team and felt more engaged. The risk registers reflected the risks to the service.

Surgery

Good

Senior nursing staff had daily responsibility for safe and effective nurse staffing levels and staffing guidelines with clear escalation procedures were in place. Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
We saw evidence that Root Cause Analyses (RCA) of serious incidents were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
Patients had good outcomes as they received effective care and treatment to meet their needs.
The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
Leadership at each level was visible, staff had confidence in the leadership. There were clear governance processes in place to monitor the service provided. The division handled 97% of complaints within trust timescales (95% target).

Summary of findings

However:
Medical staff did not reach the trust 95% target for mandatory core training completion, this included safeguarding.
Across the division, NEWS audits (March 2017) showed that 59% of observations were recorded which were worse than the 67% compliance rate in the previous audit. There were 108 missed medications recorded between March 2016 and February 2017 across the surgical division.
Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Critical care **Requires improvement**

The service was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) standards in a number of areas, for example, supernumerary nurse staffing, out of hours medical cover and continuity of care and multidisciplinary staffing. The environment and facilities did not comply with national standards. The unit used cameras to monitor patients in the side rooms. The use of the cameras was not in line with trust policy or national guidance. The service could not provide assurance that staff's training and competence with equipment was up to date.
The actual nurse staffing did not meet the planned nurse staffing numbers. The service used agency staff regularly and there was limited evidence to support their induction on the unit. The process for the multidisciplinary team and critical care outreach team to receive feedback from incidents on the unit was unclear.
The service did not have an audit lead or audit strategy.
There was limited evidence that the service measured quality. There was no evidence that senior staff had reviewed some risks and their controls had been reviewed.
However;
Patients and relatives were supported, treated with dignity and respect, and were involved in their care.
Leadership of the service was in line with GPICS standards. Staff spoke of an open culture and were

Summary of findings

proud of the team work on the unit. The service was actively involved in the regional critical care operational delivery network and the acute hospital reconfiguration.
Staff understood their responsibilities to raise concerns and report incidents. Staff assessed, monitored and completed risk assessments and met patients' needs in a timely way. Patient outcomes were mostly in line with similar units.
Fifty five percent of staff in the service had a post registration qualification in critical care. This was in line with GPICS minimum recommendation of 50%.

Maternity and gynaecology

Good

Following our previous inspection there were robust practices in place to check emergency equipment.
The service had successful bid for Department of Health Safety training and had allocated the funding appropriately.
We found good multidisciplinary working between midwifery and medical staff. We observed good and friendly interactions between staff, women and relatives. There was sympathetic engagement with staff and patients around the reconfiguration of maternity services.
The service had a comprehensive business plan, which included plans to increase staffing levels including specialist midwifery posts. The service had reviewed staffing using a recognised acuity tool and this identified a shortfall of 18 whole time equivalent midwives. The service had an agreed plan to fill these posts over three years.
However:
There was a lack of assurance that staff were competent to use medical devices. There was also little assurance that electronic equipment had an annual safety check. We were not assured of the competence of staff with regard to basic skills such as cannulation and perineal suturing.
Community midwifery caseload numbers were above the national recommendations. Attendance of community and birth centre midwives at obstetric emergency training was below the trust target of 95% at 86%. There was little information for women whose first language was not English, some staff were not aware this could be accessed on the trust intranet system.

Summary of findings

			The risk registers contained a large number of risks, and many had a review date in the past. This led to concern that the risk registers were not appropriately scrutinised.
Services for children and young people	**Good**		Staff understood their responsibilities for reporting incidents. There were incident reporting mechanisms in place and staff received feedback. Staff had the skills required to carry out their roles effectively. Children's services had employed advanced nurse practitioners. Care was planned and delivered in line with evidence-based practice. Children and young people could access the right care at the right time. There were processes in place for the transition in to adult services, although they were not as well developed as at Pinderfields, due to commissioning arrangements. A lead nurse for the trust had recently been appointed. There were effective governance processes and the leadership team understood the risks to their service. However: Staffing for children's day case surgery did not meet Royal College of Nursing (RCN) guidance and there were no specific plans in place if the staff member on duty called in sick at the start of a shift. Although there were safeguarding systems and processes in place, staff were not meeting the trust target for safeguarding training and did not receive regular safeguarding supervision. Equipment had no indication of when electronic testing was due and relied on staff contacting medical physics. Service leads told us that there had been a decision to reintroduce the labelling of equipment.
End of life care	**Good**		Nurse and consultant staffing levels for the specialist palliative care team were at full complement and reviewed daily to keep people safe at all times. Any staff shortages were responded to quickly and adequately. Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.

Summary of findings

We viewed body store protocols and spoke with body store and porter staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.

The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.

We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.

Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient including hospital staff, community staff and most GPs. They also had access to EPaCCS (Electronic Palliative Care Coordination System), which enabled the recording and sharing of people's care preferences and key details about end of life care.

We observed the use of syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.

For those palliative care patients who were already known to the service and admitted to the hospital for care and treatment, 93% were followed up by contacting the ward within 24 hours to assess the need for specialist palliative care assessment.

Staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. Body store staff told us there was always a member of staff on call out of hours. This service was available for families who requested to visit during an evening or a weekend.

Summary of findings

We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
The quality of leadership for end of life care had improved since the last inspection. Structures, processes and systems of accountability, including the governance and management of joint working arrangements were clearly set out, understood and effective.
However:
Staff we spoke to were not all familiar with the Duty of Candour and when it was implemented.
An end of life care plan had been introduced, but there was no regular audit to determine what percentage of end of life inpatients had the care plan in place. There was no regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients.
The weekly specialist palliative care team (SPCT) multidisciplinary meeting included SPCT nurses and palliative care consultants but no other discipline such as allied health care professionals, pharmacy or the chaplaincy.
We were unable to assess the level of performance in achieving fast track discharges for end of life patients due to lack of evidence; no audit work had been done to measure performance in this area since the last inspection. The service reported that 73% of all new referrals were seen within 24 hours of being referred to the team.

Outpatients and diagnostic imaging

Requires improvement

There were issues regarding referral to treatment indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment. Managers told us clinical validation had occurred on some waiting lists, for example in areas of ophthalmology. However, this had not occurred on all backlogs or waiting lists for appointments across the trust.

Summary of findings

No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks). The trust had a trajectory to be achieving the indicators by March 2018. The trust did not measure how many patients waited over 30 minutes for imaging within departments.

Although senior managers could describe the duty of candour, it was not well understood across all staff groups. Mandatory training completion rates and targets were not always met. Appraisals completion rates did not always achieve the trust target.

In main outpatients, team meetings did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.

However:

A trust incident reporting system was used to report incidents and staff we spoke with were aware of how to report incidents.

Areas we visited were visibly clean and tidy.

Medicines checked were stored securely and medicines checked were in date. Staff told us records were available for clinics when required.

Actual staffing levels were in line with the planned staffing levels in most areas.

Staff provided compassionate care to patients visiting the service and mostly ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff.

Managers were able to describe their focus on addressing issues with the referral to treatment indicators and reducing waiting times. There were referral to treatment recovery plans in place for various specialties. The Did Not Attend (DNA) rate was lower than the England average.

Risk registers were in place and managers took risks to the divisional governance meetings.

Management could describe the risks to the service and the ways they were mitigating these risks. Most staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was effective teamwork within teams and there was a culture of openness and honesty.

Dewsbury and District Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Dewsbury and District Hospital

Dewsbury and District Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in the Dewsbury area and serves a population of approximately 185,000 people in the local North Kirklees area. The trust employs around 7596 whole time equivalent staff which included 856 medical and dental staff. At Dewsbury , the trust had approximately 233 general and acute beds, four beds in Maternity and 8 in Critical care. The trust also employed 7,948 staff of which 1,517 were based at Dewsbury and included 126 medical staff 622 nursing staff.

The health of people in Kirklees is varied compared with the England average. Deprivation is higher than average and about 18.6% (15,900) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 7.9 years lower for men and 6.7 years lower for women in the most deprived areas of Kirklees than in the least deprived areas. The population had a similar age group breakdown to the England average. Approximately 185,000 people live in North Kirklees and this is forecast to grow by 3.8% over the next five years, with those aged 65 and over expected to increase by around 14.3%.

The BAME (Black, Asian, Minority Ethnic) population is noted to be increasing, especially in Batley and Dewsbury where 38% of those aged under 18 are now south Asian. In the Kirklees area there was 20.8% BAME residents which was a higher proportion than the England average of 14.6%. There are a higher proportion of babies being born to south Asian mothers, now up to 2 in 5 births and 38% of all those aged under 18 in North Kirklees. 85% of these are living in Dewsbury and Batley.

We carried out a follow up comprehensive inspection of the trust between 16-19 May 2017 in response to previous inspections in July 2014 and June 2015. Following the announced inspection in June

2015 CQC received a number of concerns and on further analysis of other evidence an unannounced focussed inspection took place in August 2015 and September 2015.

Our inspection team

Our inspection team was led by:

Chair: Carol Panteli, Director of Nursing and Quality, NHS England

Inspection Manager: Sandra Sutton, Care Quality Commission

Detailed findings

The team included CQC inspectors a pharmacist inspector, and a variety of specialists including: a consultant surgeon, medical consultant, nurse specialists, executive directors, midwives, senior nurses including a children's nurse. We were also supported by an expert by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

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?

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. We also held focus groups a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We carried out an unannounced inspection visits on 11, 22 May and 5 June 2017 and the announced inspection visit between 16 and 19 May 2017.

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. We also spoke with staff individually as requested.

Facts and data about Dewsbury and District Hospital

In total, Dewbury and District Hospital the trust had approximately 961233 general and acute beds, four60 beds in Maternity and 358 in Critical care. Dewsbury and District HospitalThe trust also employed 6,9621,517 staff.. Dewsbury and District Hospital The trust had approximately 12567596 whole time equivalent staff which included 126856 medical staff, 6222,226 nursing staff and 7694514 other groups of staff.

The trust The trust had a total revenue of over £505 million in 2016/17. Its full costs were over £543million and it had a deficit of over £8 million. During 2016/2017 the trust had 245,330 emergency department attendances, 141,103 inpatient admissions, and 722,632 outpatient appointments.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust is made up of three sites, Pinderfields (PGH), Dewsbury (DDH) and Pontefract (PGI). Each site had an emergency department.

On the DDH site they have approximately 82,000 attendances per year which equates to 220, patients a day or 7,557 patients per month.

Paediatric attendances had increased with attendances of 21,394 from April 2016 to March 2017. In 2016/2017 27.1% of patients were aged between 0- 17 years. The percentage of the total attendances per age group remained roughly the same each year.

In the adult emergency department (ED) there were two assessment cubicles and 14 trolley cubicles. The trolley cubicles were divided into two bays with six and eight beds respectively. The resuscitation area was able to care for four patients; this included one resuscitation trolley area that was equipped for the care of children. Mobile X-ray facilities were available for acutely ill patients, or if stable, patients went to the main radiology department. The children's area could care for three patients on trolleys and two sitting in cubicles. There was a dedicated waiting area for children which had toys. Paediatric admissions were accepted until 10pm.

The percentage of A&E attendances at the trust that resulted in an admission was lower than the England average, for 2015/16 for type one - major A&E units. The percentage of attendances which resulted in admission for the trust was 22%, the England average was 27.3%.

We carried out this inspection because when we inspected urgent and emergency care in June 2015, we rated safe as inadequate and effective, responsive and well-led domains as requires improvement.At the previous inspection, there were;

- Concerns over interdepartmental learning throughout all the three EDs. Sharing of lessons learned from incidents, root cause analysis and serious incidents did not occur. There was a lack of a robust integrated clinical governance framework.
- A number of infection prevention and control concerns were identified and assurance of cleanliness was not provided. Mandatory training rates showed low levels of compliance for both medical and nursing staff.
- Concerns raised about the flow and capacity in the department. People were waiting for admissions longer than the four hour target and we found evidence of patients waiting between 10-16 hours since attendance. There were examples of patients deteriorating due to overcrowding.
- Ambulance handover times were consistently worse than the England average and handovers were only taking place within the recommended window of 15 minutes from admission on 70% of occasions.
- Paediatric patients were mixed with adults overnight, and there was no specific child friendly area to wait or be assessed.
- Medicines were not always stored and stock recorded appropriately. Stock was not found to be rotated correctly and sterile stock was found out of date.
- Staff were unclear of the vision for the three EDs.

Urgent and emergency services

At this inspection, we returned to check whether services had improved. During this inspection we spoke with 43 members of staff across all grades, spoke with nine patients and if accompanied, with their families or carers. We checked 18 sets of records and reviewed information provided by the trust and external stakeholders prior to our inspection.

Summary of findings

During this inspection we saw evidence of improvement across the department particularly in areas highlighted during the previous inspection, however, we rated this service overall as Requires Improvement because:

- Staff were not meeting the trust's mandatory training targets, therefore staff were not up to date with mandatory training. We also identified this at our last inspection.
- Not all staff had completed the appropriate level of children's safeguarding training and there was no robust process to highlight vulnerable patients who had been subject to a multi-agency review conference.
- We had concerns about the robustness of the triage training process because relatively inexperienced nurses were being trained to carry out triage
- Nursing and medical staffing in the department was not always meeting planned staffing levels. Nursing staff were frequently moved to wards to cover staffing shortages, thus leaving the ED short staffed. There was a reliance on locum doctors to fill gaps in the medical rota.
- Nursing staff were not receiving annual appraisals.
- Recording of pain scores and NEWS was not consistent.
- Patients had long waits in the department once a decision to admit them had been made. This was predominantly due to the lack of beds available to admit patients in to the trust, although mental health patients were also affected.
- Information for patients in alternative formats such as large print or Braille and other languages was not available.
- Although there was a newly implemented governance process, this was yet to be embedded in practice.
- Pain scores were inconsistently recorded in the adult and children's written records we looked at despite some patients presenting with minor injuries.
- We saw examples of patients whose condition had deteriorated not always being escalated.
- There was no specific mental health assessment room in the department. The relatives room was often used, however if that was busy staff would use

a cubicle. This did not meet not meet the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983. Staff were not aware of the NHS Protect guidance on distressed patients, which could mean that patients with mental health problems may not be treated appropriately.
- Staff raised a concern that there was a lack of departmental meetings or teaching particularly for juniors on "the shop floor". It was felt that there was not enough senior or consultant involvement.

However:

- The department had developed a paediatric area for children and young adults, open until 10pm every day.
- There was a new electronic process with remote monitoring to alert staff to fridge temperatures being outside recommended levels to store drugs.
- Panic buttons had been installed for staff to use if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department.
- We saw evidence of risk assessments in patients` notes and falls bands were visible on patients identified as high risk of falls.
- There was good communication between staff within the department and outside of the department and organisation such as with the admission avoidance team and ambulance staff.
- Patients experiencing long waits were provided with hospital beds and staff were encouraged to suggest and trial new ways of working that could improve the experience of patients or improve the efficiency of the department.
- Patients received care and treatment that was caring and compassionate from staff who were working hard to make sure that patient experience was positive and supportive.
- The department was able to meet the physical and emotional needs of patients. Specialist equipment was available for bariatric patients and patients with physical disability. There was access to pastoral support for patients of any or no religion.

- There were governance processes in place to assess the quality of care patients received.
- Staff were complimentary about the executive management team of the trust and told us since our last inspection the culture of the trust felt different.
- Staff told us the senior managers were visible and approachable .The heads of flow often came into ED to find out how things were. The weekend on call executive officer also visited the department and the Head of Nursing also attended the department when they were working clinically.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- The department had nurse staffing shortages. Both qualified and unqualified nursing staff were frequently being moved to wards to cover absences or short staffing on other wards. This put pressure on remaining staff and left the department below planned staffing levels.
- Record keeping in relation to NEWS, pain scores, sepsis and comfort rounds needed to improve and we found gaps in information in the records we looked at.
- Mandatory training levels were not meeting the trust standard. We identified this as a concern at our last inspection.
- The department had not met the Royal College of Emergency Medicine (RCEM) standards in relation to patient waits in the department, including time to initial assessment and ambulance handover times.

However:

- There had been improvements since the last inspection.
- Staff were reporting incidents and there had been no never events in the department.
- The department was visibly clean and we observed good hand hygiene. During the 2015 CQC inspection the children`s area was found to be extremely dustyAt this inspection, the department was dust free and equipment and toys were regularly cleaned to meet infection control standards.
- Equipment was regularly tested to ensure it was in good working order and safe to use.
- There were processes in place make sure that medication was stored safely and securely.
- There was evidence of a continued improvement in ambulance handover times with the average handover time dropping from 12 minutes in June 2016 to eight minutes in May 2017.

Incidents

- There were no never events reported by the department at Dewsbury. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in Urgent and Emergency Care that met the reporting criteria set by NHS England between March 2016 and February 2017. The majority of these incidents (six) were “slips/trips/falls”. The second most common type was “Sub-optimal care of the deteriorating patient” (three); all three resulted in an avoidable patient death. There was one other serious incident of type “diagnostic incident including delay” that resulted in an avoidable death. Staff told us learning from these incidents was discussed at team meetings and handovers.
- There were 181 incidents between November 2016 and February 2017 at Dewsbury Hospital. Of these, one was classed as moderate (short term) harm, 21 as low harm and 159 as no harm/near miss.
- The most commonly reported categories of incidents were regarding pressure sores, transfer or admission problems, adverse events affecting staffing and delayed clinical care
- When we spoke with staff about reporting incidents staff told us that they knew how to report incidents and were encouraged to do so using the electronic reporting system.
- We spoke with staff about their responsibilities around duty of candour. Providers of healthcare services must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Most staff were unsure what the phrase meant although they were more familiar with the phrase, ‘being open and honest’. Senior staff in the department took responsibility for the formal duty of candour process. They were able to describe it and give examples of when they had used the process.

- We asked staff if they could give us any examples of changes in the department as a result of incidents, but staff were unable to give us any examples. They told us that outcomes of investigations of incidents were not often shared so lessons could be learned.
- The trust held regular mortality and morbidity (M&M) meetings and staff frequently attended and discussed relevant cases at team meetings. These had recently been amalgamated across the trust's EDs to ensure that lessons were learned cross-site.

Cleanliness, infection control and hygiene

- When we visited the department, we found it to be visibly clean. Patient rooms were cleaned between patients and waiting area floors and seating were in good order. Patient toilets were clean.
- There were cleaning schedules in place and we saw completed paperwork confirming that cleaning had been carried out. We saw staff completing the required tasks in line with schedules.
- At our last inspection, we noted a number of infection prevention and control concerns. At this inspection we did not encounter the same concerns.
- Nurses were responsible for cleaning mattresses after every patient however if they were busy, other staff took responsibility. Full mattress audits were carried out every week.
- The department sent us evidence of mattress audits. These are regular checks carried out on mattresses to make sure there is no contamination and risk of infection being passed on whilst using a hospital mattress is minimised. The reports for March, April and May 2017 demonstrated that checks had been carried out. However, the auditor noted that the foam inside the mattresses was marked, cracked or stained. These marks are usually the result of bodily fluids. According to infection prevention and control guidelines issued by the Medicines and Healthcare products Regulatory Agency in December 2014, departments should "Arrange for contaminated mattress cores to be either: cleaned and decontaminated in accordance with the manufacturer's instructions; or safely disposed of. The information in the audit did not state that these mattresses had been condemned.
- Staff could call cleaners to the department 'out of hours' if required. However, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- Staff used 'I'm clean' stickers on equipment to make it clear that equipment was ready for reuse.
- There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. However we did witness one member of agency staff who did not remove their gloves in between carrying our multiple unrelated tasks.
- We saw that sharps bins were not overfull and did not present a needle stick injury risk.
- In the paediatric ED, toys met infection control standards and had been cleaned regularly.
- The trust delivered infection control training every two years. Nursing staff were 100% compliant, medical staff 63% and 100% of additional clinical staff were up to date with the training. The trust target was 95%.
- The trust routinely monitored the cleanliness and hygiene in both the adult and paediatric EDs. We saw audits that confirmed the department cleanliness and hygiene was meeting the trust standards.
- We looked at the audits completed between September 2016 and February 2017 and found that hand hygiene compliance was consistently in the high 90% area.
- The department had isolation cubicles for patients who required isolation for the prevention and management of actual or potential infection. They had both doors and curtains to enable isolation and privacy and dignity to be maintained.
- We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.

Environment and equipment

- The waiting area used by patients was adequate with sufficient seating for patients and relatives. It was a large airy room with seats that met Infection Prevention Control (IPC) guidelines. However, the layout of the seating meant that patients had their backs to the reception staff. This meant that staff may not notice if a patient deteriorated.
- The minor injuries department had a secondary waiting room with a television and water fountain.

Urgent and emergency services

- The department was separated into four areas: paediatrics, minors (for minor injuries or illnesses), majors (for more serious cases) and resuscitation.
- There were 18 consultation rooms and four bays in main ED and seven cubicles in the paediatric area. The paediatric area had been created since our last inspection and was well planned and appropriate for children and young people.
- Consulting and treatment cubicles were an appropriate size and contained the necessary patient equipment. Cubicles had either solid doors or curtains to maintain privacy.
- We checked resuscitation equipment during our inspection. All trolleys were ready to be used in an emergency and there were records in place to show that trolleys were checked daily. The trust sent us copies of the checklist for May 2017 up to the date of our inspection. This showed that daily checks had been carried out. In addition, there were paediatric resuscitation boxes in ED which were age appropriate for a child's weight. This ensured that paediatric patients received the correct strength and doses of medication in emergency situations. However, neonatal blood pressure cuffs were not available in paediatric resuscitation boxes in ED.
- We found that other equipment in the department had been safety checked. All of the equipment we checked had up to date tests.
- Equipment was serviced and maintained in line with manufacturer's guidelines, as there were maintenance contracts in place. To ensure accuracy equipment was regularly calibrated.
- We saw there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.
- During the inspection the ED was undergoing a refurbishment including re tiling the floor and increasing the number of cubicles for assessing and treating patients. Staff we spoke with expressed very positive views in relation to the departmental refurbishment.
- Reception staff said they felt quite vulnerable overnight and although they saw staff in passing, they felt isolated where they were situated. Staff told us that if there were any trouble in the waiting area they had a panic button but sometimes security were elsewhere and busy so reception staff called the police.

Medicines

- Medicines, including controlled drugs, were stored securely and in accordance with legal requirements.
- The department used Mobile View, a computerised storage and dispensing system to store medication. This is automatically temperature controlled and flashed an alert should the temperature rise above the safe storage temperature The Mobile View provided records to show that fridge temperatures were monitored regularly. If temperatures were out of range an alert highlighted this to staff. There had been no temperature alerts by the system.
- Mobile View only allows staff to access medication once they have entered an access code or scanned their thumb. It requires two appropriate staff to sign in before dispensing the medication that has been prescribed. Medication can however be dispensed without being assigned to an individual patient.
- Mobile View ensures that controlled drugs are stored securely. Controlled drugs must be assigned to an individual patient. However, in an emergency this can be overridden to give a stat dose.
- Nursing staff in the emergency department routinely administered a select range of medications using patient group directions (PGDs) (written instructions that allow non-prescribing healthcare professionals to supply and administer specific medications to patients who meet set criteria). The practice complied with the relevant legislation (Human Medicines Regulations 2012, the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001).
- Staff from the pharmacy department completed regular checks of medication stocks held in the department and there was a system in place to make sure that any stock close to expiry was removed.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. Staff had signed to say that they understood them and were working within their guidance. Staff we spoke with told us they felt the electronic fridge temperature was an improvement on manual checks and recording which would prevent expensive drugs having to be destroyed.
- We saw evidence that the department took part in antibiotic prescribing audits. These were carried out to ensure staff were only prescribing antibiotics when

necessary and were also prescribing the most appropriate type of antibiotic for the patient's condition. Staff told us guidelines re antibiotics were on the intranet.
- There were two nurses in the paediatric ED who could dispense drugs.. Paediatric drug doses were also displayed along with commonly used pain killers in treatment rooms and the drug room.
- The drugs in the paediatric area were booked out, checked and signed for daily.
- The Pharmacy was open 8am – 8pm weekdays and 9am-5pm weekends however, patients had long waits for take home medication
- Medical gases such as oxygen and Entonox were stored safely in a separate area.
- All intravenous infusions were stored securely in their original boxes or in appropriately labelled containers.

Records

- The department used a mixture of paper and electronic record in the department. Written records were scanned to the electronic system on a daily basis.
- We looked at the records of 18 patients. We found the records showed a clear medical history, action plan and treatment plan.
- During our observations, we saw nursing care, such as supporting patients to eat, or take comfort breaks took place however, it was not documented in the records we looked at.
- We looked at NEWS charts and found a number of these did not have the patients' name recorded despite the records being completed. This meant that it was unclear to whom the NEWS charts belonged. There was a risk that information could be recorded on incorrect charts. Additionally, we noted that there was incomplete information of NEWS on the electronic recording system.
- We reviewed ten sets of adult written records who had attended in the past three weeks prior to this inspection. All were dated and legible however other information such as assessment time and pain scores were absent despite three patients attending with injuries.
- Paper records were stored securely and accessible only to appropriate people.
- Only one of the staff groups (additional clinical services) was meeting the 95% trust standard for Information Governance training. None of the other staff groups were meeting the trust standard. For example, reception (80%), administrative and clerical staff (60%), medical (75%) and nursing (60%) had failed to reach the target.
- The trust sent us examples of spot checks carried out on clinical records to ensure that care plans, and treatment pathways were being followed. These showed that although compliance was good, there was room for improvement as there were occasional gaps and missing information.
- We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks and resuscitation trolley checks. We found that these were consistently completed.

Safeguarding

- The department had systems in place to safeguard vulnerable adults and children. Nursing and medical staff we spoke with were able to explain to us about safeguarding procedures for both adults and children and were aware of their responsibilities and appropriate safeguarding pathways to use to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.
- Safeguarding check cards were completed in 80% of the paediatric records we looked at however not all of these were marked on the age appropriate cards. This showed that safeguarding checks were not being undertaken for all children who attended the department and that staff were not always using the correct documentation when they did carry out checks.
- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- The trust had two paediatric liaison nurses, former health visitors, who checked over the records of all children who had been through the EDs of the trust on a daily basis. The purpose of this was twofold; to ensure that any relevant other organisations such as GPs, social workers, school nurses or health visitors had been informed if necessary and to make sure that no vulnerable children, or incidents had been missed.
- We saw evidence that referrals for vulnerable adults and children were regularly made and information sent to health visitors about children who attended the department.

- The record system in the department routinely showed how many times a child had attended the trust ED services in the last 12 months and also in their lifetime. It also had alerts on screen to make staff aware of any special circumstances, needs or concerns relating to the patient. Children`s records included documentation to trigger consideration of abuse or neglect. These included concerns about injuries to non-mobile infants and children 11 years and under. The electronic record also showed if a child or young person was subject to a child protection plan or was looked after by the local authority. This was updated as a child`s status changed.
- Safeguarding training included specific training about safeguarding topics such as domestic violence, child sexual exploitation, people trafficking and female genital mutilation (FGM). Local police liaison officers attended the department regularly to give updates to staff about ongoing concerns or cases the department had been involved in.
- The department was not meeting the trust standard of 95% compliance for safeguarding adults level one or children level one. The trust standard for safeguarding children, level two and level three, and adults level two was 85%.A breakdown of compliance for safeguarding courses for medical/dental and nursing staff in Urgent and Emergency Care showed Safeguarding Adults Level one at 73% and Level two at 50%. Safeguarding Children Level one was at 77% and Level three at 64%.This meant that not all staff had up to date knowledge to recognise abuse and neglect. At our last inspection we identified that training levels were low and informed the department they must improve and meet the trust standards.

Mandatory training

- At our last inspection we identified that the department was not meeting mandatory training levels. At this inspection we found the same.
- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%.
- There was a trust mandatory training policy in place which referenced statutory training requirements, mandatory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act 2005 and the deprivation of liberty safeguards (DoLS)
- New staff received a corporate induction programme that included some face to face mandatory training.
- Staff had a personal training account held electronically which reflected their mandatory/essential training needs as well as expiry dates for their training.
- Staff told us completion of Mandatory training was at 75% at the time of the inspection against a trust targetof 85% for role specific mandatory training and 95% for all other mandatory training.
- All staff groups were meeting the 95% target for diversity awareness however, none of the staff groups were fully meeting the targets of either 85% for role specific mandatory training or 95% for remaining mandatory training.
- A breakdown of compliance for mandatory courses between April 2016 and March 2017 for medical/dental and nursing staff in Urgent and Emergency care showed the target was not achieved for Infection Control 64%, Manual Handling 86%, Fire Safety 64%, Health and Safety 82% and Information Governance 77%.
- Information supplied by the Trust showed the training levels as; Mental Capacity 94%, Infection Control 80% , Manual Handling 91%, Fire Safety 56 % , Health and Safety 89% and Information Governance 59%.
- The low numbers for staff who attended fire safety and information governance meant we could not be assured that staff had the most current knowledge to respond to fire hazards or keep confidential information safe.
- The low numbers for staff who attended infection control training meant that we could not be assured that staff had the most up to date skills and knowledge to prevent the spread of infections

Assessing and responding to patient risk

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust breached the standard in five of the 12 months between January 2016 and December 2016. After breaches in February and March, the trust met the target between April and September. However, the trust breached the target again between October and December. During the nine months from April to December there was a

deteriorating trend in performance. In December 2016, the trust's median time to treatment was 70 minutes compared to the overall average England figure of 60 minutes. There was no information for individual sites.

- The trust's median time from arrival to initial assessment was consistently worse than the overall England median between January 2016 and December 2016. Between March and April the trust more than halved its median time from 27 minutes down to 13 minutes. However, this improvement was not sustained and performance deteriorated thereafter. Performance over time followed the same general pattern as for median time to initial assessment: an improvement in April followed by deterioration from then until December. Between October and December 2016 the median time to initial assessment was 23 minutes each month. This was considerably worse than the average overall England figure of seven minutes in each of these three months.
- Between February 2016 and January 2017, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was consistently worse than the England average, with periods of large variance between the England average and trust performance. The trust's trends followed the England average, an improvement in April 2016 was followed by a trend of decline until January 2017. In April 2016 performance was 24.9%; in January 2017 it was 50%. Performance then improved over the following three months. In February 31.6%, in March 9.3% and in April 8.4% of patients waited between four and 12 hours from the decision to admit until being admitted. In both March and April the trust's performance was better than the England average.
- Between March 2016 and October 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes, from 54.3% in the former to 61.1% in the latter month. This was followed by an improvement between October 2016 and February 2017. In January 2017 49.3% of ambulance journeys had turnaround times over 30 minutes; in February the figure was 45.9%. There was a sustained improvement beginning from November. In May 2017 there were 16
- A review of ambulance handover data 8 May – 14 May 2017 in relation to Dewsbury showed the percentage handover time within 15 minutes (target 100%) was 84%; the average for the hospitals in the region was 70%. The average handover time was 10 minutes 22 seconds; the average for the hospitals in the region was 13 minutes 41 seconds. Dewsbury was performing better than the average comparing ambulance handover times with other hospitals in the region.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between March 2016 and February 2017 the trust reported 1,541 "black breaches". The highest monthly totals were in October 2016 (293), March 2016 (247) and June 2016 (176). Between October 2016 and February 2017 there was a considerable reduction. February saw the lowest monthly total over these 12 months with 17 breaches. Dewsbury saw no black breaches in March, April and May 2017.
- Reception staff streamed patients to the appropriate departments however when we spoke with reception staff they told us that there were no specific criteria and that they used their common sense to direct people. We had some concerns about this as reception staff had not received training to make such decisions independently and there was a risk that very unwell patients would be sent to the wrong area of ED or experience unnecessary or harmful delays.
- The department used the Manchester triage system for assessing the level of urgency to be seen by a doctor. Paediatric patients (babies and children) were assessed by specialist nurses and waited in a separate area designated for children.
- Patients were triaged on attending the department and staff based their decisions about whether the patient should be treated in the minors or majors area.
- We discussed triage with the matron. They told us that any member of staff could triage as long as they had completed some supervised triage before being able to triage alone. This included newly qualified nurses, nurses new to emergency care medicine and nurses new to the trust. We had some concerns that triage training was not robust and varied from site to site within the trust. There was no consistency in triage training of new staff across the trust.
- The trust had a sepsis pathway and patients identified as being septic should be started on the sepsis pathway immediately and receive antibiotics within 60 minutes.

There was a lack of clarity amongst staff we spoke with about who took the lead for sepsis screening. Staff thought ambulance crews carried out the sepsis assessment.

- The trust was a mortality outlier for sepsis. This meant that more people diagnosed with sepsis died than were expected to die. The national actual rate was 16.8% however this trust had an actual rate of 25.9%. CQC asked the trust to carry out some investigation to find out why this was the case. The deputy medical director's report of September 2016 in to this review revealed that on average patients waited 62 minutes for review and a further 135 minutes for antibiotic administration. Audit also revealed that staff were not routinely using the sepsis screening tool, thus were not assessing and responding to patient risk in a timely manner as per the pathway.
- Staff recorded known patient allergies in patient records. All of the 18 records we looked at had patient allergies recorded. Patients with allergies wore a red wristband to ensure that they were easily identifiable.
- The department had recently introduced a falls risk assessment and patients assessed at risk of a fall were given a green wrist band so that no matter where they were in the hospital all staff were aware and could intervene.
- We saw that there was Malnutrition Universal Screening Tool (MUST) documentation in three out of four records we looked at for those patients who were waiting four hours or more in the department.
- The department used the National Early Warning Score (NEWS) for adults and the Paediatric Early Warning Score (PEWS) for children to assist in monitoring patients and identifying when a patient's condition was deteriorating.
- On the 19th of May, the Assistant Director of Nursing - Medicine carried out a NEWS audit of 10 patient records and found that all had NEWS recorded at initial assessment and eight had a NEWS score recorded on the electronic system.
- Staff we spoke with during inspection were able to demonstrate they were aware of deteriorating patients and knew how to escalate treatment appropriately. However, we reviewed one set of patient`s notes that showed an increase in the NEWS score from five to six with no escalation action taken. Another set of notes showed there was no mention of rehydration or a blood test to exclude acute kidney injury in relation to a patient who had not passed urine for 10 hours.
- There was emergency medical equipment in the department and staff were experienced at dealing with sick patients. There were senior staff on hand to support less experienced staff until at least midnight and then by telephone after this time.
- We observed a mental health assessment being carried out in a relatives` waiting room. The room was adjacent to an open exit used by ambulances to bring patients in to ED and could have provided an escape route if the person being assessed wanted to abscond. This was not in line with national guidance. When we reviewed the patient's records we found that there was no description of the patient's physical appearance. This meant that if the patient had absconded there was no record of their appearance to support a search.

Nursing staffing

- The nurse staffing WTE was 47.95. The number of staff in post in March was 45.68. There was a vacancy of 2.27 WTE nursing staff, a turnover rate in Dewsbury of 23.6% and a sickness rate of 5.2%.
- The trust had carried out an assessment of staffing levels for the department in March 2016 to ensure that the correct number of staff with the appropriate skills and experience were on duty. The assessment resulted in an increase in staffing at Dewsbury.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners (ENPs), treating patients with minor injuries and illnesses. The trust employed 23 (ENPs) who could treat minor injuries such as fractures and limb injuries. All ENPs were also triage trained and worked across the three sites.
- There were play specialists who were trained nursery nurses and HCA`s based in CAU. They provide daily cover in ED and where required, provided distraction for children undergoing assessment or treatment.
- Both nursing and medical staff expressed their concerns about nurse staffing numbers. They also told us that nurses were frequently taken away from ED to cover staffing shortfalls in wards and when extra capacity beds

were opened. Staff had raised concerns about this practice as it had made staff reluctant to cover extra shifts in ED since they were not guaranteed to be working in ED.
- Staff told us that they submitted incident forms regularly because of low nursing numbers.
- The trust used a tool called CEM Books to record information about staffing as well as many other aspects of the department. We had requested further information from the trust about actual and planned staffing levels. Both nursing and medical staff expressed their concerns about nurse staffing numbers.
- During inspection we observed one qualified nurse in resuscitation (resus) with four ill patients. We had concerns about the low level of staffing to look after four very sick patients.
- We asked how many nursing staff had undergone advanced paediatric life support (APLS) or equivalent as required by the 2012 intercollegiate standards. The trust sent us information about immediate life support training but not about advanced training.
- We were informed that the trust supported staff to have paediatric immediate life support (PILS) training. Training information showed that 59% of nursing staff had completed their annual resuscitation training. However it was unclear what level of training this was. Additionally, 61% of nursing staff had completed their three yearly resuscitation training. It was again unclear what level of resuscitation this represented. We saw that 71 nursing staff had undergone PILS (paediatric intermediate life support) training and 66 had undergone ILS (intermediate life support) training.
- The management team told us about the action the department was taking to recruit new staff to the EDs across the trust. This was an ongoing process.
- There was an induction process in place and before agency staff were allocated to the department, they had to provide evidence of competency. The senior nurse in charge had to sign to say they were happy with the competencies of any bank staff used.
- Information sent to us by the trust showed that Dewsbury had used no agency nurses between March 2016 and February 2017. However, we have asked for further clarification of this as staff we spoke with told us that bank and agency nurses were used regularly. We are awaiting a response from the trust about the level of agency use.

Medical staffing

- Doctors staffed the department 24 hours per day seven days a week. However, after midnight, medical cover was provided by middle grade staff with consultants on call. Consultants were flexible and when the department was busy or had very seriously ill patients, consultants often worked beyond midnight. Additionally, in response to our previous inspection, the trust had added a further weekend twilight shift from 4pm to 10pm to support junior staff in managing demand.
- The cover in the paediatric department was one trained doctor per shift covering between 7am – 10pm.
- The trust was funded for 21 WTE consultants. There were 16.8 WTE in post and a vacancy of 4.2 WTE.
- The Dewsbury ED had three WTE substantive staff and four consultant vacancies. One of these was filled by a long term locum.
- There were 8.8 WTE specialty trainee vacancies across the trust
- The department used medical locums to fill gaps in rotas. Information provided to us by the trust was not split by site. From April 2016 to March 2017 locum shifts varied from 565 in December 2016 and 762 in March 2017. A total of 7375 shifts were covered by locums between April 2016 and March 2017.
- The breakdown of staff across grades compared with the England average was; consultant staff 30% compared with the England average of 26%, Middle grade in the Trust 5% compared with the England average of 13%, registrar in the Trust is 40% compared with the England average of 39% and Junior staffing in the Trust is 25% compared with the England average of 22%.
- The trust was actively looking to recruit to middle grade posts. The senior management team and senior medical staff told us it was difficult to recruit doctors in to the Emergency Department and this was a recognised national problem. In order to attract staff to the department, the trust had offered three staff development posts called CESR posts (Certificate of Eligibility for Specialist Registration). These posts had led to successful recruitment to three vacancies across the trust.
- We observed doctors discussing patients and handing over relevant information to colleagues at a formal

handover. We had no concerns about this process however some staff told us there were no departmental handovers where information was shared. We were unable to corroborate this.
- Junior medical staff we spoke with expressed their frustration at the perceived lack of training they received. They felt that training took a back seat to keeping the department functioning.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.
- The staff turnover rate (excluding junior doctor rotation) for Dewsbury, for the period March 2016 to February 2017 was 0%
- The sickness absence rate for Dewsbury ED was less than 1% for period April 2016 and May 2017.

Major incident awareness and training

- The trust had a major incident plan that clearly defined the roles of each ED site within the trust.
- The Chair of the Regional Resilience Forum worked in the trust. They provided evidence as to the roles and responsibilities of the staff and the trust in the event of a major incident either local, regional or national.
- Staff could explain their roles in the event a major incident.
- There were documents which covered roles and responsibilities including internal resilience and wider support for the region or nationally.
- There was evidence staff were trained and that some had recently taken part in a regional major incident training exercise in Sheffield.
- Staff were able to evidence awareness of the trust's business continuity plan.
- The business continuity plan had been tested during our inspection when the electronic records system temporarily ceased to function. Staff were immediately able to put contingency plans in place that did not adversely affect the service or patient safety.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because;

- The department was taking part in national and local audits such as the departmental sepsis audit. This meant that there were checks in place to make sure patients were receiving care in line with Royal College of Emergency Medicine (RCEM) standards and guidelines.
- The department offered a 24/7 service with consultant cover for at least 16 hours per day.
- Staff understood the principles of the mental capacity assessments and the need to obtain patient consent before treating patients of any age.
- There was evidence of Multi-Disciplinary Team (MDT) working with a number of different teams attending the department to see patients with conditions such as dementia, mental health needs, substance misuse or requiring a bed on a ward.
- There was an electronic system in place to enable staff to access guidelines and pathways. These were up to date and evidence based. Staff had ready access to information relating to patients.
- The paediatric area had well-planned care pathways based on NICE and RCEM guidance.

However:

- Staff had not recorded pain scores in the records we looked at despite five of 18 patients having suffered a limb injury.
- The rate of nursing staff appraisal did not meet the trust standard.
- The department was performing worse than the national unplanned re-attendance rate.
- Staff we spoke with told us no junior doctors or Middle grades wereinvolved in CEM audits. There was a lack of participation of Dewsbury in the RCEM audit process.

Evidence-based care and treatment

- Departmental policies were based upon NICE (national institute for health and clinical excellence) and Royal College of Emergency Medicine guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- The department used a resource called CEM Books. This could be accessed online or using a phone application. It meant that staff had instant access to the most up to

date guidance available. We carried out a random check of ten guidelines and found that all had an identified responsible author and a review date. All were within their review dates.
- There was a wide range of departmental policies and guidelines for the treatment of both children and adults. These were easily accessible to all staff using CEM Books. However some staff we spoke with told us they were unfamiliar with CEM Books.
- We saw evidence that the department had pathways for a number of conditions such as sepsis and head injury for both adults and children. However we noted that a recent report on September 2016 identified that staff were not always using the sepsis pathway.
- At our last inspection we identified that this department was not taking part in trust-wide sepsis audits. At this inspection we found that Pinderfields was leading a sepsis audit that was underway. The department had met their CQUIN (Commissioning for quality and innovation) target for sepsis.
- We discussed whether staff took part in any clinical audit activity at Dewsbury and staff told us that they were. We saw examples of audits such as antibiotic prescribing audit.
- The department sent us their clinical audit report. This showed that the department had under taken a number of clinical audits including; Vital signs in children, VTE risk in lower limb and procedural sedation in adults all of which were completed in March 2017 and were in the report writing stage at our inspection. This demonstrated that the department were working within recognised guidelines and pathways and had quality assurance checks in place.
- The department had a process in place for consultants to check x-rays. This made sure that there were no missed fractures.

Pain relief

- We looked at the records of 18 adult patients who had attended the department within the last three weeks. Of these, five had injuries that may warrant pain relief. None of the patients had a pain score recorded and none of the patients received analgesia. We looked at the records of nine paediatric patients who had recently attended the department with injuries and found that none of the records had a pain score recorded.
- We observed patients being brought in by ambulance. They were asked if they had already had pain relief or offered pain relief if required. We also heard staff asking patients whether they required any pain relief when they carried out duties around the department.
- Some staff such as ENPs used PGDs to administer medication such as pain relief.
- In the CQC A&E Survey 2014, for the question "How many minutes after you requested pain relief medication did it take before you got it?" The trust was "about the same" as other trusts.
- For the question "Do you think the hospital staff did everything they could to help control your pain?" The trust scored "about the same" as other trusts.
- We saw one example of a patient involved in a car accident who was not offered pain relief at any time despite having a neck injury. This did not comply with the Faculty of Pain Medicines Core Standards for Pain Management 2015.

Nutrition and hydration

- Staff told us that sandwiches and beverages were available to patients. Staff always made sure that patients were not fasting before offering them drinks or snacks. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks.
- There were vending machines and water fountains available for patients and relatives to use.
- We spoke with two patients who confirmed they had been offered a drink and informed of the location of the water fountain.
- None of the patients in the department needed fluid balance charts. This was the same for the patients whose records we looked at. Staff told us that if required, fluid balance charts were used. The department provided us with evidence that records were checked to make sure all appropriate care plans such as malnutrition universal screening tool (MUST), fluid charts and pressure care had been completed as necessary.
- In the CQC A&E Survey 2014, for the question "Were you able to get suitable food or drinks when you were in the A&E Department? the trust scored "about the same" as other trusts.

Patient outcomes

- Between February 2016 and January 2017, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5%. In December 2016, the trust performance was 8.7% compared to the overall England performance of 9.2%.
- The department sent us their clinical audit report which showed that the department had under taken an number of clinical audits including; RCEM Vital signs in children, RCEM VTE risk in lower limb and RCEM procedural sedation in adults.
- The trust had participated in all the recent RCEM (Royal College of Emergency Medicine) audits however it was unclear whether Dewsbury contributed to the RCEM audits.
- Results for the RCEM Vital signs in children audit showed that the trust was performing in the upper quartile for two of the standards, vital signs recorded within 15 minutes and enhanced vital signs recorded within 15 minutes. This was better than the England average. The department was in the lower quartile for standard three, explicit evidence in records that the clinician had identified abnormal vital signs.
- Results for the RCEM Procedural sedation in adults audit showed that the trust was performing in the upper quartile for one standard, standard four, ensuring the correct staff are present when carrying out sedation. This was better than the England average. The trust was performing in the lower quartile for two standards, standard one, documented pre assessment and standard seven, formal assessment of suitability prior to discharge.
- Results from the RCEM VTE risk in lower limb audit showed that the trust was performing in the upper quartile for standard one, documented evidence of patient receiving or being referred for thromboprophylaxis. However, the trust was not meeting standard two, documented evidence of patients being given a leaflet to seek advice if they developed VTE symptoms.
- The department took part in the trust's sepsis audit. This was ongoing at the time of the inspection.
- There were also three ongoing clinical audits; RCEM Consultant Sign Off, RCEM Asthma and RCEM Severe sepsis and septic shock. These were due to complete in June 2017.
- The department was also taking part in trust wide and interdepartmental clinical audits.
- We were provided with evidence of actions resulting from clinical audits along with assigned responsibilities. Some of these action were outstanding and it was unclear why the delays and whether any action was being taken.

Competent staff

- According to information provided by the trust, as at 1 March 2017, 83% of nursing staff and 81% of additional clinical services staff had undergone an appraisal within the last 12 months.
- Staff felt able to discuss clinical issues and seek advice from colleagues and managers.
- Recently appointed staff were supported by colleagues. Newly qualified staff had preceptorship in place to support them to gain their competencies.
- The department employed emergency nurse practitioners to work predominantly in the minors department to treat minor injuries and illness.
- The department used a triage system to assess the urgency of need of patients attending the department. We had some concerns because there was no single training process across the trust to make sure that staff were competent to carry out triage. Each site trained and assessed staff competency differently and each had different minimum standards before a staff member was eligible to triage
- Senior members of staff informally monitored staff competencies throughout the year as well as through appraisal however this would only be recorded if concerns were identified.
- Junior medical staff were supported by joint training from the radiology department and consultants to make sure that they were competent to assess x-rays correctly. The aim of this was to ensure the number of missed fractures was reduced as well as ensuring the junior medical staff were fully competent in reading x-rays.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The ED teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite.

- The Admission Avoidance Team and the Hospital Avoidance Team (HATS) played an active role in the department engaging in multi-disciplinary and multi-agency working to support the department to reduce unnecessary admissions.
- There was good access to psychiatry clinicians within the department with 24 hour access to psychiatric liaison staff. The mental health liaison team were very responsive and aimed to attend the department within one hour of being called. Delays for mental health patients were a result of waiting to see the CRISIS team who supported mental health patients who had further support needs.
- There was a substance and alcohol misuse liaison team available to support patients and staff treating them with advice. This service was available to patients of any age.
- Allied health professionals attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.

Seven-day services

- The ED and a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24 hour period.
- The department was staffed by middle grade and junior doctors overnight. Although consultants were due to leave the department at midnight, all the staff we spoke with told us that consultants frequently stayed in the department beyond this, particularly if the department was busy or had very unwell patients.
- There was 24 hour, seven day access to diagnostic blood tests.
- Radiology tests such as x-rays, CTs and MRI scans were available at any time of day or night, 365 days of the year.

Access to information

- Staff were able to access patient information using an electronic system and paper records. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan.
- Regular locum and agency staff were provided with access to blood and other test results in line with access afforded to substantive staff.
- Patients transferred to other services or sites took copies of their medical records with them.
- Clinical guidelines and policies were available on the trust intranet and via a phone application called CEM Books.
- The senior management team could also access CEM Books. The shift leader updated it regularly with information about attendance numbers, staffing levels, patient waits and bed requirements. This meant that senior staff could monitor the department remotely but attend and offer support if required.
- Safety performance information, audit results and some pathways were displayed in the emergency department for staff to access readily.
- During the inspection we saw that TV screens were present to display waiting times in the waiting area. Patients could see how many patients were in the department, the length of wait for the next patient to see a doctor and the likely total waiting time in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the legal requirements of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and consent arrangements. Some of the staff we spoke with had a reasonable understanding of the trust's policy and of the legislation.
- Staff told us they would consult with a senior member of the team for advice and would seek the advice of appropriate professionals to ensure decisions were made in the best interests of patients.
- Staff were aware of the actions they should take if a patient was detained under the Mental Health Act and there was support available from the psychiatric liaison team when this happened in the department.
- All staff we spoke with understood the concepts and differences between the Gillick Competencies and Fraser Guidelines when treating young people under the

age of 16 years. Staff were able to confidently explain about assessing competency in young people and we had no concerns about their knowledge of these matters.
- Staff understood the importance of gaining consent from patients and we observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.

The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberties level one training had been completed by 94% of staff within Urgent and Emergency Care.

Are urgent and emergency services caring?

Good

We rated caring a Good because:

- We observed good interaction and communication between doctors, nurses and medical crews. Nursing staff showed care and compassion towards patients.
- We used a recognised tool SOFI (Short observational framework for inspection) to observe the quality of care given. This was following a review of patient complaints and concerns raised to CQC. The observation period demonstrated a high level of compassionate care.
- The department performed better than the England average in the friends and family test.
- Patients told us the staff were kind, caring and helpful. They answered questions in language that patients could understand.
- Pastoral support was available for patients and families of any or no religious belief.

Compassionate care

- During our inspection we spoke with nine patients as well as their relatives. They were happy with the care they received.
- Patients described to us how staff treated them with dignity and respect.
- As part of our inspection we used a recognised tool (SOFI) as a way of observing the quality of care patients received. We did this because of concerns raised to us about the care of elderly and vulnerable patients in the department. The SOFI provided us with robust evidence that patients received kind and compassionate care from staff.
- We saw that medical staff cared for the patients in a calm and unhurried way even though the department was busy. The observation period demonstrated a high level of compassionate care.
- We saw an example of how staff dealt with a patient who had deteriorated and their concerned family. Staff showed compassion to the patient and the family as they reassured them and supported the distressed patient.
- We observed a patient assessment and found the nurse treated the patient with respect introducing themselves by name and asking if the student nurse could observe. When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel as though they were being well taken care of.
- In the patient led assessment of the care environment survey undertaken in April 2016, Dewsbury and District Hospital scored 75% for privacy, dignity and wellbeing. There were no figures specifically for the Emergency Department.
- The friends and family test showed that between February 2016 and January 2017, the department performed better than the England average for percentage of patients recommending the department to friends or family. In April 2017 96% of patients would recommend Dewsbury. Only 2% of patients would not recommend Dewsbury. The national averages were around 87% and 7% respectively.
- During our time in the department we saw patients being treated with dignity and respect. Staff were conscious of the cultural needs of some patients and made sure this was respected whilst delivering their medical care.
- In the Paediatric ED, staff were patient and supportive of children and their parents. They were gentle in the way they administered treatment.

Understanding and involvement of patients and those close to them

- Staff involved patients in their care. We saw consultants and nursing staff keeping family members up to date

with information about patients. Patient's families reported good communication about care. Patients and relatives we spoke with knew about their family members' diagnosis, treatment and investigations.

- Staff made sure the information they gave was in language that the patient and their family could understand. Relatives told us how assured they felt as their loved ones' condition was clearly explained to them.
- During our inspection we witnessed a number of very good interactions with patients. We spoke with the parent of a five year old patient. They were happy with the treatment. They told us staff were always friendly and very good. All the treatment was explained to them.
- We saw patients being given information and supported to make decisions about the treatment they would like to receive.
- The results of the CQC A&E survey 2014 showed that the trust scored "better than" other trusts for one of the questions relevant to the caring domain: Q26. Did a member of staff explain the results of the tests in a way you could understand? (9.2/10)
- The trust scored "worse than" other trusts for one question relevant to the caring domain: Q8. Were you told how long you would have to wait to be examined?
- The trust scored "about the same" as other trusts for the remaining 22 questions relevant to the caring domain.

Emotional support

- Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them. However, they sometimes found this difficult when the department was busy, due to staffing levels. We did however witness this in practice both in the adult and the paediatric ED when patients were upset, distressed or frightened.
- We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.
- The SOFI observation provided good evidence of emotional support being given to anxious and sometimes vulnerable patients and their relatives. Staff were very aware that the ED environment may cause an elderly patient to be anxious.
- Staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available via the alcohol liaison team.
- There was pastoral support available for patients of any or no religious belief.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- The department was failing to meet Department of Health access and flow standards for four hour waits, 12 hour decision to admit waits and patients leaving the department before being seen.
- Patients had long waits in the department once a decision to admit had been made. This was predominantly due to lack of beds being available within the hospital.
- Despite seeing the psychiatric liaison team quickly, mental health patients had long waits to see the CRISIS team and therefore had to wait in the department for long periods of time.
- There was no written information for patients who required information in alternative formats such as other languages or Braille.
- There was inconsistency in how learning from complaints was disseminated with no standard approach.

However:

- The department was equipped to deal with the individual physical needs of patients. Bariatric and other special equipment was available either within the department or on site on loan from other departments.
- Patients whose first language was not English could access telephone interpreters.
- The department was meeting the RCEM consultant cover recommendations.
- The trust's monthly median total time in ED for all patients was better than the overall England performance in eight of the 12 months between January and December 2016.

- There was a good complaints system in place and evidence that complaints were investigated thoroughly.

Service planning and delivery to meet the needs of local people

- The trust had three EDs and was in the process of reviewing how to best make use of each site and the resources they had most effectively.
- Dewsbury District Hospital was a trauma centre. This meant that the department was staffed by consultants between 8am and midnight every day. The department was meeting the RCEM 'Rule of thumb' recommendations for consultant cover of 16 hours each day.
- As a trauma centre there were strict criteria for the type of patients accepted by ambulance. Patients suffering suspected stroke, trauma, obstetric emergencies, cardiac arrest or suspected heart attack were taken to Pinderfields as Pinderfields had specialist support for these conditions. Any patients suffering major burns or trauma were taken to the nearest major trauma centre. Staff told us that they submitted incident forms on a daily basis because paramedics were bringing inappropriate cases to the department.
- Because there was a paediatric ED, the hospital accepted babies, children and young people of any age. The newly opened unit meant that children received care and treatment more tailored to their needs.
- Managers were aware of the type of patients who attended the department and the potential incidents that could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- The department had acknowledged the mental health needs of the local population and had quick access to initial assessment mental health services on site.
- The department worked with a charity to support patients to be discharged rather than admitted when appropriate.

Meeting people's individual needs

- The trust scored "about the same" as other trusts for all three A&E Survey questions relevant to the responsive domain.
- The waiting room was able to accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available.
- There were facilities, such as beds and wheelchairs, for bariatric patients either in the department or around the trust for loan.
- There were vending machines present in the department that relatives and carers could access and the hospital had a number of shops and places to purchase food.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that, in an emergency situation, they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. During our inspection we saw a patient whose first language was not English having communication difficulties at reception. They were not offered telephone interpreting although we were told that nursing staff were informed that this would be a requirement for the clinical part of their visit to the department.
- There were a limited number of leaflets around the department and none of the leaflets in the waiting room related to clinical care. We also noted leaflets were in English and did not offer a choice of other languages, large print or braille. Staff we spoke with were unsure whether they could access written information in alternative formats.
- The department had access to sign language interpreters for people living with hearing impairment.
- There were private areas for relatives to wait whilst patients were being treated and there was a relatives' room close to the department.
- When a patient passed away, whenever possible, they were moved to a side room so that family could have privacy to visit.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs.
- Staff told us that whenever possible, people living with dementia or a learning disability were seen as quickly as possible in order to minimise distress for the patient.
- Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
- There was no specific mental health assessment room in the department. The relatives room was often used,

however if that was busy staff used a stripped out cubicle to ensure there were no ligature points. Staff we spoke with were unsure if the curtain rails were collapsible which presented a possible ligature point. There was light weight furniture in the room which was easily moveable. This did not meet not meet the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983. Staff were not aware of the NHS Protect guidance about distressed patients, which could mean that patients with mental health problems did not receive optimum care or support.

- Staff were aware of the actions they should take if a patient was detained under the Mental Health Act and there was support available from the psychiatric liaison team when this happened in the department. Staff told us that this team was very quick to respond. However when patients were referred on to the CRISIS team for further mental health support, long delays occurred meaning patients had to wait in the department. Staff we spoke with thought this was not an ideal situation for the patient since an ED is not the most suitable place for a person with mental health problems.
- There was access to chaplaincy services for patients and relatives of all different faiths or none.
- There were no waiting time information on display during our inspection although the department did have the facility to provide this via their electronic patient administration system.
- Staff told us the lack of a palliative care team out of hours had created difficulties in obtaining hospice beds and arranging transfer thus patients at the end of their life faced delays being transferred to their preferred place of death.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival at the department. The department consistently failed the standard between January 2016 and January 2017. Performance was also consistently worse than the overall England performance. On this site, the rate ranged from 76% to 93% short of the standard. This reflected the pressure the department was under.
- Between February 2016 and January 2017, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was consistently worse than the England average, with periods of large variance between the England average and trust performance. The trust's trend followed the England average, an improvement in April 2016 was followed by a trend of decline until January 2017. In April 2016, performance was 24.9%; in January 2017, it was 50.0%. There was no information for this individual site.
- Over the 12 months, seven patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in February 2016 (five), June 2016 (one) and January 2017 (one). There was no information specific to this site available.
- At both our announced and unnanounced inspection we saw examples of patients waiting significant time before being transferred to a ward, once admission had been agreed. Staff told us that unfortunately these waits were not unusual. The reason was that the demand for hospital beds outstripped capacity in the entire hospital. The department was working hard to reduce the risks for patients who had long waits, such as by moving patients from trolleys to hospital beds and using pressure relieving equipment for patients who were a high risk of developing pressure sores. Patients were transferred to a ward as soon as a bed was available.
- The monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was worse than the overall England performance in 11 of the 12 months between February and January 2017 (May 2016 was the exception). Performance followed the same pattern as four hour target performance and the percentage of patients waiting between four and 12 hours from the decision to admit until admission. Following an improvement in April 2016, performance deteriorated between May (3.2%) and December 2016 (5.0%). For comparison in the latter month the overall England performance was 3.5%. This information was not available for each individual site.
- The trust's monthly median total time in A&E for all patients was better than the overall England performance in eight of the 12 months between January and December 2016. Performance followed the same pattern as many of the metrics above: an improvement in April 2016 was followed by a deteriorating trend from

then until December 2016. In April 2016, the median time was 133 minutes; by December it had increased to 160 minutes. There was no information available specific to this site.

- Staff told us of concerns regarding children who attended at night. Children's Assessment Unit (CAU) is open from 10am till 10pm, any children after this time would be seen in paediatric emergency department and if requiring admission would be transferred to Pinderfields. There was a twilight paediatric CAU nurse and HCA on duty untill 12 midnight to support any children waiting for transport. There was also a paediatric nurse on duty overnight in the emergency department and children were quickly triaged after booking in and transferred to the children's area. The trust's aim was to have a paediatric nurse available at all times to be able to assess and recognise a sick child and escalate appropriately. A sick child would be seen by an emergency department doctor, but the on call paediatric consultant would attend if the child's health deteriorated.

Learning from complaints and concerns

- Patients and relatives we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department.
- There was information about how to raise concerns about the department or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- Between March 2016 and February 2017 DDH received 62 complaints about the Emergency Department at Dewsbury. Of these, none were rated as high risk, 43 as medium and 19 low risk.
- The most common causes for complaint were; delays and waits (five), staff attitude (seven), delayed or missed diagnosis/missed fracture (six) discharge (two).
- Of the complaints made, the trust upheld eight, partially upheld 32 and did not uphold 21. The outcome of one was yet to be decided.
- Lessons learned from complaints were shared via the Clinical Governance meeting. The information was then disseminated to an appropriate Lead Nurse and discussed with staff involved. Individuals were asked to write a reflective piece about the incident to support their learning.
- Wider lessons learned from complaints were contained in the ED communication book. The content was discussed every day during shift handovers so staff were kept informed as to what was current. However, some staff told us that there was inconsistency in the approach to sharing learning whilst others told us they received regular emails.
- Feedback to people who raised complaints was either by letter, or in person, usually when the complaint was complex or high risk.
- Where applicable, the department generated action plans in response to complaints and followed up with patients and staff as appropriate.
- There were some themes running through the complaints such as missed fractures and missed diagnosis. The trust sent us evidence of action taken to address these misses including introducing teaching sessions a second x-ray reporter and peer support sessions.
- As a result of a number of complaints by patients, TV screens displayed waiting time information in the waiting room. This information was also available on the trust website along with information about the number of patients in the department. Unfortunately at the time of the inspection, the TV screens were out of order.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- Staff told us the executive team were visible and approachable .The heads of flow team often visited ED in person to monitor the bed requirement situation. The weekend on call executive officer also visited and the Head of Nursing attended when they were working clinical days.
- Staff reported an improved relationship with the new Chief Executive Officer (CEO) and clinicians felt involved in discussions and decisions about the department.

- Staff felt included and consulted on changes/ improvements to the department.
- Staff spoke positively about working at Dewsbury describing the atmosphere on the "shop floor" and interpersonal relationships as good.
- The Trust had developed various work streams to assist in delivery of the Hospital reset which was due for completion by October 2017

However:

- Staff felt that the Dewsbury department was seen as less important by senior managers than the department at Pinderfields
- Staff raised a concern that there was a lack of departmental meetings or teaching particularly for juniors on "the shop floor". It was felt the way to improve would be to had more senior involvement at consultant level.
- Despite positive comments regarding the trust strategy some staff did tell us they felt that in the future things would continue the way they were now.
- Some staff we spoke with were not aware of the social media group where information was shared.

Leadership of service

- The EDs across the trust were led by a clinical lead, matrons and a business manager. Each site had their own matron. We met with the clinical, nursing and business managers as part of our inspection. The team appeared to work well together to provide a cohesive management team.
- Nursing staff told us that they felt well-led at a local level and they had no concerns with their line managers. They felt they could raise concerns and be confident they would be resolved whenever possible in a timely manner. They told us the management team was open, approachable and provided good leadership.
- Staff told us that senior executives from across the trust occasionally visited the department.
- Staff reported an improved relationship with the new CEO. Clinicians felt involved in discussions and decisions.
- Staff told us that much of the trust's focus since our last inspection had been about improving services at Pinderfields meaning that Dewsbury had not been the focus of attention for making service improvements. Because of this, staff felt less important as a department than Pinderfields.

Vision and strategy for this service

- The trust had a vision for the service and was working with local providers and commissioners to ensure that services met the needs of the local populations.
- The ED was undergoing reconfiguration across the three sites with changes to service provision.
- The Trust had developed various work streams to assist in delivery of the strategy for this service .These included, ED Streaming to Primary Care The trust were engaged with key stakeholders and were planning to have a Hospital Ambulance Liaison Officer (HALO) to be in place by 31 October
- The trust sent us information about their plans for developing services to deal with changes in the demand of the public on urgent and emergency care. This included developing new roles, working with primary care practitioners, implementing new procedures in the department to ensure it worked efficiently and effectively.
- Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to try to manage demand.
- Despite many positive comments regarding the Trust strategy some staff did tell us they felt that in the future things would continue the way they were now.

Governance, risk management and quality measurement

- At our last inspection we had some concerns about the clinical governance structure in place. This was because there was poor interdepartmental learning, particularly between Dewsbury and Pontefract. At this inspection we found there was a clinical governance structure in place involving all three sites. The trust had implemented a cross site clinical governance committee that staff could access via teleconference facilities if they could not attend in person. The meeting was introduced in January 2017, therefore was quite new. However staff we spoke with were very supportive of this initiative.
- Senior staff received regular emails covering risks, performance targets and attainment, management issues, lessons learned from clinical incidents and operational issues.

- The cross site clinical governance committee covered mortality and morbidity where patient deaths were reviewed.
- Managers told us all staff were invited to attend clinical governance, patient safety and clinical audit meetings however staff were unaware of this and there was rarely staffing capacity for them to attend
- There was a process in place to ensure all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- All of the staff we spoke with were clear about the challenges and risks the department faced.
- The introduction of CEM books meant that shift leaders entered regular 'sitreps', in other words, information about the current situation in the department such as number of patients waiting to be seen, number of patients currently receiving treatment, staffing levels and bed needs. This supported managers with planning and also made sure any risks or capacity concerns were logged and escalated appropriately.
- There was a process in place for ensuring the results of radiology investigations were followed up to ensure any "missed abnormality" was followed up in a timely manner. Where abnormalities had been missed, staff involved were informed and offered regular and structured support and training with radiologists to ensure the risk of future errors was minimised.
- The department had a risk register with actions given a RAG (Red for high, Amber for moderate or Green for low) status dependent upon levels of risk. The following actions were identified as having a red RAG status; Risk of crowding within the ED , failure to meet national guidelines (children`s nurse available in the EDs 24 hours a day) and doubling up of patients in cubicles due to high volumes and lack of flow. Senior staff regularly updated the risk register as the situation in the department changed. These risks correlated with the risks we observed during our time in the department.
- When we spoke with the senior management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed.
- Managers discussed waiting time breaches regularly to identify any themes and were able to take actions to address issues, such as bed shortages across the trust.

Culture within the service

- Staff told us that they would be comfortable to report concerns without fear of recriminations and had confidence in their line managers that action would be taken whenever possible.
- Staff spoke positively about working at Dewsbury describing the atmosphere on the "shop floor" and interpersonal relationships as good. A number of staff from different disciplines said that colleagues were supportive of each other, cross discipline and across seniority. They described the department as friendly and like one big family. Staff we spoke with told us , " I feel looked after at Dewsbury" and " Medical and nursing staff are on the same page".
- The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked as a team to ensure patients received good care.
- Staff wanted to flag what a good job the department was doing with limited resources.
- Staff felt that their hard work was recognised and they felt appreciated by colleagues and line managers
- Staff felt able to suggest changes in practice to improve patient experience or efficiency. The department used the PDSA (plan do study act) methodology to try new ideas. Staff told us if the ideas didn't work it was not viewed as a failure.

Public engagement

- The department participated in the Friends and Family Test and CQC surveys but had not carried out any local surveys in relation to the quality of urgent and emergency care services.
- The trust had worked with the local Health Watch to determine why people attended A&E when they couldn't get a GP appointment. The results were shared with the local clinical commissioning group.

Staff engagement

- The three EDs had a closed social media page, which had approximately 300 staff members. Staff were able to share information, concerns and discuss events in the departments. Senior staff were able to see the issues within departments and monitor concerns and problems discussed by staff however, the page was not formally monitored. Senior staff were able to make sure there were no problems with morale and take action if anything caused them concern. However several of the

staff we spoke with at Dewsbury were unaware of the page or how it was used. One member of staff told us they felt the Facebook group was "not useful at all" and graphs of performance were often not representative of the real situation.

- Staff from the department had taken part in trust wide engagement exercises such as online surveys however there had been no specific engagement work carried out with the department.
- Staff told us they were kept informed about opportunities to personally progress.
- Staff told us they felt there had been a change in the Trusts culture. They told us they felt involved in any change process, One person told us, "They are breeding a culture of change" by consulting and involving staff in managing change and improvement.
- There was a health and well-being day planned for staff the week after our inspection.
- Staff reported that they received regular e-mails with trust information although did not always have the time to read them.
- Some of the medical staff told us there were not enough team meetings within the department.

Innovation, improvement and sustainability

- We saw plans for improving the Dewsbury Hospital Family Room. All the internal furnishings were going to be supplied free of charge from a global retailer.
- Staff told us that they were working on introducing a" Red Chair" system to identify patients who did not need to be in the majors area. Senior clinicians including Consultants and Registrars will then treat the patient.

Medical care (including older people's care)

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

Information about the service

Dewsbury and District Hospital is part of The Mid Yorkshire Hospitals NHS Trust and provides medical care services across the areas of Wakefield and North Kirklees.

Between December 2015 and November 2016, Dewsbury and District Hospital had 18,753 medical episodes of care. Emergency admissions accounted for 11,901 (63.5%) of these. There were 343 (1.8%) elective cases and the remaining 6,509 (34.7%) were day case.

The top three specialities for admission were; general medicine, elderly and respiratory.

Medical care at Dewsbury and District Hospital was provided across eight wards. Specialities included, elderly medicine, neurology/stroke rehabilitation, general and respiratory medicine. There was a medical assessment unit (MAU/ward11), short stay ward (ward 10), and two 'surge' wards were open at the time of the announced inspection, wards6b and 15. At the unannounced inspection ward 15 was being utilised as a 'medically fit' ward for those patients who were medically ready to leave hospital but required a package of care to be in place.

During our inspection we visited all these areas. In addition, we visited the discharge lounge, the endoscopy unit, the ambulatory care unit and the Cavell unit (oncology and haematology).

We also observed care using a short observational framework for inspection (SOFI) as part of an unannounced inspection on the 11 May 2017. A SOFI is a specific way of observing people's care or treatment looking particularly at staff interactions. This helps us understand the experiences of people who may find it difficult to communicate.

Prior to the inspection, we attended a number of staff focus groups.

Prior to the inspection, we also reviewed performance data from and about the trust.

During our inspection we spoke with 41 staff, including nurses, doctors, health care support workers, therapists and administration staff. We spoke with 29 patients and relatives. We reviewed 34 patient records and 19 medication charts.

Medical care (including older people's care)

Summary of findings

Dewsbury and District Hospital was previously inspected in June 2015. All five domains were inspected and an overall rating of requires improvement was given. Safe, effective and well-led were rated as requires improvement. Caring and responsive were rated as good.

The main areas of concern from the last inspection in June 2015 and the actions the trust were told they must take were;

- Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- Ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented.
- Ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are adequately met.
- Ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment.

At this inspection in May 2017 we rated this service as requires improvement because:

- Nurse and medical staffing numbers were a concern. Planned staffing levels were not achieved on any of the medical wards we visited during our inspection. The trust was heavily reliant on the use of locums to fill gaps in rotas.
- We found that as nursing staff were working under such pressure, they were not always able to give the level of care to their patients that they would have liked.
- We found examples of patient safety being compromised as a direct result of low staffing numbers. This included a failure to escalate deteriorating patients in line with trust and national guidance and a lack of understanding and implementation of sepsis protocols.
- Mandatory training figures were below the trust target in the division of medicine. There had been a deterioration in training rates since the last inspection. Safeguarding and resuscitation training compliance were a particular concern.
- We found poor completion of documentation, particularly in relation to risk assessments relating to falls and monitoring of nutrition and hydration. This had been highlighted at the previous inspection.
- The trust showed poor performance in a number of national patient outcome data audits. The trust also had six active mortality outliers in which the division of medicine were involved.
- We lacked assurance that all patients were receiving pain relief in a timely way and we did not find care plans for pain management in place.
- Issues in relation to the monitoring and assessment of patient's nutrition and hydration needs had been identified at the previous inspection. A project plan had been put in place to address the issues in April 2016; however there was a lack of progress against this. We found poor documentation in relation to nutrition and hydration, with only 28% of the records we reviewed being fully completed.
- We also found that nursing care plans did not reflect the individual needs of their patients, and not all patients felt involved in their care.
- The number of nursing staff and allied health professionals who had undergone an annual appraisal was below the trust target of 85%.
- We found trust policies with regards to infection prevention and control were not being followed. We found commodes that were heavily stained and bathroom areas for patients that were not visibly clean
- The trust had exceeded their target for the number of cases of clostridium difficile. We found that trust guidance was not being followed with regards to isolation of patients with an infection.
- We were not assured that learning from incidents was being shared with staff. There was also a backlog of incidents awaiting investigation. This meant there were potential risks which had not been investigated, and learning undertaken.

Medical care (including older people's care)

- Information was not shared consistently. Consequently learning from incidents was not embedded with all staff.
- Access and flow within the hospital was a challenge with a number of medical outliers on wards, and a large number of patient moves occurring after 10.00pm.
- Directorate meetings were variable in their structure and content meaning information was not shared consistently. Consequently, learning from incidents was not embedded with all staff.
- There were large numbers of patients attending the endoscopy unit having their procedure cancelled on the day. Data also showed an increasing trend of patients waiting for diagnostic testing within endoscopy, of which 493 had breached the six-week threshold.
- We were concerned that the number of new appointments at local leadership level were not able to fulfil their roles as they were working clinically for much of the time. This meant they lost the ability to assess and seek to improve the care provided on their wards in an objective way.

However:

- There had been a significant piece of work undertaken to reduce the incident of falls. This had been very successful with the number of falls resulting in severe harm or death reducing by 72%.
- Policies and guidelines were evidence based and easy for staff to access.
- We saw lots of examples of good multidisciplinary working across different areas.
- Overall there was good evidence of seven day working clinical standards being met with some areas above regional averages.
- We did receive positive feedback from some patients and recognition of how hard the nursing staff were working.
- Service planning was collaborative and focused around the needs of patients.
- The average length of stay for elective and non-elective medical patients was below the England average.
- Staff reported a positive change in culture with the new management team and felt more engaged.
- The risk register reflected the risks to the service.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- There had been no significant improvement since our last inspection in 2015. In several areas there was a noted deterioration.
- We were very concerned that monitoring and appropriate escalation of deteriorating patients was not being done in line with national and trust guidance and found several examples of this.
- Staff demonstrated a lack of awareness, understanding of the sepsis bundle and were not using or fully completing the sepsis pathway documentation.
- We were concerned about nurse staffing levels on all the wards we visited. Planned staffing levels were not achieved on any of the medical wards we visited. Additional beds and two surge wards being open added to the staffing shortages which increased the risk to patients using the service.
- Between 42% and 56% of medical shifts were covered by external locums.
- We were concerned that trust guidance was not being followed in relation to infection prevention and control. We found 19 out of 20 commodes were visibly stained. Also bathroom and toilet areas for patient use were not visibly clean.
- We also found trust guidance for patients requiring isolation for infection prevention and control reasons was not always followed. This was a concern as between March 2016 and February 2017, within the medical division the number of cases of trust attributable clostridium difficile was 35 against a target of 21.
- We were not assured that staff were aware of learning from incidents. There was also a backlog of incidents awaiting investigation, which meant there were potential risks, which had not been investigated, and learning undertaken.
- We had concerns that medications were not being given in a timely way and that staff were seen to be distracted whilst undertaking medication rounds.
- There had been deterioration in safeguarding training compliance rates since the last inspection. Compliance in level one and two adults and children's safeguarding was below the trust target of 95% for medical and nursing staff.
- Mandatory training compliance was below the trust target and had declined since the last inspection. It was noted resuscitation training compliance was particularly low.
- Medical records were not stored securely. We saw gaps and incomplete records in all of the 34 records we looked at. This included risk assessments not completed/reviewed or appropriate plans of care in place.

However:

- There had been a significant piece of work undertaken to reduce the incident of falls. This had been very successful with the number of falls resulting in severe harm or death reducing by 72%.

Incidents

- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between March 2016 and February 2017, the trust reported two incidents, which were classified as never events and attributable to medicine. Neither of these occurred at the Dewsbury site. One occurred at Pinderfields general hospital and related to a wrong route administration of medicine, the second related to a wrong site surgery incident in the endoscopy unit at Pontefract hospital.
- We reviewed the investigation reports and related action plans which were thorough and identified a root cause.
- There were nine serious incidents (SIs) relating to medical care at Dewsbury and District Hospital between March 2016 and February 2017. Serious incidents are incidents that require further investigation and reporting. The most common type of SI related to slips/trips and falls. All falls categorised as SIs were considered at a falls panel. The panel met every three weeks and had representatives from all divisions to share learning and focus on best practice.

Medical care (including older people's care)

- From March 2016 to February 2017, there were 1,613 incidents reported relating to medical care at Dewsbury and District Hospital. Of these 1,087 (68%) reported no or insignificant harm; 489 (30%) reported low/minor harm and 37 (2%) reported moderate harm.
- Of the 37 incidents reported as causing moderate harm the majority (43%) related to falls. We spoke with the quality and safety team who presented the ongoing work with falls prevention. This included implementation of the falls care bundle, gathering information from staff about their knowledge in relation to falls, completion of a gap analysis and a falls prevention work stream had been established.
- Additionally safety huddles had been introduced which we were told were starting to become embedded in ward areas. We observed three safety huddles during the inspection. These highlighted any patients at risk, for example with known pressure damage or at risk of falling.
- All staff were aware of how to report an incident and gave examples of the types of things they would report. This was generally around falls and pressure ulcers. Senior staff on the wards felt there was a good reporting culture but were not as confident about reporting near misses.
- We found evidence within the ward managers' meeting minutes from March 2017 of a backlog of incidents awaiting investigation. This had reduced from over 700 In December 2016 to 250 in May 2017. There was a risk there could be a reoccurrence of an incident as review and learning had not been undertaken. This had been added to the divisional risk register in February 2017, with a recovery plan put in place.
- Incidents were monitored through the trust's departmental governance meetings. We reviewed several meeting's minutes. We found agendas were not standardised across the specialities and incidents were not routinely discussed. For example, in the October 2016 neurosciences clinical governance minutes, against review clinical incidents it stated, 'not discussed'. This was also the case for the respiratory meeting minutes in February 2017.
- We viewed the incident dashboard, which gave each ward manager sight of all incidents in their area. We were told information on incidents was shared in a variety of ways, including team meetings, briefing sheets, handovers and safety huddles.
- Incidents specific to endoscopy were discussed at the endoscopy users group meeting.
- Within the ward managers' meeting whilst incidents were an agenda item, there was no evidence of shared learning. The information in the February 2017 and March 2017 minutes related to reducing the backlog of incidents to investigate and not what incidents had been reported.
- We saw ward meeting minutes from ward 2. These had not occurred regularly, the last meeting had been in March 2017 and November 2016 prior to this. There was no standard agenda and incidents were not discussed at either meeting.
- With the exception of two staff, no others we spoke with were able to articulate any learning or changes in practice as a result of an incident and many said they did not get feedback from incidents.
- We spoke with staff about the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff were aware of the need to be open and honest. Some were unfamiliar with the term the duty of candour. Senior staff were responsible for the formal duty of candour process. We saw in the investigation reports we reviewed evidence of the duty of candour regulation being met and apologies and explanations given to patients and their families.
- We saw evidence of mortality and morbidity reviews within the different specialities as part of the governance meetings. Each displayed evidence of discussion and lessons learned.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thromboembolism (blood clots), and catheter and urinary tract infections. The information is collected monthly.
- We saw information displayed on notice boards in ward areas and safety crosses were competed to indicate if an incident had occurred on a particular day of the month.
- Data from the trust showed there had been no category three or four pressure ulcers on the medical wards at

Dewsbury and District Hospital between January 2017 and April 2017. However, there had been incidences of between two and ten category two pressure ulcers for each medical ward for the same time period.

- We were provided with data in relation to the number of falls within the division of medicine (excluding the emergency department) per 1000 occupied bed days. From 2015/2016 to 2016/2017 the total number of falls at the trust had reduced by 13%. The number of falls resulting in severe harm or death had significantly reduced by 72%.
- Specific to medical wards at Dewsbury and District Hospital there were eight falls with harm reported in January 2017. There were seven in February and ten in
- March. Senior staff told us falls with harm were still a concern.
- Venous thromboembolism (VTE) risk assessments were carried out within the trust. Quarterly compliance data for the medical division showed an improving picture from April 2016 to March 2017. In quarter one compliance was 89.8% this had risen to 92% in quarter four. However this was below the trust target of 95%.

Cleanliness, infection control and hygiene

- Concerns in relation to infection prevention and the use of personal protective equipment (PPE) had been highlighted at the previous inspection.
- We found 19 out of 20 commodes checked on various medical wards had lids which were corroded and heavily stained/discoloured. One was unclean on the metal foot bar. In the sluice room on ward 15, we found a commode containing faeces and when checked an hour later it had not been emptied.
- On Ward 15 the flooring was stained in the assisted bathroom and the shower curtain had brown coloured stains on it. One toilet had not been flushed since patient use and wet paper towels were on the floor, another had wet paper towels left on the hand basin.
- On the medical assessment unit (MAU) we found a toilet not flushed after patient use with faeces splattered in the bowl. On Ward 2 in one bathroom the toilet seat had become detached and was on the floor next to the toilet. Another toilet had a dirty patient gown and paper pants on the floor. There was another toilet which had not been flushed since patient use.
- Single rooms were available for those patients requiring isolation; signage was in place to advise anyone prior to entering an isolation room. We lacked assurance that this guidance was adhered to and that it was kept up to date for individual patients. For example; on ward 15 we observed staff entering a side room which indicated the patient required isolation without wearing PPE. This was fed back to the trust and we were told the patient no longer required to be isolated. During a ward round the doctors on the same ward asked if another patient in one of the side rooms was still being 'barrier nursed'; they were told no and that the sign could be removed.
- On the short stay unit (SSU) we also observed staff entering a side room which had a sign indicating the patient required isolation. PPE was not worn by the staff entering the room.
- We reviewed the care plan of a patient in an isolation room on ward 6. This indicated the patient had experienced loose stools on 30 April 2017 and a sample had been sent that day. There was an entry the following day stating no loose stools. There had been no further documentation from then to our visit on the 5 June 2017 so it was unclear as to whether the patient still needed to be isolated.
- The care plans related to patients who required isolation state the door should be kept closed to reduce any spread of infection. On ward 6 three side rooms had the doors open. They each had signs on indicating the patient was being isolated for infection prevention reasons. We asked staff why the doors were open; we were told one was due to patient preference. No reason could be given for the other two patients. We found no documentation in the care plans related to this.
- We observed that separation of clinical and non-clinical waste was in line with trust policy in ward areas. Linen was stored appropriately in the areas we visited.
- Arms bare below the elbows guidance was adhered to by staff in the clinical areas we inspected. We observed some good practice in relation to hand hygiene. However, we observed a ward round on ward 15. Medical staff did not use alcohol gel between patient contacts.
- Infection prevention and control training formed part of the trust's mandatory training programme. Compliance rates for the medical division from April 2016 to March 2017 were 78% for medical staff and 85% for nursing staff. This was below the trust target of 95%.
- Front line ownership (FLO) audits were conducted monthly in each clinical area. They looked at

compliance against ten elements of infection prevention and control and were red, amber and green (RAG) rated. The matron and infection control nurse then undertook a three monthly assurance audit.

- We reviewed data for the medical wards at Dewsbury and District hospital from November 2016 to February 2017. The most recent audit from February 2017, showed data had not been collected from MAU. Ward 6b and the SSU had undergone their assurance review and the scores were significantly lower than the ward's own audit. For example, on the SSU's own audit they had scored 100% (green) for general environment, compared to an assurance audit score of 83% (red).
- Information on these audits was displayed on wards. However they did not all have dates to indicate when the audit had taken place.
- The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre assessment. The screening rate for elective patients was 100%.We reviewed compliance rates for non-elective screening and noted they were between 90% and 93% from March 2016 to February 2017 with the exception of December 2016 when they were 89%.
- Between March 2016 and February 2017, there had been no reported cases of trust attributable methicillin resistant staphylococcus aureus (MRSA) within the medical division.
- For the same time period within the medical division there had been 35 cases of trust attributable clostridium difficile against a target of 21. A failure to meet the clostridium difficile target had been on the divisional risk register since June 2014. This was reviewed in March 2017 with a plan to review identified cases and remind staff about early sampling and prompt isolation for patients.
- Decontamination of endoscopy equipment was done on site. An annual review by The Institute of Healthcare Engineering and Estate Management (IHEEM) of the facilities at the Dewsbury site had taken place in February 2017. Clean and dirty equipment was segregated, which was noted in the report. The only concern related to some storage cabinets, which may not have met the current BS EN 16442 standard, which was published in 2015.

Environment and equipment

- We found on most wards storage of equipment was an issue. This was also mentioned by some of the staff we spoke with. However, we found clinical areas were generally free from clutter.
- We inspected ward 15 and went into bay 4. From speaking with staff we discovered the bay was part of ward 14. There was no signage to indicate this on exterior doors.
- We were concerned that ward 2 had a fire escape at the end of the ward that was easy to access and led to a staircase. We spoke with staff about this who stated they were not aware of any incidents of this being accessed by patients. We reviewed incident data from March 2016 and February 2017 which supported this.
- It was noted that the stage one recovery area in the endoscopy unit had limited space. Five trolleys were in a small area with little space between them. Staff were aware of this but stated they had received no complaints from patients in relation to this. On occasions male and female patients were in the area at the same time. They would be separated by a curtain. We were concerned that if an emergency arose it would be very difficult for staff to gain access to the patient if the recovery area was full.
- We inspected equipment for evidence of electrical safety testing. We found some equipment with out of date stickers and a range of different stickers were used. Information from the trust stated equipment was being serviced on a risk basis and monitored via an electronic system, in line with MHRA device bulletin (2006) (05). We were provided with data in relation to safety testing from 2016/2017 which showed that compliance for testing of high risk equipment was 92% against a trust target of 95%. High risk equipment is defined in the trust policy as 'those items which deliver an energy or fluid to the patient and which would result in a major consequence in the event of failure'.
- Ward staff reported having sufficient equipment to meet the needs of their patients, for example moving and handling equipment.
- Resuscitation trolleys were easily located on main corridors in ward areas. The exception to this was ward 4 where the trolley was stored in the clinical room accessed by keypad entry. This was not in line with guidance from the resuscitation council.
- Best practice is for resuscitation trolleys to be checked daily. We inspected resuscitation equipment in five of the wards and in the discharge lounge and were assured

that daily checks had been undertaken. It was noted on MAU that there were several entries relating to items being out of stock. However, the contents were complete at the time of inspection.

- It was also noted that none of the trolleys had tamper proof seals. This meant the contents of the trolleys were easily accessible so staff could not be assured that equipment was still in situ following checks being completed. However, as per resuscitation council guidance, emergency drugs had tamper-proof seals in place.

Medicines

- Medicines and intravenous fluids were stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drug's records on medical wards. Accurate records and checks were completed in line with trust policy. Three monthly controlled drug checks were also done by a matron from a different area.
- We observed fridges for storing medications and found these to be locked and temperatures recorded daily via an electronic system.
- Ward pharmacy cover was available Monday to Friday with a dispensary-based pharmacy service in the mornings on weekends, and an on call system at all other times.

Pharmacy staff told us they saw all new patients and that medicines reconciliation was done on MAU.

- We reviewed 19 prescription charts and found seven had gaps, so we could not be assured medications had been given. For example on one chart daily phosphate enemas had not been signed for on the 15, 16, or 17 May so staff were unsure if they had been administered. We also found omissions where the reason for the omission had not been documented on the chart.
- This was supported by data in the matron's health check audit data. One of the areas audited was omission codes completed. In July 2016, October 2016 and January 2017 the division of medicine was RAG rated amber with compliance between 84% and 88%.
- Two charts did not have the patient's allergy status completed.
- We found that patients receiving oxygen therapy had this prescribed on their charts.
- Eight wards in the division took part in the antimicrobial resistance audit. Data from 2016/2017 showed good compliance with the 72 hour review process for antibiotics taking place. Performance exceeded the 90% target.
- We were concerned that medications were not always administered in a timely way due to staffing shortages on the ward. We observed on ward 6 the morning medication round did not start until 09.05am. At 10.00am on ward 6b the morning medication round had not been completed.
- We observed red aprons being worn by nursing staff when administering medications. However, most were disposable plastic aprons so it was not clear what their purpose was. Ward 4 was the only ward where we saw tabards which stated 'do not disturb' on them being used on medication rounds. We also observed on most wards staff being interrupted during medication rounds to either speak on the phone, talk to relatives or other staff members.
- There was a risk identified on the divisional risk register of staff not adhering to medicine's management policies. This had been on the register since June 2014 and identified that the medicines management e-learning did not include a competency check. The mitigation in place was for targeted training from pharmacy when an error had been made by an individual staff member. This was felt to be reactive and did not address the underlying causes.

Records

- We reviewed 34 sets of nursing and medical records across the medical wards at Dewsbury. We checked 18 of the nursing records in detail looking at care plans and risk assessments. Without exception we found gaps and assessments either not completed accurately or not updated regularly.
- Within medical records we found that General Medical Council (GMC) numbers were not being recorded by doctors. This was reflected in the trust documentation audit from July 2016 to December 2016. Within the medical division 216 records were audited and GMC numbers were only recorded in 15% of these. An action plan was developed from this which included ongoing audit and promotion of standards of documentation.

- Information governance was part of the trust's mandatory training programme. Compliance rates for the medical division from April 2016 to March 2017 were 69% for medical staff and 66% for nursing staff. These figures were below the trust target of 95%.
- We found in three records in different ward areas (MAU, ward 8 and ward 15) assessments had been undertaken by healthcare support workers. The guidance on the document clearly stated; section one could be completed by a healthcare support worker but the remainder had to done by a registered nurse. The assessments completed by a healthcare support worker had not been countersigned by a registered nurse. This meant patients may not have been appropriately assessed and had all risks identified.
- Medical records were not stored securely in any of the areas we visited. Notes trolleys were used which had no lids were often in open areas where anyone could access them.
- We found different systems in use for the storage of nursing documentation which made locating and reviewing notes difficult. For example on ward 15 all nursing notes were in a file on a work surface outside the bays. On ward 8, nursing and medical records were kept together in an open notes' trolley in front of the nurse's station. Ward 8 planned to move nursing records to the patient's bedside to encourage contemporaneous documentation and we saw files being prepared for this.

Safeguarding

- All staff received mandatory training in safeguarding of vulnerable adults and children. The trust target was not met for any safeguarding training for any staff group. Adults safeguarding level 1 was 90% for medical staff and 76% for nursing staff. Adults safeguarding level 2 was 69% for medical staff and 68% for nursing staff.
- Children's safeguarding level 2 was 67% for medical staff and 79% for nursing staff. This data was for the medical division and from April 2016 to March 2017. This was a significant deterioration from the last inspection were compliance rates were between 81% and 100%.
- Trust protocols and guidance on safeguarding were easily accessible and staff could describe what signs to look for and how they would escalate any safeguarding concerns. There was also a safeguarding team who were available for advice.
- Ward managers reported feeling confident that staff would escalate any concerns. We saw an example of this in a patient's record who had been admitted from a nursing home following an episode of choking. It had been identified the patient should have been receiving thickened fluids but had been given water. A safeguarding concern was reported by the ward staff.

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children.
- Training was provided in full and half day sessions to make it easier for staff to complete training. Feedback from staff was that this was very helpful.
- Mandatory training had been on the divisional risk register since June 2014 for a risk of failing to meet targets. At the previous inspection overall compliance in the division of medicine was 88%; this had fallen slightly to 84%. Compliance within medical wards specific to the Dewsbury site was 81% as of June 2017.
- Role specific training had a target rate of 85%. Data from June 2017 specific to Dewsbury showed an overall rate of 62% for nursing staff on the medical wards. This included training such as blood transfusion safety, conflict resolution and resuscitation training.
- Some managers reported basic life support training was difficult to access as there were insufficient training days for this. We were told staff could get a fast pass for training via the director of nursing. This gave them quick access to training.
- Some staff reported training being cancelled as staffing numbers on the ward would not allow them to be released. This was particularly noted on ward 8 which had a high number of staffing vacancies. Their mandatory and role specific training rates were one of the lowest at 78% and 62% respectively.

Assessing and responding to patient risk

- The national early warning score system (NEWS) was used in each ward area as a tool for identifying deteriorating patients. The trust had also introduced a software system to help monitor the condition of hospital patients. Nurses recorded patient observations and entered them onto an electronic device that

automatically calculated the NEWS score and when observations needed to be rechecked. There was a clear escalation policy in place for when patients had an elevated NEWS score.

- A trust wide re-audit in to NEWS scores and the escalation of deteriorating patients was undertaken during September 2016 and December 2016 with the report published in February 2017. Ten areas at Dewsbury and District hospital and 89 patients were included in the audit. The results were compared with previous data before the introduction of the software system.
- Results showed that only 49% of patients had observations recorded as indicated by the software system. Further data showed that 45 of the 89 patients did not have their observations recorded on time. This was worse than the previous audit data.
- The results also showed that 12.5% of the patients reviewed at Dewsbury did not have appropriate escalation.
  - During our inspection we were shown the software system and conducted case reviews of patients with elevated NEWS score of five or above across four of the medical wards. Out of 15 patients only five had evidence of appropriate escalation.
- For example; on the SSU on the 17 May 2017 a patient had a NEWS score of five at 18.27. They had scored nine earlier in the day (11.17am). Their medical notes evidenced they had been seen by a junior doctor but no reference was made to their raised NEWS score. At 21.15, no further observations had been recorded and no documentation relating to their NEWS score was in the nursing record.
- On the same day at 18.31 on MAU a patient had a NEWS score of five. They had been scoring between three and eight since 04.48 with no evidence of escalation or review by medical team.
- In addition to this, we were concerned that when these findings were escalated to the sister on three of the wards no immediate action was taken and the situation had to be escalated further. We discussed some of the cases we identified with staff. We were met with a complacent attitude towards patients potentially deteriorating. Four staff also stated as patients had certain medical conditions a raised NEWS score would be usual for these patients. When asked if agreed parameters for observations had been identified and documented in the notes staff were not certain. On checking the patients' medical records, no parameters were documented.
- There was a critical care outreach team who would come and support ward staff if a patient was deteriorating. We found they had only been contacted for one of the 15 patients we identified with a high NEWS score.
- The trust's public board papers for March 2017 reported 24 red flags on the eRoster system for the medical wards at Dewsbury and District hospital where vital signshad not been recorded.
- We were therefore very concerned that patients were not having observations monitored and escalated as per trust guidance and that some staff did not seem concerned when patients had high NEWS scores. We were told by medical staff of three patients who were admitted to intensive care the week before our inspection. They felt this was as a direct result of delays in acting upon deteriorating conditions.
- We reviewed the records of a patient who had been 'unwell' since 8.30am with a raised NEWS score. This had continued throughout the day culminating in a 'crash call' being put out at 18.10pm. At this point they were being transferred to intensive care.
- We observed hand over on three wards. These varied in the quality and amount of information handed over. We were concerned that when we spoke with night staff on MAU and the SSU, information about patients who had had a raised NEWS score during the day had not been handed over.
- On four occasions we also found several patients whose observations were overdue for being recorded. For example on the 22 May at 19.20pm on Ward 6b there were seven patients whose observations were overdue by between two and four hours.
- We reviewed data on training compliance for resuscitation. The figures were low. For example on ward 2, eight out of 25 staff met the requirement and on ward 4, 18 out of 31 staff met the requirement.
- There was an identified risk of failing to manage deteriorating patients on the divisional risk register. This risk was identified in June 2014 but was related to the Pinderfields site. An update in December 2016 identified there had been two SIs in relation to this with a plan to continue to monitor via divisional quality meetings.

- The Mid Yorkshire Hospitals NHS Trust had been flagged as a mortality outlier for rates of septicaemia. Sepsis had been included in staff induction, mandatory training and continuous development for doctors and nurses. The trust also had an awareness promotion campaign in December 2016 to advertise use of the new sepsis screening documentation.
- From reviewing records we found three patients with a possible diagnosis of sepsis. Pathways had not been completed for any of these patients. We asked a doctor on the ward about this and they were not aware of any formal documentation in relation to sepsis. A senior nurse also told us they were not confident sepsis screening and treatment was being done properly as 'the pathway was new no one has trained anyone on how to use it'.
- We saw laminated copies of the pathway on the notes trolleys on ward 8 and information displayed on sepsis and the use of the BUFALO tool. This is a mnemonic for the six elements of care for treating sepsis.
- Staff on the Cavell unit (oncology and haematology unit) stated they had undergone sepsis training and were confident about implementing the pathway.
- We reviewed the trust's sepsis action plan for 2016/2017. There were objectives of; increased compliance with screening and antibiotic administration, this had a date of completion of March 2017; and awareness of new sepsis guidelines and pathway. This had no completion date. Neither had anything documented in the evidence/review column.
- Patient risk assessment documentation for falls, pressure areas, and nutrition were included in care records. We reviewed care plan documentation and risk assessments of 18 patients on various medical wards at Dewsbury and District Hospital. In nine sets of records (50%), we found the falls risk assessment and/or care bundle documentation to be incomplete/inaccurate or absent. For example, on the 17 May on MAU a patient had been assessed as 'not at risk'. However it was identified the patient took more than four medications; the guidance stated this would identify them 'at risk'.
- On the 17 May on ward 15, the outcome of the assessment had not been circled to indicate the level of risk. The patient would have been 'at risk' as they had had a recent fall. The falls risk safety tool and care plan not been completed.
- Significant work had been done in relation to implementation of the falls care bundle. This had been developed from research and used the best intervention models. A senior nurse carried a falls bleep from 08:00 to 17:00 Monday to Friday. This person responded to staff where a fall has taken place and ensures policy has been followed. Six wards had been awarded a bronze certificate from the improvement academy relating to the reduction in the number of falls.
- We saw information displayed about falls prevention and the post falls checklist in the wards we visited.
- We were still concerned that staffing shortages were impacting the wards ability to safely manage patients at risk of falling. For example; on ward 2 there were 13 patients on enhanced care in four areas of the ward. The matron had been contacted over staffing concerns and did attend the ward.
- We visited ward 6 which had two qualified nursing staff and two health care support workers on duty. Three patients had been identified as at risk of falls. They were being cared for in three areas of the ward. One safety guardian was in place (these are non-registered staff employed to provide close supervision for patients who are at risk of falling). At our time of arrival a patient had just fallen, they had not been identified as at risk of falling. We did observe appropriate post fall processes being followed.
- Ward 8 was the respiratory ward and cared for patients requiring non-invasive ventilation (NIV). There were clear guidelines on which patients were suitable to go to this ward.
- Whilst all patients requiring NIV on ward 8 would not be classified as requiring level 2 or 3 care as defined by Intensive Care Society - Levels for Critical Care, 2009 and require a nurse to patient ratio of 1:2; we were concerned that overnight there was only one nurse on duty competent to care for patients requiring NIV. During one visit there had been five patients requiring NIV overnight and seven on another occasion. We asked the staff how they would have a break if they were the only staff able to look after this group of patients. They told us they did not take breaks during night shifts. We were also concerned that if one of these patients became unwell, there would be no other staff on the ward able to care for the other patients requiring NIV. Whilst we found no incidents relating to patients requiring NIV, staff felt there was a potential risk.

Nursing staffing

Medical care (including older people's care)

- Nurse staffing at this hospital had been identified as an issue at the last inspection and we found this was still the case. The wards completed Safe Care acuity and dependency tables on the electronic nurse roster to calculate the Nursing hours per Patient per Day (NHPPD). Red flags were also used to indicate any concerns such as patient falls and missed regular checks on patients.
- As of March 2017, the trust reported required nurse staffing levels of 628.89 whole time equivalent (WTE) for the medical wards at Dewsbury and District hospital. The number of staff in post was 560.47 WTE giving a vacancy rate of 11%.
- We were concerned that staffing levels were unsafe for the numbers of patients on the ward and their acuity. This was supported by all the staff we spoke with during our inspection who felt staffing was a risk. Comments such as 'we are short staffed every shift' and 'I have never known staffing as bad' were made. Planned staffing numbers were not achieved on any of the medical wards we visited during our inspection.
- All divisional wards at Dewsbury reported qualified nurse staffing vacancies. Ward 6(Gastroenterology) and ward 8 (respiratory) were the areas with the highest staffing vacancies. They were 7.34 WTE and 8.95 WTE respectively.
- This situation was compounded by additional beds being open on ward 2 (eight beds) and the SSU (six beds). Two additional 'surge wards' were also open, ward 15 (21 beds) and ward 6b (23 beds). These wards had a band 6 and band 7 nurse assigned to them. The rest of the shifts were filled with bank or agency staff or movement of staff from other areas.
- The trust safe staffing report for March 2017 showed that planned qualified nurse numbers for day shifts on ward 6b were 1152 WTE, actual numbers were 649.68, giving a fill rate of 56.4%. Often if qualified nurse shifts cannot be filled additional healthcare support workers will be requested. For the same time period healthcare support worker fill rates were 69.6%. The quality indicators noted two falls with harm and three category 2 hospital acquired pressure ulcers occurred during this month.
- On the 19 May we inspected Ward 6b there were two qualified nurses on duty for 28 patients with no support staff. In response to this the bleep holder and a nurse from the discharge lounge had come to help. Following our concerns we had been provided with information from the trust about the planned staffing levels for the weekend.
- We revisited the ward the following Monday and found that planned numbers had not been achieved on the Saturday or Sunday. We had been told by all the senior staff that the electronic rostering system was a 'live system' and any staff moves would be captured. On the 22 May we visited ward 6b and looked at their staffing rotas for the weekend. During the day on Saturday staffing levels were one qualified nurse and two health care support workers. We were told that a nurse would have been moved from another area. This was not recorded on the electronic rostering system. The night shift on Saturday had two qualified nurses on duty however both were bank staff. Again we were told a swap would have been done with a substantive staff member from another ward. This was not recorded on the electronic rostering system. The situation for the Sunday was similar. We were therefore not assured that the electronic roster was fully capturing staffing on the wards.
- Discussions with senior nurses and reviews of rotas showed this was not a unique situation and nurse staffing was a daily challenge. We reviewed staffing fill rates for ward 6b for February 2017 to April 2017. The majority of the fill rates for registered staff for day and night duty were 67%.
- All of the medical wards at this site had been RAG rated as red for qualified nurse fill rates for day shifts. Percentages were between 58% and 69% (February and March 2017 public board papers). This was significantly worse than at the previous inspection where fill rates for registered nurses in May 2015 and June 2015 had been 82% and 83%.
- There had also been 49 incidences where 1:1 care could not be provided when required (February and March 2017 public boards papers).
- Ward 8 had 46 out of 89 days from February 2017 to April 2017, with qualified nurse fill rates of 54% or less.
- On ward 6 from February 2017 to April 2017, there had been no days where 100% fill rates had been achieved for qualified staff, and only 11 days when fill rates of above 80% had been achieved.
- For the same time period there had been 35 out of 89 night shifts with two qualified nurses on duty. This gave a nurse to patient ratio of 1:14.

- On MAU from January 2017 to April 2017, there were 22 days where fill rates for qualified staff were 60% or less. There were 37 night shifts with fill rates of 75% or less and only one of these 37 nights had fill rates for unqualified staff of over 100%.
- Ward 2 had eight additional beds opened during our inspection. Although additional shifts had been requested these had not been filled. On the 18 May, there were three qualified staff on duty for the day shift giving a ratio of 1:10.6.
- We visited ward 2 on the 22 May as part of the unannounced inspection. There were two qualified nurses on duty for the night shift, with three health care support workers and a safety support worker. We found 14 of the 28 patients required an enhanced level of supervision (1:1 or 1:3). One patient had absconded the day previously (staff had highlighted this to the matron). The patients were in three separate bays and three side rooms which made adequate supervision challenging.
- During the same visit, ward 8 had planned to have three trained nurses on the night shift but one had been moved to MAU. They had five patients requiring NIV overnight and two patients with acute chest drains.
- Ward 14 was a surgical ward which had a significant number of medical patients during the inspection. We reviewed their staffing numbers and found for the previous 17 days 12 had reporting staffing levels below their planned numbers. Staff reported being at 'crisis point' due to the acuity of the patients they were caring for.
- The escalation process for staffing involved contacting the designated divisional bleep holder then the Matron of the Day. The site co-ordinator was contacted out of hours. Feedback from managers who carried the staffing bleep said issues often were managed by moving staff from one area to another creating a shortage elsewhere. We also observed the matron and bleep holder working clinically to support with staffing which then created a challenge in completing their other duties.
- Bank and agency staff were used regularly in each ward to fill gaps in staffing. Issues were reported on each ward over the reliability of agency staff and that often they did not arrive for shifts. Staff reported and we observed uncertainty at the start of day shifts and night shifts over what the actual numbers of staff working would be. We observed that this then led to staffing plans having to change as agency staff had not turned up. We were told this was reported to the relevant agencies and managers continued to report when this happened. However, it remained an ongoing issue.
- Between March 2016 and February 2017, within medicine at Dewsbury and District Hospital, the trust reported a bank and agency usage rate of 22%.
- Between March 2016 and February 2017, within medicine, the trust reported a turnover rate of 19% for registered and unregistered nursing staff at Dewsbury and District hospital. For the same time period, staff sickness absence was at 8%.
- Between March 2016 and February 2017, there were 50 incidents reported relating to staffing shortages. The Division of Medicine risk register detailed a risk arising "from the number of nursing vacancies across the Division." The risk description stated the division "does not meet the minimum number of qualified nurses on individual areas." This had been on the risk register since June 2014.
- Nurse staffing concerns were raised consistently in focus groups held with consultants, junior doctors, matrons, allied health professionals, registered nurses, student nurses and health care assistants.
- There was an ongoing programme of recruitment and the matron informed us a recent recruitment day had been very positive. The divisional lead nurse confirmed 13 posts were filled recently and staff were due to be inducted during summer 2017.

Medical staffing

- In December 2016, the proportion of consultant staff reported to be working at the trust was higher the England average and the proportion of junior (foundation year 1-2) staff was lower. Junior doctors gave examples where they had to cover two specialties due to reduced numbers.
- Junior and senior doctor posts were on the divisional risk register. This risk had been identified in June 2014. An update in January 2017 stated monthly reviews of vacancies were taking place and review and revision of the escalation policy was being developed.
- The divisional leadership team reported 21 consultant vacancies across the trust. We reviewed medical staffing data sent by the trust for March 2017 to May 2017. This showed there had been no gaps in consultant cover. Between 42% and 56% of shifts were covered by external locums.

Medical care (including older people's care)

- There were identified 'hot-spots' in acute medicine and gastroenterology. There had been only one gastroenterology consultant for last six months at Dewsbury and District hospital. If they were on leave there was no specialist cover. There was no gastroenterology registrar.
- However, all clinical heads were substantive consultant appointments. Divisional leaders also highlighted challenges in covering middle grades positions. From March 2017 to May 2017, there were between 0.7% and 0.9% unfilled registrar shifts; between 1.4% and 3.6% of CT2/FY2 unfilled shifts and 2.7% and 3.0% for FY1 shifts unfilled. This data was not specific to Dewsbury and District hospital. To support recruitment, the division had appointed a recruitment lead for the division.
- Divisional leaders made consultant job plans a priority. This had seen an increase in 'sign-off' from 20% to 80% in the last 12 months.
- Data from March 2016 provided by the trust showed that they were compliant with daily ward rounds taking place in all medical specialties. The patient records we reviewed corroborated this.
- Between March 2016 and February 2017 the sickness rate and turnover rate for permanent medical staff at Dewsbury and District hospital was 0%.
- The MAU was led by two consultants who were present on the unit from 8.30am to 4.30pm Monday to Friday. From 2.00pm to 8.00pm, there was on call physician of the day present, after this, they were available by phone. At weekends, a physician was present from 8.00am to 8.00pm and on call from 8.00pm.
- Medical cover at night at this site was one registrar and two junior doctors (one Foundation Year One and one senior house officer), supported by the call consultant. The registrar may also be called to the emergency department.
- We visited MAU at 7.45pm where there were nine patients awaiting clerking. We asked medical staff if this was affecting patient care. They gave an example of a patient who had not had their methadone, as it had not been prescribed.
- Ward 14 was a surgical ward had a large number of medical patients (27 on the day we visited). There was no dedicated junior doctor for these patients. Nursing staff reported this could cause delays in getting routine jobs completed such as prescribing intravenous fluids.
- Medical handovers took place twice a day. We did not observe this but feedback from medical staff was that they were comprehensive and highlighted any patients that were a concern.
- We observed a ward round and saw that the medical team involved the patients in the discussions and explained what was happening. It was noted that there was not a nurse present. The medical staff we spoke with said it was usual to not have a nurse present due to their staffing numbers and that sometimes this did cause delays, particularly around patient discharges.

Major incident awareness and training

- The trust had major incident and business continuity plans in place that could be accessed via the trust's intranet. The trust's major incident plan provided guidance for departments and staff.
- Most of the wards had a major incident 'Majax' file on the ward containing information for staff so it could be easily accessed. We checked the contents of the file on ward 15 and found the policies and guidance contained to be up to date.
- Senior managers considered seasonal demands when planning medical beds within the trust.
- The division followed NHS England guidance on the Operational Pressures Escalation Levels Framework (OPEL). This framework supported managers with demand pressures and escalation procedures.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- With the exception of the National Diabetes Inpatient Audit, patient outcome audit results in all areas were significantly worse than expected when compared with other similar services. The trust had six active mortality outliers in which the medical division were involved.
- We lacked assurance that all patients were receiving pain relief in a timely way and care plans for pain management were not in place.
- We found poor documentation in relation to nutrition and hydration, with only 28% of the records we reviewed being fully completed. Issues in relation to the monitoring and assessment of patient's nutrition and

hydration needs had been identified at the previous inspection. A project plan had been put in place to address the issues in April 2016, however there was a lack of progress against this.
- The number of nursing staff and allied health professionals who had undergone an annual appraisal was below the trust target of 85%.
- The endoscopy unit did not hold Joint Advisory Group accreditation on Gastrointestinal Endoscopy (JAG) accreditation.

However:

- Policies and guidelines were evidence based and easy for staff to access.
- We saw lots of examples of good multidisciplinary working across different areas.
- Overall there was good evidence of seven day working clinical standards being met with some areas above regional averages.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) level 1 training figures were above the trust target.

Evidence-based care and treatment

- Policies and treatment were based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. The Ambulatory Care Unit followed standardised pathways for patients with conditions such as suspected pulmonary embolus and deep vein thrombosis.
- The trust policy for non-invasive ventilation was in line with British Thoracic Society guidance.
- The division had developed guidance for the management of sepsis in March 2017 which met all but one of the recommendations for sepsis management.
- Staff accessed policies, procedures and other guidance through the trust intranet. This was easy to navigate. We reviewed five policies and found them to be in date with version control and a named author.
- We saw evidence of local audit activity. Ward managers completed a weekly standards of care assurance framework. This was discussed monthly with matron. It looked at areas such as, nutrition and hydration, privacy and dignity, end of life care and reducing hospital acquired infections. We saw improvement plans for individual wards based on this data.
- The medical division had planned to undertake 18 priority level one audits in 2017/2018 including diabetic ketoacidosis (DKA) and the national audit for oesophageal gastric cancer. This was a reduction from 28 audits for 2016/2017.

Pain relief

- On each of the 19 medication charts we reviewed we saw that pain relief was prescribed. Pain scores were recorded on the software system.
- We were not assured about the assessment of pain for those patients who may not be able to communicate that they were in pain. We did not find from the records we reviewed any care plans related to pain management.
- We reviewed the records of a patient who had been experiencing pain. They had been prescribed a type of benzodiazepine which was prescribed 'as required'. It was recorded in the nursing documentation for the previous two days that this had only been relieving the patient's pain for a short period. There was no evidence of any action taken in response to this, such as involvement of pharmacy/pain specialist/medical team. The patient did not have a care plan for pain management and was not able to verbally communicate their needs.
- Another patient receiving regular analgesia said they were not aware of having their pain levels assessed and that staff did not come back to check if the analgesia had been effective.
- Three of the patients we spoke with who were requiring regular analgesia reported this was given on time and staff came back to check if it had been effective.
- We reviewed data from the trust from the matron's health check audit from April 2016 to March 2017. Bi monthly a 13 point check was done of ten patient records, pain management was part of the checks. The audit looked at pain assessment, care plans and reassessment. Data for the medical wards showed varied results ranging from 0% to 100% compliance.
- Delays in 'as required' pain relief being administered were reported as red flags. Data from the trust showed there had been 14 incidences of this occurring in the months of February and March 2017. The majority of these occurred on ward 6.

Nutrition and hydration

- Following the previous inspection the trust was told they must make improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs were adequately met.
- We reviewed care plan documentation and risk assessments of 18 patients on a number of wards at Dewsbury and District Hospital. There were five records which had been fully completed (28%). We found 13 sets of records (72%) where fluid, food and/or intentional rounding charts were absent, incomplete or only partially completed.
- For example, instructions had been given for hourly urine monitoring for a patient on MAU on the 22 May 2017 at 11.50am. At 6.00pm there were only two entries on the fluid balance chart one at midday and one at 3.00pm. The Mid Yorkshire Hospitals NHS Trust had been flagged as a mortality outlier for rates of acute kidney injury.
- On the 17 May 2017, we reviewed a patient on ward 8 whose fluid balance chart for the day was blank; it was unclear from the care plans if this should have been completed. We also found intravenous fluids and fluids given via nasogastric tubes were often not included on fluid balance charts.
- The Malnutrition Universal Screening Tool (MUST) was recorded on the software system for each of the patients we reviewed. However, some wards were recording this on paper copies as well. MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese.
- We observed meal times on wards 4, 6, 6b and ward 8. Whilst meals were being served staff were given roles of either serving food, helping patients requiring assistance or to deal with any non-meal time related activities such as answering nurse call bells. Due to many wards running below planned staffing levels this system did not work. However, staff told us they were moved to other areas to support patients with their meals.
- Red trays and jugs we used to highlight those patients who needed assistance or closer monitoring of their intake. Ward 8 had introduced a nutrition and hydration board indicated where red trays and jugs were needed any special dietary requirements. This was updated by staff on night duty.
- Protected meals times were not in place on all wards due to flexible visiting times. Some staff felt this should be introduced. However often family members would visit to support their relatives at meal times.
- From the 29 patients we spoke with there were five (18%) who gave negative comments about food. There was a variety of dietary options available. However, feedback from one patient was that there was difficulty in getting a Halal meal and often had to have the vegetarian option. We saw most patients could reach a drink and feedback from the patients we spoke with was that drinks were offered throughout the day.
- The Nutrition and Hydration Improvement Group Project Plan implemented in April 2016 (updated 13 January 2017) provided 31 identified tasks across six domains (initiation, hydration, nutrition, policy, measures/data and learning and sharing). Of 31 tasks identified, ten were reported as being complete. However 17 were reported as 'In Progress', two were reported as 'Not yet started' and one was reported as 'Overdue'.

Patient outcomes

- Between November 2015 and October 2016, patients at Dewsbury and District Hospital had a higher than expected risk of readmission for elective admissions and a slightly higher than expected risk for non-elective admissions when compared to the England average. Elective Medical oncology had the highest risk of readmission from the top three specialties based on count of activity.
- In the 2015 heart failure audit, Dewsbury and District hospital performed worse than the England and Wales average for all four of the standards relating to in-hospital care. They were also worse than the England and Wales average for five of the seven standards relating to discharge.
- In the National Diabetes Inpatient Audit for 2016. Dewsbury and District Hospital scored better than the England average in ten metrics and worse in seven. The indicator relating to 'patients with active foot disease seen by the multidisciplinary foot team in 24 hours had the largest difference against the England average at 0% compared to an England average of 56.1%.
- The division took part in the National Diabetic Foot Audit (NDFA) between July 2014 and April 2016. Overall the report showed 44.7% of patients in the audit had a SINBAD (assessment tool covering the variables of site,

ischemia, neuropathy, bacterial infection, and depth to predict ulcer outcome) score of three or above (compared to 45.6% nationally). The division reported that 12 and 24 week outcomes were better than national average figures.

- In the British Thoracic Society (BTS) Community Acquired Pneumonia (CAP) audit 2015, the division reported variable outcomes. Only 39% pf patients had a senior review within 12 hours (compared to 70% nationally). The service had better length of stay, better in-patient mortality, better time to chest x-ray and antibiotic administration compared to national average figures. The division also reported findings above national average figures confirming diagnosis of CAP within four hours (88% compared to 77%) and x-ray review before antibiotics (78% compared to 61%). There was poor compliance against urinary pneumococcal antigen testing (5% against 60% benchmark).
- The division completed a local NIV audit in 2015. The findings identified good points around appropriateness of NIV usage in all patients, 81.6% success rate against a national rate of 66%.
- The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 1.8%, which was worse the audit minimum standard of 90%. The 2015 figure had been 90.5%.
- The trust also participated in SAMBA. This is an annual national audit of the quality of care delivered by acute medicine and MAUs in the UK. It is focused on four clinical quality indicators which underpin the delivery of acute medical care. The report from May 2017 showed a significant decline from 2015 and compared to the national results. For example, the number of patients admitted receiving a medical review within four hours had reduced from 96% to 26% against a national result of 65%.
- The trust had six active mortality outliers in which the medical division were involved. These were linked to acute cerebrovascular disease, septicaemia, acute and unspecified renal failure, coronary atherosclerosis and fluid and electrolyte disorders.

Competent staff

- Data from February 2017 showed that 76% of nursing staff had undergone an annual appraisal. This was below the trust target of 85%. Only 50% of allied health professionals had undergone an annual appraisal. The target of 91% had been met for medical staff.
- Senior staff reported having to work clinically impacted on the time available to undertake staff appraisals. There were no plans in place to ensure all appraisals were completed.
- There was a comprehensive preceptorship package in place which was tailored for individual staff. The development programme had 89 competencies. We saw evidence of these being completed in staff files.
- At the time of inspection there were no competency documents for nurses who care for patients requiring NIV. We were told there were eight nurses competent in this area on ward 8. They were highlighted on the electronic roster to ensure there was always one of these staff members on duty.
- We spoke with two agency nurses who said their induction had included orientation to the ward and fire safety information.
- We spoke with a new healthcare support worker who had been supernumerary for a week. They reported feeling supported by their peers.
- There were identified 'super users' for the software system who could trouble shoot and provide training for other staff.
- Medical wards (with the exception of the surge wards) provided placements for student nurses. Mentors who had undergone training were allocated to both student nurses and newly qualified nurses to support their learning.
- We were told all substantive medical staff had general Internal Medicine (GIM) training and one of the consultants was the educational and clinical supervisor. The GIM curriculum outlines the competencies needed to allow participation at a senior level and to provide advice on the investigation and management of inpatients and outpatients who have acute and chronic medical problems.
- Junior doctors reported their compulsory reading time was sometimes affected by staffing. This time should be protected and be 'bleep free'. However, we were provided with examples of when they had to return to the wards when there was a patient who was unwell.

Multidisciplinary working

Medical care (including older people's care)

- We observed good multidisciplinary working in the areas we visited. We observed a 'board round' on ward 4 and ward 8 which was well attended by all members of the multidisciplinary team (MDT). We also saw evidence of MDT involvement documented in patient's care records.
- We saw specialist nurses visiting wards to support staff in areas such as diabetes. There were clear internal referral pathways to therapy and psychiatric services.
- The falls team were heavily involved in MDT working the lead attended the Yorkshire falls groups and was a member of the falls practitioner network.
- Discharge teams were based on wards to support discharge planning and an in reach team was available to facilitate early discharge from MAU. Many wards had developed strong links with community colleagues, for example there was a specialist team for those patients being discharged requiring home oxygen or NIV.
- On the haematology unit, voluntary services provided a drop in session once a week to provide advice on finances or just to chat.
- The dementia team had engaged with community colleagues and the local vanguard to share best practice and provide training on dementia initiatives. The team had extended this to include colleagues working in care homes, supported living and intermediate care.
- The surge wards had no dedicated therapy staff which staff reported caused delays.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards. We reviewed evidence against the four priority clinical standards; these being time to first consultant review, diagnostics, interventions and on-going review for the medical division.
- The medical division engaged in the trust seven day service standards audit which was published in September 2016. The review audited 196 case notes of which 139 (71%) were from the medical division.
- 88% of patients were seen by a consultant within 14 hours of admission during the week and 80% at weekends. Overall, this was better than regional and national percentages
- The audit found 98% of patients requiring computerised tomography (CT) and 87% requiring magnetic resonance imaging (MRI) could access this urgently during the week.
- Upper gastrointestinal endoscopy, ultrasound, echocardiography and laboratory tests ranged from 78% to 98%. These rates varied at the weekend with CT and MRI reporting 96% and 58% respectively. The other areas provided a range between 32% (echo cardiology) to 92% (microbiology). Overall, this was better than regional and national percentages.
- Patients had 24 hour access to consultant directed interventions such as cardiac pacing, critical care and thrombolysis for stroke.
- Access to interventional endoscopy and radiology was available with figures in line with regional and national averages.
- Daily and twice daily consultant review figures were better than regional and national averages.
- There was availability of physiotherapy and occupational therapy staff Monday to Friday. At weekends there was a limited service which was provided on a priority of need basis.

Access to information

- Electronic patient boards were used in ward areas. These provided up to date information linked to icons, such as, any patients who were living with dementia or who were diabetic. Estimated discharge dates were also displayed.
- Staff had access to relevant guidance and policies via the trust's intranet.
- Blood results, x-rays and scan results could be accessed electronically.
- Medical staff produced discharge summaries and sent them to the patient's general practitioner (GP). This meant that the patient's GP would be aware of their treatment in hospital.
- Information leaflets were available in ward areas on a variety of subjects. Information about the discharge lounge had been incorporated into a leaflet and shared with the wards to encourage staff to use it, and explain its purpose to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) level 1 training had been completed by 92% of staff within the medical division.
- Mental Capacity Act (MCA) assessments were undertaken by the occupational therapy staff or the

consultant responsible for the patient's care. We lacked assurance that assessments were formally recorded as we did not find any completed assessment forms in patient's records.

- For example, in one patient's medical notes it was recorded that they had been 'aggressive' and the doctor had 'tried to assess capacity but patient disorientated, doesn't have capacity to leave hospital does not understand why she is here'. We found no evidence of a formal capacity assessment being done and this was confirmed with the sister on the ward.
- Deprivation of Liberty Safeguards (DoLS) were completed by nursing and occupational therapy staff and referred to the trust's safeguarding team. We reviewed the nursing records of a patient with DoLS in place. Whilst the appropriate paperwork had been completed, terminology such as 'wander some' and 'pleasantly confused' were used which did not demonstrate the person lacked capacity about their need to remain in hospital to receive care and treatment.
- Staff demonstrated a good understanding of mental capacity and DoLS. We were told and we observed this being discussed during board rounds.
- We observed staff providing explanations and obtaining verbal consent prior to completing procedures.
- Staff told us best interest meetings were held for patients who lacked capacity to make decisions for themselves.

Are medical care services caring?

Requires improvement

We rated caring as requires improvement because:

- We were told and we observed staff shortages impacting wards staffs ability to provide the level of care they would like to. As a result of working under such pressure and time constraints we did observe some care which was not of an acceptable standard. Some patients also reported this was affecting the length of time it took for call bells to be answered.
- Although patients had care plans these did not reflect individual needs and preferences. Additional details were not put in to care plans to guide staff on how to meet the needs of their patients. This was reflected in some of our observations of international rounds comfort rounds.
- 24% of the patients we spoke with were not aware of their plan of care, staff had not explained this to them.
- The number of Friends and Family Test responses was variable. Data for February 2017 showed that percentages for those who would recommend the service were significantly lower for four out of the six medical wards.

However:

- We did receive some positive comments from patients and they recognised how hard the staff were working.

Compassionate care

- We reviewed Friends and Family Test (FFT) data from February 2017 to April 2017 for medical wards at Dewsbury and District Hospital. With the exception of ward 2 and MAU response rates were good, with percentages between 31% and 103%. The trust reported some areas could score over 100% as FFT responses from the discharge lounge were allocated to areas where patients spent most time during their stay. The response rates for MAU and ward 2 were between 9% and 30%, these were RAG rated red.
- The percentages of patients who were likely to recommend were variable. In March 2017 and April 2017 all medical wards at Dewsbury and District Hospital were RAG rated green indicating high numbers of patients who responded to the FFT would recommend the service.
- The percentages for February 2017 were variable with some areas such as ward 4 and the SSU rated red for the percentage of patients who would recommend the service; wards 6 and 8 were amber rated and ward 2 and MAU were rated green.
- There was a risk of not meeting patient expectations and maintaining privacy and dignity identified on the divisional risk register. This was added in February 2017 and related to patients not always being cared for on the appropriate ward.
- Seven of the 29 patients (24%) we spoke with made reference to the long wait in call bells being answered. We did observe two call bells on two wards taking several minutes to be answered.

- We also observed a gentleman in a side room who was on a commode who twice had manoeuvred himself to the door to open it and call for staff to say he needed help. We were unsure if his call bell was out of reach or if he did not know how to use it.
- On ward 6 we observed handover taking place at the nurse's station, confidential information was being discussed in the middle of the ward. We were told this was due to staffing shortages.
- We observed intentional rounding taking place but did not feel patients were always engaged in the process. For example, we observed a staff member calling to a patient in a side room from the doorway 'do you have any pain'. It appeared they didn't want to go in as they would have had to put on PPE as the patient required isolation. The patient could not hear what was being asked, so the staff member called louder repeating the question.
- We spoke with another patient who felt because of their individual circumstances they were treated differently to other patients. They also said they felt afraid to raise their concerns with the staff, as it would further impact upon their care.
- On one ward we observed there was a bay with five patients at risk of falls. There was one safety guardian in the room observing all of these patients. One patient wanted to leave the bay and walk around. The safety guardian repeatedly persuaded them to stay in the room as she had to watch the other patients. The patient was seen to be getting distressed about having to stay in the bay. Whilst we acknowledge patient safety must be maintained if the patient had been able to walk around it may have deescalated the situation. We found nothing in his care plans about what methods could be used to calm him or what actions would cause him distress.
- Staff told us that they sometimes felt unable to provide the level of care they would like due to the staffing pressures on the ward. This was reflected in the NHS staff survey results. Medical care scored 70% against a national average of 80% for the statement; 'I feel able to do my job to a standard I am pleased with'.
- We did receive some positive comments from other patients reporting that they felt safe on the wards. Staff were described as 'lovely' and 'brilliant'.
- Patient dignity was part of the matron's health check audit. There were six parts to this including; patient call bell in reach and patients are warm and clean. The report from April 2017 showed an improving picture within the medical division. The most recent data was from January 2017 and all sections within patient dignity were RAG rated green.
- We reviewed Patient Led Assessment of the Care Environment (PLACE) data relating to Dewsbury and District hospital from January 2016. The hospital scored 75% for privacy, dignity and well-being; this was above the organisation average of 70%.

Understanding and involvement of patients and those close to them

- Each of the 18 sets of patient records and care plans we looked at in detail contained generic pre-printed care plans. None of them contained any additional information specific to the individual patient. The care plans did not inform the reader on how to meet the individual needs of a patient.
- For example; on the 17 May on ward 15 the nursing assessment identified that the patient had Alzheimer's disease, an indwelling catheter and was a high risk for MRSA. The patient was receiving 1:1 supervision; there was no documentation as to the reason for this. There was no further information relating to the catheter, why it was in situ, when it was inserted, what size it was. There was no further information as to why he was high risk of MRSA and no associated care plan or any additional precautions in place.
- On the 17 May on ward 8, we found a patient who had been treated for sepsis. They had required NIV, had also been seen by the dietician as had recently been on the intensive care unit with a 36kg weight loss in a week. The nursing assessment also identified they had an indwelling catheter and chronic leg ulcers. The patient was being nursed on a bariatric bed. Bed rails were in situ however no risk assessment had been completed. There was no evidence a capacity assessment had been completed. There were no care plans for any of the areas identified above and it was unclear when NIV had stopped and the reason why.
- Physiotherapy staff told us they tried to involve family members in initial assessments. They gave an example of taking a patient's wife with them to undertake a stairs assessment to assure them they could safely manage these.
- Data provided by the trust from the Seven Day Services Survey Results: September 2016 showed that the overall

proportion of patients made aware of diagnosis, management plan and prognosis within 48 hours of admission was 54% (97 patients). At weekends this averaged 46%.
- This reflected what we found from speaking with patients. Several reported being 'unclear' about what was happening with them and not involved in their care planning.
- We observed on several wards relatives waiting to speak with staff. Reduced nurse staffing numbers meant some had to wait. We observed and spoke with some relatives who reported getting impatient and wanting to know what was happening.

Emotional support

- We found no care plans relating to the emotional needs of patients. Some of the records we reviewed were for vulnerable patients who had been in hospital for a number of days.
- Staff talked about how they provided support patients who were anxious or upset, and also for relatives of patients who were particularly unwell. Staff said they would like to have more time in such situations but staffing levels did not allow for this.
- The trust had a policy of open visiting for friends, carers and family members. The relatives and patients we spoke with were generally positive about this. However, some patients said there were occasions when visitors would stay until late in the evening which disturbed their sleep. Other reported occasions where there were a number of visitors around one bed which could be noisy.
- All wards had access to link nurses specialising in dementia, learning disability and safeguarding.
- Multi faith chaplaincy services were available on site and staff could access these for patients. Leaflets were also available on the spiritual care offered and how to access support.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Access and flow within the hospital was a challenge. There were a number of medical outliers and there were large numbers of patients being moved at night.
- Additional beds on two wards and two 'surge wards' were open at the time of inspection. This impacted further on nurse staffing.
- There were large numbers of patients attending the endoscopy unit having their procedure cancelled on the day. Data also showed an increasing trend of patients waiting for diagnostic testing within endoscopy, of which 493 had breached the six-week threshold.
- The trust was not achieving the target for delayed transfers of care. In May 2017 the percentage was 5.17% against a target of 3.5%.

However:

- Service planning was collaborative and focused around the needs of patients.
- The average length of stay for elective and non-elective medical patients was below the England average.

Service planning and delivery to meet the needs of local people

- For service planning, senior staff worked with local commissioners of services, the local authority, other providers, GPs and patient groups to co-ordinate care pathways.
- The Mid Yorkshire Hospitals NHS Trust provided services across three hospital sites. There were plans to reconfigure medical services which included planned changes at Dewsbury and District Hospital to better meet the needs of patients.
- The ambulatory care unit was open from Monday to Friday with patient pathways in place for specific conditions.
- The in reach service on MAU was provided from Monday to Friday. We were told they could see up to 200 patients a month. They had no set criteria or age limit and would see any patients with complex needs and support early discharge from hospital if appropriate.

Access and flow

- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for elective admitted pathways for medicine was consistently similar to the England average. Data for January 2017 showed 93% of this group of patients were treated within 18 weeks versus the England average of 89%.

Medical care (including older people's care)

- No mixed sex accommodation breaches had been declared by the trust for this hospital in the 12 month period prior to our visit.
- Between December 2015 and November 2016 the average length of stay for medical elective patients at Dewsbury and District Hospital was 3.0 days, which is lower than England average of 4.1 days. For medical non-elective patients, the average length of stay was 5.3 days, which is lower than the England average of 6.7 days.
- Inappropriate bed moves in elderly medicine had been added to the divisional risk register in February 2017. It stated this could lead to delays in clinical treatment or patient deterioration. The mitigation for this was to plan for better flow management through the day to reduce moves at night. Ward staff and site coordinators told us that there was no 'cut off time' for patient transfers.
- We were provided with data for five of the medical wards from September 2016 to February 2017 in relation to patient moves after 10.00pm. The numbers varied greatly from ward to ward. For ward 4 there were low numbers between one and four each month. For ward 2 they varied from 14 to 18 per month. Ward 6b were between nine and 58.
- Between April 2016 and March 2017, 34% of patients did not move wards during their admission and 66%% moved once or more. The majority (53%) of patients moved once, 10% of patients moved twice and 3% moved three times or more.
- Information provided by the trust from February 2017 to April 2017 showed that the number of medical outliers at this site was between ten and 40 each day.
- This was particularly apparent on ward 14 which had between 27 and 30 medical patients when we visited.
- We did see that outlying patients were being reviewed by medical staff. This was supported by entries in the medical records we reviewed.
- Ward 4 reported having medical outliers on the ward was impacting them being able to repatriate patients from other hospitals who required rehabilitation.
- We visited the discharge lounge who felt they were underutilised. Staff told us they were proactive and visited the wards each morning to identify any suitable patients. The staff were able to assist with discharges and perform tasks such as removing cannulas and completing district nurses referrals.
- Staff reported some patients could be in the discharge lounge for a long time and the two patients we spoke with supported this.
- There were two 'surge' wards open at the time of the announced inspection ward 6b and ward 15. When we returned for the unannounced inspection ward 15 had become the 'medically fit ward'. This had been done to improve access and flow. Any patients medically fit for discharge but awaiting a care package or placement in a care home were transferred here. It was anticipated this would provide more acute beds on other wards for urgent admissions.
- Information from the trust board scorecard from May 2017 showed that delayed transfers of care at trust level were RAG rated red and were 5.17%. The target of less than or equal to 3.5% had been achieved in two out of the last six months.
- Data from March 2016 to February 2017 showed the main reasons for delayed transfer of care at the trust were patient or family choice (43.7%), followed by waiting further NHS non-acute care (14.8%).
- Data for 2016/2017 showed for this site there had been 558 patients cancelled on the day of their endoscopy procedure. Managers were not aware of this at the time of our inspection. We have been told this information was to be added into the endoscopy recovery plan with mitigating actions to be implemented.
- Information from the Integrated Performance Report from March 2017 reported the division had reported an increasing trend (from September 2016) of patients waiting for diagnostic testing. 7,670 patients were waiting of which 493 had breached the six-week threshold. All these patients were awaiting endoscopy procedures.

Meeting people's individual needs

- The wards were accessible for people who used a wheelchair or walking aids.
- Bariatric equipment was available from the equipment pool.
- 'This is me' personal patient passports were available. However, we did not find evidence of them being completed in the records we reviewed. These were a tool to support patients with dementia and with a learning disability by understanding more about them.
- The Vulnerable Inpatient Scheme (VIP) was used by medical wards. This identified any patients who had a learning disability (LD). The LD liaison team had activity

boxes which contained audio and visual equipment, games, colouring activities and sensory activities which supported alleviation of boredom and distraction of patients whilst attempting clinical investigations.

- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs. The trust had a dementia strategy for 2015 to 2018. The vision was to embrace a culture of compassion, dignity and respect by putting the patient first, through collaborative working.
- Dementia awareness training compliance within the medical division had increased from less than 10% compliance in 2014 to over 53% compliance in April 2017.
- The dementia team had engaged with the wider community to raise dementia awareness outside the hospital setting. This included presentations in community settings, pop-up stands at local supermarkets and engaging with community religious leaders including the local mosque.
- Ward areas, for example ward 2, had a table set up for afternoon tea in the dayroom. However further work was needed such as dementia friendly signage.
- We were provided with information from the trust on improving nutrition and the dining experience for patients living with dementia. This outlined simple things which could improve patient experience and try to stimulate a patient's appetite.
- Ward 2 had access to 'Mylife computers'. These were systems to promote patient safety and reduced anxiety and stress.
- Staff on ward 2 had previously had a dining table in two of the bays to encourage rehabilitation and normalise meal times. During our inspection the dining tables had been removed and used as additional bed spaces.
- Translation services were available for people whose first language was not English.
- We saw information displayed on how to communicate with a deaf person and how to optimise poor vision.

Learning from complaints and concerns

- Data from March 2017 showed there had been 13 complaints relating to medical care at Dewsbury and District hospital. We found 100% of these had been acknowledged within three days and 85% had been responded to within 30 days.
- At the weekly quality catch up meeting (16 May 2017), the division reported a total of 78 active complaints. All complaints were allocated to a clinician or patient service manager subject to the nature of the points raised. The majority of these complaints originated from the medicine specialities. Senior staff identified complaint themes to be broadly related to treatment, staff attitude and time to appointments.
- The division also reported 23 active reopened complaints. There were meetings booked or being arranged to discuss the issues with the complainant.
- The divisional governance lead also maintained an Ombudsman tracker. There were currently seven cases listed of which four had been closed as not upheld (3) and partially upheld (1).
- Patient Advice and Liaison Service (PALS) leaflets were available in the wards and departments we visited. However staff said they would always try and resolve any issues at the time.
- Clinical governance meetings were used to discuss complaints and any lessons learnt. Matrons would also share any learning with individual ward areas as required.
- A newsletter for the medical division had been launched in April 2017 this detailed the number of complaints in the division and any themes. It also encouraged staff to ask relatives if they had any queries or concerns to try and address these at an early stage.
- As some wards had not been having regular staff meetings we were lacked assurance that learning from complaints was always shared.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Directorate meetings were variable in their structure and content meaning information was not shared consistently. Consequently learning from incidents was not embedded with all staff.
- We were concerned that the number of new appointments at local leadership level were not able to

fulfil their roles as they were working clinically for much of the time. This meant they lost the ability to assess and seek to improve the care provided on their wards in an objective way.
- We were concerned that some staff did not recognise the importance of following procedures such as escalation when patients became unwell.
- We were concerned that low staffing levels were directly impacting the levels of care provided to patients.

However:

- Staff reported an improvement in the culture with the new management team and felt they were being listened to.
- The risk register was reflective of the risks to the service.

Leadership of service

- The medicine division (included urgent care, elderly medicine and speciality medicine) had a clear management structure defining lines of responsibility and accountability. The division was led by a Clinical Director, a Director and Deputy Director of Operations and a Head of Nursing.
- There were Deputy Associate Directors of Operations and Deputy Heads of Nursing with responsibility for the urgent care and elderly medicine stream and the speciality medicine stream. These were further supported by the respective Heads of Service for elderly care, cardiology and respiratory, gastrointestinal and diabetes, neurosciences and spinal injuries and specialist medicine. Each Head of Service had an aligned Patient Service Manager and Matron.
- The divisional leadership had undergone some changes since the previous inspection with a new senior management team now in post. This included a matron for medicine based at Dewsbury and District hospital. These changes were bringing stability to the division. Any changes were communicated to staff via a weekly blog.
- The leadership team had an understanding of the current challenges and pressures impacting on service delivery and patient care.
- Local leaders on the wards at Dewsbury and District hospital were in very challenging roles. They had limited time to carry out their management roles as they were working clinically due to staffing shortages. Several of the ward managers were new in post which added to the challenge.
- For example, we were concerned that some practices such as health care assistants completing patient assessments and escalation procedures not being followed for deteriorating patients were not been picked up and addressed by ward managers.
- Many of the ward managers had recently been appointed into seconded roles. On ward 8 they reported there had been eight different ward managers in a two and a half year period.

Vision and strategy for this service

- The divisional strategy reiterated the organisational mission 'to provide high quality healthcare services and to improve the quality of people's lives' to achieve 'excellent patient experience every time'.
- Divisional managers had progressed the strategy into a '12-point plan' which formed the basis of the divisional objectives. This broadly mirrored the trust core values addressing issues such as performance and standards, staff engagement, reducing patient harms and improving services.
- The vision and strategy for the medical division at Dewsbury and District hospital was focused around the reconfiguration of services. The trust and been an active participant in West Yorkshire Accelerator Zone. This was focused on urgent and emergency care and partnership working across the area.
- The matron was working towards making the site an attractive place for staff to work to improve recruitment and retention.
- The trust's values were high standards, caring, respect and improving. The trust also had a set of behaviours aligned to each of these. Staff were aware of the overall trust values and behaviours and the importance of being patient focused.

Governance, risk management and quality measurement

- The division had clear governance channels into the wider organisational executive management structure. The Risk and Clinical Executive Group and the Quality Committee reported to the trust board. The medical division had a designated governance lead with multi-specialism clinician input.

Medical care (including older people's care)

- We reviewed monthly divisional and specialist services clinical governance and NCEPOD meetings. The agenda framework varied across specialisms. However, they broadly covered the same topics such as patient safety, patient experience, risk management, clinical guidelines and audit, mortality and morbidity reviews and workforce issues. It was noted a number of agenda items were not discussed or minuted in some specialities.
- The Division of Medicine Governance Group highlighted concerns about the absence of key members from the meetings, therefore meetings were not always quorate. The group had logged this as an action. Some specialisms therefore did not provide an update for their clinical area.
- We attended the weekly quality catch-up meeting attended by the Head of Nursing, Assistant Heads of Nursing and Governance Lead. This meeting discussed reported incidents, themes and trends, serious incident investigations, the incident reporting backlog and complaints.
- They also recognised areas of good practice and quality improvement by way of a challenge award. This meeting preceded the Divisional Quality Improvement group meetings also held weekly where key quality and safety items were considered such as pressure ulcers; falls and the team considered SIs and root cause investigation findings. The outputs from this meeting fed into the Assurance Panel and Corporate Improvement Group.
- The divisional clinical director attended monthly meetings with Heads of Departments which were linked cross-site by way of teleconferencing facilities. There were monthly clinical meetings with other clinical directors and the medical director.
- We were provided the divisional risk register dated 22 March 2017. This was described as a live document with on-going review, actions taken and progress. Of the 60 current risks listed across the division in the March 2017 update, there were 18 risks which attracted a rating of 15 and above categorised as 'Major to Catastrophic'. These related to service provision, patient safety (falls, infection risks, care of outlying medical patients, management of extra-capacity in-patients, delay in identifying patient harm and delay in learning from incidents), nurse and medical staffing and not meeting financial plan. The top three scoring risks with a rating of 20 related to a risk of not providing the hyper-acute stroke service, a reduction in HIV service provision and JAG accreditation for endoscopy services.
- Three risks were specific to Dewsbury and District hospital. These related to staffing on the SSU, ligature risks and absconding patients. These risks had been on the register since 2013. They had been reviewed in February and May 2017 and the risk scores had reduced with mitigating actions in place.
- However, other entries on the risk register dating back to 2013 remained current concerns for the division. There was evidence of on-going review for those risks which had remained on the register for a longer period of time.
- The risk register was reflective of the risks identified during our inspection from observations and speaking with staff. Whilst there was a process for escalating staffing concerns we were not assured this was sufficient to maintain patient safety. As described in the safe domain there were several concerns identified which could be directly attributed to reduced staffing numbers. We observed the wards being busy with staff working under increasing pressure due to staff shortages. Medical staff also reported, and we saw that nurses were not present on ward rounds. This could result in the nursing staff not being fully aware or up to date regarding patient's plans of treatment and care.
- Concerns over staffing levels were raised at the time of inspection; the staffing plans put in place were not achieved. We lacked assurance over the validity of the actual staffing numbers as the electronic rostering system was not 'live' and did not capture staffing moves when we reviewed rotas. Additional beds being open and two 'surge' wards added to the problems with nurse staffing.
- This was supported by commissioners who highlighted the prolonged use of additional capacity beds and impact on nurse staffing.
- We were concerned that the clearly defined escalation process for patients with a raised NEWS score was not always followed. Ten out of 15 patient's records we checked with a NEWS score of four or more had no evidence of the escalation process being followed. We were equally concerned that when this was raised with senior nurses on the ward, on two occasions further escalation was required as we were not assured immediate action would be taken.

- In the Division of Medicine risk register created it identified "inappropriate bed moves" as a concern and confirmed patient flow processes are under regular review. We were told and we found evidence of a number of patient transfers taking place after 10.00pm. Numbers varied from three to 58 per month on the medical wards at Dewsbury and District Hospital.
- There was a backlog of incidents awaiting investigation. The recovery plan for incidents was reliant on band 7 nurses who were already stretched and working clinically for the majority of their shifts. A backlog of incidents had also been highlighted at the previous inspection.

Culture within the service

- Staff we spoke with described a hardworking and committed culture but one where staff were feeling the pressure of a prolonged period with severe staffing shortages. Staff also felt they were not always able to provide the care they wanted for their patients; however this had become the norm. As a result there was felt to be an acceptance of poor care amongst some staff.
- Staff did report a positive change with the change in management. They spoke about 'things getting done quicker' in relation to the reconfiguration of services and staff felt more informed.
- Staff reported small gestures such as boxes of chocolates and being told 'thank you' made them feel more valued.
- All staff reported that managers were approachable and they felt they could escalate any concerns. Staff said they felt their concerns were listened to but remained concerned over staffing shortages. They were also concerned about the level of support for new staff nurses to ensure they remained at the trust.
- Some junior doctors spoke about been reduced to tears by the way other staff including nurses and consultants had spoken to them which was a concern.

Public engagement

- We saw leaflets in ward areas encouraging feedback, both positive and negative, from patients.
- Wards displayed feedback from patients and improvements they had made in response to this. This was called 'listening to you'. This formed part of the patient, family and carer experience strategy.
- We did not see this information displayed on every ward and some did not have a date displayed so it was not clear how recent the feedback was. For example on ward 15 information displayed on the quality board said; you told us, 'meals' followed by; improvements made, 'menu choices given'.
- Ward managers were very visible on the wards. The nurse in charge was identified by a badge; this meant patients and relatives knew who to speak to.
- The falls team had produced a leaflet for patients on 'six simple steps to keep yourself safe in hospital.' This included advice such as wearing good fitted shoes.
- The falls team had also built relationships with Age UK, Well-being Wakefield and St George's Crypt to prevent the patients who are frequent fallers being admitted to hospital. This was done by increasing patient/public awareness about fall and falls prevention in the community.

Staff engagement

- The feedback from the staff we spoke with was that staff engagement was much better with the change in senior management. Senior managers communicated to staff through the trust intranet and blogs.
- All of the staff we spoke with felt confident in raising concerns, however they were not always sure action would be taken. This was because most of the concerns related to staffing shortages.
- The division had celebrating success awards to recognise the contributions of individuals or teams. Details of this were shared as well as any good news stories via a newsletter.

Innovation, improvement and sustainability

- A 'MYLife computers' was donated to ward 2, this system promoted patient safety and reduced anxiety and stress for patients living with dementia.
- The trust is part of the future hospitals programme which won an innovation in healthcare award
- Medical wards have participated in ward accreditation schemes and improvement planning.
- Wards had implemented safety huddles to identify any patients at risk to ensure appropriate plans could be put in place.

Surgery

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

Information about the service

Dewsbury and District Hospital provided elective and day case surgery for colorectal, ENT (ear, nose and throat), ophthalmic, oral and maxillofacial, orthopaedic, urology, general and vascular surgery.

During this inspection we visited surgical wards 12 and 14 and the day surgery unit. We visited all theatres on site and observed care given and surgical procedures undertaken.

We spoke with 22 patients and relatives and 24 members of staff. We observed care and treatment and looked at 12 care records.

Summary of findings

The overall surgery rating from the 2015 inspection was 'requires improvement'. Actions the trust were told they must take were:

- Ensure there were systems in place to identify themes from incidents and near miss events.
- Ensure all theatres were monitoring compliance with the five steps to safer surgery.
- Ensure all staff understood the process for raising safeguarding referrals (in the absence of the safeguarding lead).
- Reduce and improve readmission rates.
- Ensure there were clear risk assessments in place for situations where practice deviates from the guidance.
- Continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

During this inspection we rated surgical services at this hospital as 'good' because:

- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels and staffing guidelines with clear escalation procedures were in place.
- The proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.

Surgery

- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- We saw evidence that Root Cause Analyses (RCA) of serious incidents were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- The Friends and Family Test (FFT) response rate for the hospital was better than the England average (29%) patients who would recommend the hospital was higher than across the division.
- The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
- The division completed network meetings which were also held with neighbouring trusts from Sheffield, Huddersfield and Leeds for hip and knee replacements, upper limb and foot and ankle work.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity.
- The trust had developed a joint 'Planned Care Group' with the Clinical Commissioning Group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- A trust-wide patient experience plan project had been developed which looked at elements of patient care.
- The division handled 97% of complaints within trust timescales (95% target).
- There were clear governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- Leadership at each level was visible, staff had confidence in the leadership and staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.

However:

- Medical staff did not reach the trust 95% target for mandatory core training completion, this included safeguarding.
- NEWS audits in March 2017 showed that 59% of observations are recorded as prescribed/indicated by the mobile electronic system used for monitoring vital signs, down from 67% in the previous audit cycle. The key reason for reduced compliance was observations being overridden without a set of observations being undertaken at time of the override.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.
- The proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.
- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- The surgical site infection (SSI) rate was zero (April 2016) for total hip replacements at the hospital.
- The division held regular emergency surgery and elective care business unit meetings where serious incidents (SIs) were discussed, investigations analysed, and changes to practice identified.
- We saw evidence that Root Cause Analyses (RCA) investigations of SIs were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- We observed the 'Five Steps to Safer Surgery' checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.

However:

- The qualified and unqualified nurse vacancy rate at this hospital was 19% (February 2017). National and international campaigns were in place to address the recruitment gap.
- Medical staff did not reach the 95% target for any of the trust's core training including safeguarding.
- Across the division, NEWS audits (March 2017) showed that 59% of observations were recorded which was worse than the 67% compliance rate in the previous audit.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division.

Incidents

- In accordance with the 'Serious Incident Framework 2015', the trust reported five serious incidents (SIs) in surgery between March 2016 and February 2017, which met the reporting criteria set by NHS England. Of these, the most common type of incident reported was 'Medical equipment/ devices/disposables incident meeting SI criteria' with two of the five incidents.
- We saw evidence that Root Cause Analyses (RCA) investigations of Sis were comprehensive and highlighted immediate actions taken, chronology of events, findings, care and delivery problems, root causes, recommendations, lessons learned and action plans.
- Staff told us how they reported incidents through the electronic system and said learning was shared through ward meetings, safety huddles, team briefings, and handovers. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.
- Matrons and ward sisters had an overview of every incident, complaint and concern and operated a system of response and feedback to patients and staff. Evidence of this was documented in minutes of clinical governance meetings.
- Duty of candour is a process of open and honest practice when something goes wrong. We saw that legal requirements were explicitly stated within trust policies, intranet guidance, and training.
- Staff were aware of the duty of candour Regulations. There was e-learning and written paperwork for staff to follow. We saw evidence of duty of candour carried out and staff were able to identify action they would take.
- All relevant staff attended mortality and morbidity meetings in all specialities to review case notes with joint surgical and anaesthetic reviews and reflective practice. Specialties also discussed cases at governance half-day meetings.

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Between March 2016 and February 2017, the trust reported one incident, which was classified as a 'Surgical/invasive procedure' never event for surgery. There was evidence of trust wide learning recorded in minutes of surgery ward meetings, clinical governance minutes and directorate operational team meeting minutes.

Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information.
- Trust-wide data showed that the surgical division reported 16 new pressure ulcers, seven falls with harm and eight new catheter urinary tract infections between February 2016 and February 2017. There had been no more than one fall per month in surgery and there had been no new catheter urinary tract infections since September 2016.
- Venous thromboembolism (VTE) screening audits showed assessment compliance was 98% (January 2017), above the target of 95%.

Cleanliness, infection control and hygiene

- The trust had policies in place for aseptic techniques, patient transfers, hand hygiene, clostridium difficile infection (C difficile), Methicillin-sensitive Staphylococcus aureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA). These were available on the trust intranet.
- The division reported one incidence of MRSA and seven incidences of MSSA between March 2016 and February 2017.
- Nine cases of C. Difficile were reported in the same period. However, five of these cases were non-trust acquired.
- The surgical site infection (SSI) rate was zero (April 2016) for total hip replacements at the hospital.
- Infection control audits were completed each month and monitored compliance with key trust policies such as hand hygiene, 'bare below the elbow', catheter and cannula insertion and on-going care.
- Hand hygiene and 'bare below the elbow' targets (98% compliance) were met for all wards between March 2016 and February 2017.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. These showed 100% compliance with clean commodes, hand hygiene, cannula and catheter audits.
- We observed staff washing their hands and all patients we spoke with confirmed this was done. Hand gel was available throughout the hospital and at the point of care. Staff used personal protective equipment (PPE) compliant with policy.
- Wards and surgical areas had daily, weekly and monthly cleaning schedule for domestic staff, housekeepers and nursing staff. We observed clean equipment and completed cleaning records throughout surgical areas.
- Clinical and domestic waste disposal and signage was good and we saw staff disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.

Environment and equipment

- All wards and surgical areas were uncluttered and in a good state of repair. All surgical areas had storeroom capacity which was easily accessible and tidy.
- We inspected resuscitation trolleys, suction equipment on wards, and found all appropriately tested, clean, stocked and checked as determined by policy.
- We saw compliance with trust policy 'Portable Electrical Testing of Equipment' to fit a dated label of the test to the equipment tested.
- All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips and falls. Risk assessments included types of hazard and likelihood of occurrence, quality and condition of flooring, maintenance and cleaning procedures.

- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2016). The results showed the surgical division scored 97.4% on the cleanliness and 94.7% for the condition of the environment.

Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks. Audits were carried out by the wards and pharmacy.
- All medication was prescribed and administered in line with the trust policy and procedures. Pharmacists liaised with the ward team regularly. We found allergies clearly documented. We checked records at random and found all correctly completed.
- Medicines requiring refrigeration were stored securely, with maximum and minimum temperatures recorded in accordance with national guidance. Staff had been trained in the use of the recently introduced automatic electronic recording system.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- There were 108 medicines related incidents recorded between March 2016 and February 2017 across the surgical division. These were reported through incident reporting procedures and resulted in increased training and learning for teams and individual members of staff.

Records

- We looked at 12 sets of patient, medical and nursing records on the wards and theatres at the hospital. We saw they were complete, legible and organised consistently. Records were signed and dated, clearly stating named nurse and clinician.
- All records reviewed included a pain score and allergies documented in the notes.
- Patient notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection.
- Appropriate risk assessments were completed accurately for falls, pressure ulcers National Early Warning Scores (NEWS), sepsis screening and malnutrition. Staff were aware of escalation procedures.
- Daily entries of care and treatment plans were clearly documented and care plans had observation charts and evaluations, with consent forms and mental capacity assessments where necessary.
- We saw good examples of detailed and complete preoperative checklists and consent documentation in patient's notes.
- Theatre and anaesthetic notes in all post-operative files were comprehensive and detailed.
- We reviewed handover sheets used by ward staff and found documentation was effective in communication and decision making for those patients at risk of deterioration.

Safeguarding

- Safeguarding information was shared with the patient safety panel on a fortnightly basis with regular feedback received and disseminated to all teams trust wide. Safeguarding updates were discussed at ward rounds and safety huddles.
- We found that staff within the division understood their responsibilities and discussed safeguarding policies and procedures confidently and competently.
- Staff felt safeguarding processes were embedded throughout the trust. The trust advised that they had increased ward visibility of the safeguarding team to ensure access for support and assistance for staff.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.
- Within the division compliance rates for nursing staff for Safeguarding Adults Level 1 (96%) and Safeguarding Children Level 1 (96%). Data showed 81% of nursing staff had completed Safeguarding Adults Level 2 and 79% had completed Safeguarding Children Level 2. The division did not meet the compliance target for Safeguarding Children Level 3 (67%) – one member of staff had not completed training.
- Medical staff in the surgical core service did not reach the 95% target for mandatory safeguarding courses.

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness,

infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%. Mandatory training for nursing staff had met compliance targets across the division in manual handling, Mental Capacity Act (MCA) Level 1 and health and safety. The lowest compliance figures were for resuscitation training (77%) and fire safety (77%).

- At this hospital we were given data that showed compliance with mandatory and statutory training at 100% and that 90% of staff had received an appraisal within the last twelve months.
- Medical staff in the division did not reach the target (95%) for any of the trust's core mandatory training. Mandatory training for medical staff had not met compliance targets across the division in, for example, resuscitation training (45%), medicines management level 2 (65%), information governance (57%), MCA Level 1 (90%).
- We interviewed managers within the division who outlined local and divisional plans to address low compliance rates with mandatory training. These involved identifying time and resources to encourage staff to address shortfalls in their training as well as identifying alternative ways to access training.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and by face to face training. Although staff confirmed they were up to date with mandatory training, they felt this was being impacted by staff shortages.
- Staff said they were supported with professional development through education and revalidation and that they had robust induction, mentorship and preceptorship programmes.

Assessing and responding to patient risk

- The trust had recently introduced the NEWS risk assessment system for recognition and treatment of the deteriorating patient. NEWS audits in March 2017 showed that 59% of observations were recorded which was down from the previous audit (67%).
- The audit also showed that of those patients whose care was escalated, 86% of those patients had been escalated appropriately or had a plan in place.
- We saw that the completion of NEWS audits had been raised through meetings and communication books on wards. Ward managers told us they were talking to staff members on a team and individual basis to raise compliance with NEWS audits.
- The trust have been flagged as a mortality outlier for rates of septicaemia. The target is 90% for both emergency and inpatient settings for patients to be screened for sepsis, as per the national CQUIN guidance. The Trust achieved 98% for inpatient areas in 2016/17.
- An extensive awareness campaign had been launched to advertise use of the new sepsis screening documentation in December 2016.
- A trust audit (November 2016) showed 97% compliance with the 'Five Steps to Safer Surgery' for the team brief before surgery. The audit also showed 91% 'time out' opportunities taken by all members of the theatre team to stop and listen to patient safety information. Debrief was recorded at 98% attendance rate.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patients' nutritional needs. Pain scores and diaries for patients were available.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, falls stockings, symbols to identify risk on display boards and nurse call system in reach.
- Ward managers, matrons and managers in surgical wards and areas were available and visible and involved in supporting staff and addressing issues.
- Risk assessments, handover processes and safety briefs were observed and we saw all staff worked and communicated well as a team. We observed 'risk approach' handover sheets used by ward staff and escalation plans were effective in decision making for patients at risk of deteriorating.

Nursing staffing

Surgery

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- The division reported a nurse vacancy rate of 3.4% on inpatient wards and 9.4% for health care assistants. The vacancy rate within theatres was much higher at 20% for nurses and 25% for operating department assistants.
- The qualified and unqualified nurse vacancy rate at this hospital was 19% (February 2017). National and international campaigns were in place to address the recruitment gap.
- The division reported a qualified and unqualified nurse sickness rate of 6% (February 2017) at this hospital.
- Between March 2016 and February 2017, the division reported a bank usage rate of 12% in surgical care and 13% at this hospital. The average 'fill rate' was 90% for nursing staff and 100% for health care assistants. The trust had an established staff 'bank', which provided cover for short notice requests.
- The trust reported a turnover rate of 13% for all staff groups in the surgical division (February 2017) and 20% at this hospital.
- The average divisional 'fill rate' was 90% for nursing staff and 100% for health care assistants. The trust had an established staff 'bank', which provided cover for short notice requests. Local information (Ward 14) showed lower average 'fill rates' for both nursing staff (day 74%, night 89%) and for health care assistants (day 80%, night 86%).
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours by senior nurses with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On all wards inspected, actual staffing levels were in line with those planned. An advanced nurse practitioner was present on every shift.
- The division collected acuity data daily using an electronic application to identify how many patients are at specified levels of acuity. 'Red flags' indicated concerns such as falls and the inability to respond to patients due to staffing levels.
- Staffing levels were checked daily by a ward manager and supported by a matron. This information was recorded centrally, and helped inform decisions to support wards where staffing was depleted.
- Staffing reviews were carried out annually, based on data from available systems and on clinical judgement based on activity and demand. There was a process in place for reassessing staffing levels when services changed.
- The trust aimed to staff areas on a ratio of one qualified nurse to eight patients with a co-ordinator outside of these numbers. At the time of inspection the trust was moving towards "Care Hours per Patient Day" as a more informed methodology for providing care at peak times of demand.
- Although, most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts.
- Staff told us the processes in place to move staff to other wards and departments to ensure safe staffing levels caused anxiety over experience and suitability. During the inspection we saw medical 'outliers' on surgical wards, staff said this added to their workload and anxiety. Staff expressed concern over the lack of medical cover for medical patients over 75 years of age placed on surgical wards.

Surgical staffing

- In December 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was higher than the England average.
- As at 28th of February 2017, the trust reported a vacancy rate of 8% in surgical care. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing.
- Over the same period, the division reported a turnover rate of 6% and a sickness rate of 1%.
- Locum usage in theatres between January 2017 and March 2017 was highest in anaesthetics with 981 shifts filled by locums across the trust. A further 921 shifts were covered by locum staff across the trust for all other specialities in the same period.

- Consultants and junior doctors were available for handovers, ward rounds and MDTs. Staff had good relationships with senior surgical doctors and consultants.
- Consultant led surgical handovers took place daily at the hospital in private areas to maintain confidentiality and systems and policies were in place for escalation of a deteriorating patient.

Major incident awareness and training

- The trust had major incident and business continuity plans in place that included protocols that included deferring elective activity to prioritise unscheduled emergency procedures. Major incident plans were reviewed and updated annually.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response. There were business continuity plans for surgery and senior staff were able to explain these during interview.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.
- Potential risks were taken into account when planning services and consideration given at daily safety huddles regarding seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.
- The impact on safety when carrying out changes to the service and staff, was assessed and monitored through robust, embedded assessments, staff engagement and ongoing service monitoring.
- The trust had centralised acute surgery on the Pinderfields site and to comply with the NHS England Emergency Preparedness Resilience and Response Framework had undertaken a review of the service reconfiguration to ensure it was able to comply with its category one EPRR requirements under the Civil Contingencies Act.

Are surgery services effective?

Good

We rated effective as good because:

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- The surgical division prioritised 33 level one clinical audits covering a range of specialties. Outcomes from each audit were reported to the trust's quality panels and directorate operational team meetings.
- The trust undertook patient satisfaction surveys in relation to pain management which showed that overall patients were happy with their pain management and associated support, information and guidance.
- Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against national patient outcomes and to maintain standards.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- Enhanced recovery pathways were used for patients and ensured patients were escorted through the care pathways and ensured each patient received continuing care, including preoperative assessments, perioperative admission and postoperative discharge and follow up.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.

Surgery

- The surgery division took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- During the previous year the division prioritised 33 level one clinical audits covering a range of specialties. Outcomes from each audit were reported to the trust's quality panels and directorate operational team meetings.
- The Trust was not eligible for the National Vascular Registry (NVR) audit.

Pain relief

- Patients told us they were regularly asked about their pain levels, particularly immediately after surgery. We saw this was recorded in patient notes on a pain scoring tool that was used to assess patients' pain levels.
- Following an audit of pain management in the recovery room, the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief had been put in place.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the 'Friends and Family Test' and directly from patients.
- Staff asked patients regularly if they had any pain, so they could administer analgesia promptly.
- A pain link nurse had been identified and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- Each ward maintained good links with the pain management team. All patients we spoke with reported their pain management needs had been met.
- A dedicated pain team was accessible to educate staff on new equipment and medications. The pain team visited patients with PCAs the day after surgery. Anaesthetists provided support with pain relief as required.
- The trust undertook patient satisfaction surveys in relation to pain management. The trust reported that 129 surveys were completed (2016) and showed that patients were happy with their pain management and associated support, information and guidance.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients. Staff identified patients at risk of malnutrition by working with patients and their families to complete a Malnutrition Universal Screening Tool (MUST) score.
- Ward audits confirmed patients received a nutritional risk assessment on admission and a timely review. We saw appropriately completed fluid balance charts and dietary intake charts.
- The nutritional risk assessment identified the levels at which dietitian referral was recommended. The dietetics service received inpatient referrals and provided input as required. The division had protocols in place for enteral feeding out of hours ensuring patients did not have to wait.
- We saw a range of food choice, meals and snacks for patients who required nutritional support. Patients reported their meals to be good, with a hot breakfast, choice and staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether surgery was in the morning or afternoon.
- We reviewed 12 records and saw nurses completed food charts for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic department.

Patient outcomes

- Between November 2015 and October 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions when compared to the England average.
- Of the top three specialties with the highest activity, General Surgery and Plastic Surgery both have relative risk of readmission higher than the England average for elective admissions.
- At Dewsbury and District Hospital the relative risk of readmission for elective admissions was in line with the England average although general surgery had a higher than expected risk of readmission. For non-elective admissions the overall relative risk of readmission was in line with the England average however oral surgery had a relative risk of readmission of more than six times the England average.

- The Bowel Cancer Audit (2016) showed that 81% (80% in 2015) of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than than the national average.
- The risk-adjusted 90-day and two year post-operative mortality rates were within the expected ranges. The risk-adjusted 30-day unplanned readmission rate was 6.5% which falls within the expected range.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54% which falls within the expected range. The 2015 figure was 58.2%.
- In the Bowel Cancer Audit (2016), 81% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average.
- The risk-adjusted 90-day and two year post-operative mortality rates were within the expected ranges.
- The risk-adjusted 30-day unplanned readmission rate was 6.5%, which falls within the expected range.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54%, which falls within the expected range. The 2015 figure was 58.2%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10.5%. This placed the trust within the middle 50% of all trusts for this measure.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3%, significantly lower than the national average.
- In the 2016 National Emergency Laparotomy Audit (NELA), the hospital achieved an amber rating for the proportion of cases with pre-operative documentation of risk of death and achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames (39 cases).
- The division achieved an amber rating for the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 22 cases and a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively (15 cases).
- The risk-adjusted 30-day mortality for the hospital was within expectations, based on 39 cases.
- The Patient Reporting Outcomes Measures (PROMS) from April 2016 to March 2017, showed three indicators where patients' health improved and fewer patients' health worsened than the England average. Four indicators showed fewer patients' health improved and more patients' health worsened than the England average, and four were in line with the England average.

Competent staff

- The trust provided data that showed 73% of nursing staff appraisals had been completed against a target of 85% (February 2017). The completion rate of medical staff appraisals within the surgical division was 80% (target of 91%). Divisional and action plans were in place to ensure compliance with trust targets.
- Staff told us that the appraisal process was effective and allowed them to discuss developmental and learning objectives agreed between staff and managers. Generic training needs were addressed through the trust and local induction as well as ongoing mandatory training sessions and updates.
- Support was provided for nursing revalidation by identifying expectations and the continued education required.
- Staff felt supported with their training and in maintaining competence. We found staff were encouraged to undertake additional learning when time allowed.
- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge and experience to do their job when they started their employment. A system had been developed to identify the experience level of staff through wearing different uniform badges. Experienced members of staff were gradually encouraged to take on additional role and responsibilities once it had deemed appropriate.
- Simulators had been developed on the Pinderfields Hospital site to allow training for doctors in knee arthroscopy.
- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The division had developed surgical simulators in the trust education centre and a training programme director for regional registrar and junior doctors training had been identified to facilitate the 'Core Surgical Skills Course'.

- The trust will host the Fellowship of the Royal College of Surgeons (Trauma & Orthopaedic) exit examinations in 2018.

Multidisciplinary working

- Twice daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately. Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- We saw a multi-disciplinary approach to assessing, planning and delivering people's care and treatment. Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Staff advised that there were good working relationships with pharmacy staff, that the pharmacy department was easily accessible and additional support available as required. There was pharmacy input on the wards during weekdays and with pharmacy access seven days per week at the hospital.
- Staff explained to us they worked with local authority services as part of discharge planning. We saw that discharge planning commenced at pre-assessment.
- Protocols had been developed for the effective handover of patients when required. These involved the identification of bed availability, NEWS assessment and both verbal, and written transfer of information.
- Ward staff worked closely with the patient, their family, allied health professionals and the local authority when planning discharge of patients with complex needs to ensure the relevant care was in place and that discharge timings were appropriate.

Seven-day services

- A comprehensive transfer plan was in place for deteriorating patients to access emergency care within the trust seven days a week. Consultants were available at all hours on call and attended daily ward rounds over seven days to review new admissions and provide emergency patient care.
- There was access to a full range of diagnostic services across seven days to deliver high quality and efficient care to patients.
- During the inspection, we found that all surgical specialities had 24 hour consultant cover with seven day daytime cover in general surgery, urology, plastics and orthopaedics.
- The hospital ran Saturday clinics to provide joint injection treatment to patients.
- All surgical wards planned to develop 'Keogh ward rounds' to improve seven day working. 'Keogh ward rounds' are consultant-delivered ward rounds providing a structured and consistent opportunity for the multidisciplinary team to review patients' progress, share information and communicate with the patient.
- There were dedicated physiotherapist and occupational therapists available Monday to Friday. There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need.
- Pharmacy services were provided during weekdays from 9am to 5pm from the Pinderfields General Hospital site. The Pharmacy services are also provided on weekends and bank holidays from 9am to 12.30pm from the on-site pharmacy. An emergency drugs cupboard was available for access to medicines out of hours and an on call pharmacist was available for urgent advice and supplies when the pharmacies are closed.
- The elective orthopaedic service operated up to six days of the week. Elective admissions were planned based on consultant availability and complexity of procedures. The trust had plans in place to increase the service with daily extra theatre lists and by extending hours at the weekend.

Access to information

- We saw that risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- Surgical wards utilised an electronic observation monitoring system which allowed immediate access by any other clinician or professional providing care. The system was actively used on all surgical wards.

- We reviewed discharge arrangements and planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. Staff we spoke to stated they were competent using the intranet to obtain information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The division had policies and procedures in place that ensured capacity assessments were completed and consent obtained. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. Patients also consented on the day of procedure.
- We looked at 22 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.
- The trust had policies in place to inform and guide practice around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Information and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- Staff we spoke with were confident in identifying issues about mental capacity and knew how to escalate concerns in accordance with trust guidance.
- MCA assessments were undertaken by the nurse or consultant responsible for the patient's care and DoLS were referred to the trust's safeguarding team. MCA and DoLS assessments were included in risk assessments.
- MCA and DoLS training was delivered as part of staff induction. The divisional completion rate for MCA and DoLS training was 89% at level two and 91% at level three for nursing staff. Medical staff completion rates for MCA level two was 60% and 84% for level three.
- There was access to an Independent Mental Capacity Advocate (IMCA) when best interest decision meetings were required.

Are surgery services caring?

Good

We rated caring as good because:

- The Friends and Family Test (FFT) response rate for the hospital was 41%, which was better than the England average (29%) and higher than the average for the division. The FFT results for patients who would recommend the trust was 97%.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers were available on the wards so that relatives and patients could speak with them as necessary.
- Patients and relatives said they felt involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained procedures and treatment.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- Patient and family feedback was very complimentary. Patients we spoke to said that they were happy with the care they received, that the staff were polite, helpful and that staff took the time to explain the surgical procedure and process.

Compassionate care

- The Friends and Family Test (FFT) response rate for the division was 31%, better than the England average of 29% (February 2016 to January 2017). At this hospital, the response rate was higher than the England average at 41%. The FFT results for patients who would recommend the trust was 97%.

Surgery

- In the Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for 11 questions.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2016). The results showed the surgical division scored 79% for providing privacy and dignity for patients and 66% for dementia care.
- Patients we spoke to said that they were happy with the care they received, that the staff were polite, helpful and that staff took the time to explain the surgical procedure and process.
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- During inspection, we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood and saw staff took the time to reassure and comfort patients.
- Staff spoke to patients as individuals and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people's personal, cultural, social and religious needs, and considered these when delivering care and planning discharge. We observed staff take time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People's privacy and dignity was respected when assisting with physical or intimate care.
- Staff promoted independence and encouraged those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty.

Understanding and involvement of patients and those close to them

- Patients said staff took time to explain procedures, risks and possible outcomes of surgery and after care. Complex information was repeated more than once by different staff so that they understood their care, treatment and condition.
- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan and felt involved in their care. Regular ward rounds gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients and relatives felt involved in their care, due to regular ward rounds with consultants. Staff provided an opportunity to ask questions, and explained patients surgery and treatment.
- We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to take relatives or friends to the consultation.
- The trust offered a 'forget me not' passport of care for patients with dementia or learning difficulty. This was completed by families and carers, telling the staff how to care for the person in their unique way. The trust operated a befriending service across all wards. The befrienders provided social and emotional support, helped with drinks and nutrition, were able to refer to community services and assisted patients with information relating to their discharge home.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs. These care plans were complete in case notes observed on wards and surgical areas. The trust operated a policy of open visiting for friends, carers and family members.
- Psychiatric liaison and dementia support workers were employed by the trust and supported patients as necessary. The trust aimed to screen all patients admitted acutely over age 75 years for potential and actual dementia and delirium.
- All wards had identified link nurses specialising in dementia, learning disability and safeguarding.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.
- The trust's chaplaincy team provided a range of spiritual and holistic support, including regular visits to wards to meet with patients.

Surgery

- The team acted as apoint of contact with the appropriate faith community, provided Christian and Muslim worship and prayers in the hospital chapels and prayer rooms, Holy Communion at the bedside and 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.

Are surgery services responsive?

Good

We rated responsive as good because:

- The trust had made changes to the way services are organised to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care.
- The divisional business plan (2017/18 to 2018/19) supported the implementation of a comprehensive operational plan which delivers the trust strategic aims and links directly with capacity, workforce and financial plans.
- The division held network meetings with neighbouring trusts from Sheffield, Huddersfield and Leeds for hip and knee replacements, upper limb and foot and ankle work.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity.
- The trust had developed a joint 'Planned Care Group' with the Clinical Commissioning Group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- A trust-wide patient experience plan project had been developed which looked at elements of patient care.
- Surgical wards were signed up to the Dementia Friendly Hospital Charter to improve and maintain a dementia friendly environment.
- Surgical wards followed the 'Vulnerable Inpatient Scheme' (VIP).
- The division handled 97% of complaints within trust timescales (95% target).

However:

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.

Service planning and delivery to meet the needs of local people

- The Mid Yorkshire Hospitals NHS Trust runs services across three sites in Wakefield (Pinderfields Hospital), Dewsbury and Pontefract. The trust has made changes to the way services are organised to ensure local people have access to the care they need when they need it, delivered by the most appropriate health professionals.
- In September 2016, the trust made changes to the provision of surgery, concentrating emergency and complex surgery on the Pinderfields Hospital site. This met national guidance of separating planned and urgent care to improve clinical outcomes, access to urgent surgery, improve local treatment for non-complex planned surgery, reduce cancellations, improve surgical cover and reduce infection risk.
- The divisional business plan (2017/18 to 2018/19) supports the implementation of a comprehensive operational plan which delivers the trust strategic aims and links directly with capacity, workforce and financial plans.
- The trust was actively working with Clinical Commission Groups (CCG's) to provide an appropriate level of service based on demand, complexity and commissioning requirements. Commissioners were also involved in annual reviews of the service and discussion had been held with national commissioning groups.
- Advanced nurse practitioners worked on wards, running fracture clinics and holding arthroplasty clinics and also run clinics alongside orthopaedic consultants.
- The trauma and orthopaedic service is consultant led and reviews of all hip and knee replacements are performed during the week in a weekly arthroplasty meeting. Network meetings are also held with neighbouring trusts from Sheffield, Huddersfield and Leeds on a regular basis for hip and knee replacements, upper limb, foot and ankle procedures.
- New ways of working had led to a number of improvements, e.g. reduced post treatment support and reduced waits for patients who required enteral feeding.

Access and flow

Surgery

- The trust had 54,683 surgical spells between December2015 and November 2016. Emergency admissions accounted for 18,777 (34.3%), 30,317 (55.4%) were day admissions, and the remaining 5,589 (10.2%) were elective.
- A pre-assessment appointment was made with the patient before their surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. The use of advanced nurse practitioners reduced the numbers of cancellations and improved patient checks.
- Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust used enhanced recovery programmes to assist in patients recovering from orthopaedic surgery and included the mobilisation of patients on day zero after hip and knee replacement surgery. The MDT worked closely to support recovery and patients were routinely discharged with reduced length of stay.
- There were four beds within the recovery area resulting in some patients being recovered in theatres until a bed became available on the wards.
- We saw that the care and rehabilitation of patients following surgery was particularly effective through the provision of on-going physiotherapy and occupational therapy services.
- A trauma dashboard had been developed to monitor overnight admissions across the division and highlight the need for extra bed capacity. Daily trauma meetings were held to discuss patients and to plan procedures. A database and patient management system for trauma management has been introduced.
- The trust average length of stay for surgical elective patients of 3.1 days (February 2016 to January (2017) and at this hospital (3.2 days) was lower than the England average (3.3 days).
- For surgical non-elective patients the trust average length of stay was 3.1 days in the same period, lower than the England average (5.1 days) and at this hospital it was 3.9 days.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- The latest figures for January 2017, showed 44% of this group of patients were treated within 18 weeks versus the England average of 71%. Over the last 12 months there has been a gradual decline in performance.
- There were no surgical specialties above the England average for admitted RTT (percentage within 18 weeks). Seven surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- RTTs were not met within trauma and orthopaedics (43%, England average 65%), general surgery (61%, England average 75%), urology (74%, England average 79%), ENT (40%, England average 68%), ophthalmology (38%, England average 77%), plastic surgery (66%, England average 82%) and oral surgery (41%, England average 69%).
- The trust developed a joint 'Planned Care Group' with the Clinical Commissioning group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- The National Cancer two week wait target of general practitioner (GP) referral to first appointment confirmed performance was 98% (target 95%) and the referral to breast first appointment confirmed performance was 97.4% (target 93%) between February 2016 and January 2017 across the division
- However, the 62 days from diagnosis to treatment measure confirmed performance was 82.2% and did not meet national targets (85%) between February 2016 and January 2017.
- The hospital had an escalation policy and procedure to deal with busy times. Capacity bed meetings and cross site working was working well to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

- However, across the trust, 726 procedures had been cancelled between January 2015 and December 2016 and 1% of these were not re-scheduled within 28 days. The trust's performance has been consistently better than the England average for the same period.
- Theatre utilisation at Dewsbury and District Hospital ranged from 67% to 132% (October 2016 to December 2016).
- Two consultant led ward rounds were undertaken daily for general surgery to increase discharge and flow.

Meeting people's individual needs

- A trust-wide patient experience plan project had been developed which looked at five elements of patient care including privacy and dignity, sharing information with patients, staff communication with patients and their families, reviewing of patients emotional needs and reducing complaints.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthesia.
- We saw good access and facilities for wheelchair users and disabled bathrooms and toilet access. Signage, lifts and corridors at the hospital had tactile numbers and floor announcements for people with visual impairment.
- The division applied the 'This is me' personal patient passport and health record to support patients with dementia. Plans were in place for all admitted patients over age 75 years to be screened for potential and actual dementia and delirium. There were defined dementia care pathways across all surgical wards.
- Surgical wards were signed up to the Dementia Friendly Hospital Charter to improve and maintain a dementia friendly environment. A dementia lead and two healthcare assistants were in place and provided support and information for staff as necessary.
- Surgical wards followed the 'Vulnerable Inpatient Scheme' (VIP). The VIP symbol was used on the VIP hospital passport. The passport helped alerted staff to additional patient needs and was accessible in patients notes and a VIP sticker was placed above the patient's bed.
- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care.
- There were no mixed sex accommodation breaches over a 12 month period.
- Senior nursing staff were visible on the day of inspection and they reported that the ward manager and matron were available for patients and their relatives to speak to on a daily basis. It was made clear to patients and visitors to the wards who was on duty as this was displayed at the ward entrance.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required and the trust had policies in place covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- There was a system in place for open and individual visiting for relatives and friends of patients.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.
- The trust had implemented the 'Forget-me-Not' scheme across all areas of the division. On discharge home 'Forget-me-Not' fridge stickers would be provided in the community and nursing homes.
- We saw a range of food choice, meals and snacks, safe storage and an additional supply of crockery and cutlery that met the needs of patients with dementia and staff had a good understanding of the nutritional needs of patients in their care.
- Systems were in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.

Surgery

Learning from complaints and concerns

- Within the division 392 complaints had been received since April 2016 and trust data showed 97% of complaints were handled within trust timescales (95% target). Orthopaedic surgery received the highest number of complaints overall (134) across all three sites.
- Complaints were discussed at ward meetings as a standing agenda item. A full report was provided to the Directorate Operational Team (DOT) meeting on a monthly basis.
- Contact details for the Patient Advice Liaison Service (PALS) and Complaints were clearly available. Wherever possible the PALS team would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as good because:

- There were clear governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice were introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible, staff had confidence in the new leadership and felt managers listened to them. Discussions with management teams gave assurance that historic management and clinician divides were no longer an issue.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of pride and teamwork within the surgical division with staff speaking highly of their colleagues. They showed commitment to the patients, their responsibilities and to one another.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary.
- Actions were monitored through audit processes and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.

Vision and strategy for this service

- The trust is in a first wave implementation for the four priority 'Keogh' seven day standards of time to consultant review; access to diagnostics; access to consultant directed interventions; and ongoing review.
- Senior managers had a clear vision and strategy for the surgical division and identified actions for addressing issues. The strategy clearly identified the vision, behaviours and goals for the division.
- Specific objectives had been set for transforming and improving patient care, maintaining safety, developing a workforce for the future and financial sustainability, e.g. review the pre-op assessment process, ensure all staff within the division complete mandatory training and appraisal.
- The vision and strategy had been communicated throughout the division and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Staff told us that the governance framework had greatly improved. We were advised that divisional management meetings, divisional operational team meetings and clinical governances meeting took place each month. The risk register, incidents, complaints and lessons learned were discussed. Matrons disseminated information with ward staff at ward meetings and safety huddles.
- The team were involved in specific strategies, such as service reconfiguration, to meet the challenges within the division and had signed up to the changes to facilitate improvements. Senior staff were motivated

and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Ward managers, senior managers and clinical leads showed knowledge, skills, and experience.
- A clear responsibility and accountability framework had been established. Staff at different levels were clear about their roles and understood their level of accountability and responsibility.
- The surgical division had a risk register, which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. Governance meeting minutes showed risk register were reviewed regularly.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken.
- All senior staff in the service were responsible for monitoring performance and quality information. Measures included complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance. The matrons conducted audits of the ward areas with ward managers to measure quality.

Leadership of service

- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level.
- Clinical management meetings were held weekly and involved service leads and speciality managers. During inspection, this approach was observed and reported to us by all levels of staff.
- Monthly surgical speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- Staff told us the division had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held group discussions throughout surgical wards, theatres and units.
- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Most staff felt that they received appropriate support from management to allow them to perform their roles effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- However, long standing issues regarding the number and acuity of medical 'outliers' on surgical wards and also the uncertainty over the further reconfiguration of services was identified as a cause of concern for some staff.
- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. Management staff told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.
- Most staff described good teamwork within the division and we saw staff work well together. There was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- However, some staff told us they had been working in difficult circumstances over a prolonged period to cover staff and skill shortages. Although, staff were enthusiastic about their work, the service they provided and the trust, staff morale was variable but had increased greatly in theatres with the advertising of new staffing posts.

Public engagement

- The trust engaged the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care provided. Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.
- The NHS Friends and Family Test (FFT) in February 2017 showed 97% of patients would recommend the hospital to family and friends for respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Patients were very complimentary about the care and treatment at the trust.
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Complaints Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.

Staff engagement

- In the FFT staff survey (March 2017), 61% of staff within surgery said they would recommend the trust to friends and family as a place to receive care and treatment. The survey also showed 18% would not recommend the trust as a place to receive care and treatment; this had improved from 24%. The response rate was 22%.
- The survey showed 44% of staff would recommend the trust as a place to work, with 32% not recommending the trust as a place to work.
- We were told that management engaged with the staff more now than in recent years. We saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held staff meetings eight weekly, which discussed key issues for continuous service development.
- All staff were invited to speak with the ward manager and were able to voice their opinions, receive feedback and discuss any concerns.
- Staff we spoke to said they felt appreciated by the ward manager and listened to when they raised concerns. However, they did not feel as strongly when discussing the senior management team.
- Staff reported that most difficulties on the wards and theatre areas were related to staff shortages, which compromised their ability to provide more care and time for patients.

Innovation, improvement and sustainability

- Emergency Surgical Clinics were established in January 2017, which provided an opportunity for admission avoidance for the less acute patient that requires a surgical review. These patients were previously admitted and waited as an inpatient for this service. The service also provided fast track access to diagnostics for the patient e.g. ultra sound and CT scans as well as providing access to theatre lists, which provides 20 hours of expedited operating capacity.
- The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience across the division and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department.
- The trust had centralised acute surgery. All acute surgery has been provided at Pinderfields General Hospital since September 2016.
- The surgical division ran a Saturday service for joint injections. Joint injections under image intensification were removed from theatre and performed as outpatient activity in the dressing clinic to improve efficiency and response times.
- The trust developed and implemented a trauma dashboard for trauma and orthopaedics acute theatres to improve monitoring and flow.
- The urology department had been working with the local Clinical Commissioning Group (CCG) with the aim of keeping patients out of hospital whilst having their treatment.
- There were quality improvement projects within the urology department such as patient support groups, clinical trials and research, one stop clinics, patient direct contact, urology newsletter, safer patient flow pathway, hot clinics, CT/ultra sound access within 24 hours, and nurse led cystoscopes.

Critical care

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

Information about the service

The Mid Yorkshire Hospitals NHS trust provides critical care services at Dewsbury and District Hospital (DDH) and Pinderfields Hospital (PH). The division of surgery manages the service.

There is one critical care unit at Dewsbury and District Hospital. The high dependency unit was closed in January 2017 as the service was unable to staff the unit safely. The critical care unit is a combined level three (patients who require advanced respiratory support or a minimum of two organ support) and level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) unit. It is staffed to care for a maximum of four level three patients and four level two patients. The unit has two bays of three beds and two side rooms.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April and 31 December 2016 there were 200 admissions with an average age of 58 years. Eighty five percent of patients were non-surgical and 15% emergency or unplanned surgical. The average (mean) length of stay on the unit was three days.

The critical care outreach team is a team of consultants and nurses who provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. They also run monthly follow up clinics for patients who have been discharged from critical care. The team is available seven days a week between 7:30am and 6pm.

The critical care service is part of the West Yorkshire Operational Delivery Critical Care Network.

During this inspection we visited the critical care unit. We spoke with two relatives and 10 members of staff. We observed staff delivering care, looked at three patient records and two prescription charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

We rated critical care as requires improvement overall because:

- The service was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) standards in a number of areas, for example, supernumerary nurse staffing, out of hours medical cover and continuity of care and multidisciplinary staffing.
- The service did not collect and review some information in line with GPICS standards, for example, morbidity and mortality and admission to the unit within four hours of referral.
- The environment and facilities did not comply with national standards.
- The unit used cameras to monitor patients in the side rooms. The use of the cameras was not in line with trust policy or national guidance.
- The actual nurse staffing did not meet the planned nurse staffing numbers.
- The service used agency staff regularly and there was limited evidence to support their induction on the unit.
- The service could not provide assurance that staff's training and competence with equipment was up to date.
- The service did not have an audit lead or audit strategy.
- There was limited evidence that the service measured quality, for example, an action plan from the regional network peer review had not been completed and Intensive Care National Audit and Research Centre (ICNARC) data was not routinely reviewed and shared with staff.
- Staff were unable to tell us of a long term strategy in critical care beyond the acute hospital reconfiguration.
- We identified some risks in the service that were not recorded on the risk register, for example, the non-compliance with some of the GPICS standards and national building standards.
- There was no evidence that senior staff had reviewed some risks and their controls had been reviewed.
- The process for the multidisciplinary team and critical care outreach team to receive feedback from incidents on the unit was unclear.

However;

- Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.
- Staff spoke of an open culture and were proud of the team work on the unit.
- Staff understood their responsibilities to raise concerns and report incidents.
- Staff assessed, monitored and completed risk assessments and met patients' needs in a timely way.
- Patient outcomes were mostly in line with similar units.
- Patients and relatives were supported, treated with dignity and respect, and were involved in their care.
- Staff provided emotional support for patients and relatives, for example, at the bereavement group and through the use of patient diaries.
- The service was actively involved in the regional critical care operational delivery network and the acute hospital reconfiguration.
- The follow up to critical care patients following discharge from hospital was in line with the GPICS standards.
- Fifty five percent of staff in the service had a post registration qualification in critical care. This was in line with GPICS minimum recommendation of 50%.

Critical care

Are critical care services safe?

Requires improvement

We rated safe as requires improvement because:

- The service was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) standards in a number of areas, for example, supernumerary nurse staffing, continuity of care from consultants, out of hours medical staffing, and morbidity and mortality reviews.
- The unit did not have regular microbiology input. This was not in line with GPICS standards.
- The process for the multidisciplinary team and critical care outreach team to receive feedback from incidents on the unit was unclear.
- The actual nurse staffing did not meet the planned nurse staffing numbers.
- The unit used agency staff regularly and there was limited evidence to support their induction.
- The environment and facilities did not comply with national standards, we reviewed the critical care and corporate risk registers and could not see evidence that this was recorded as a risk or of any controls the service had put in place. This was not in line with GPICS standards.
- Safeguarding adults and children level two training was worse than the trust target.

However;

- There had been no never events, one serious incident and the incidents reported had mainly resulted in low or no harm. Staff understood their responsibilities to raise concerns and report incidents.
- Systems and processes in infection control, medicines management, patient records, risk assessments and the monitoring, assessing and responding to patient risk were reliable and appropriate.

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The service did not report any never events between March 2016 and February 2017.
- The service reported one serious incident at Dewsbury and District Hospital between March 2016 and February 2017. We reviewed an example of a serious incident report, the investigator had received training in completing investigations and the report identified a cause for the incident, the lessons that should be learnt from the incident, recommendations and an action plan.
- The service reported 389 incidents between March 2016 and February 2017. Of the incidents reported, 93% were classed as no harm and 7% as low harm. Frequently reported incidents were classified as infrastructure (including staffing, facilities and environment) and access, admission, transfer and discharge.
- Information from the National Reporting and Learning System (NRLS) showed that, between March 2016 and February 2017, 99% of incidents were reported within 30 days of occurrence.
- All staff we spoke with understood what to report as an incident and how to report it using the electronic system. They gave us examples of incidents that staff reported on the unit; these matched the themes we saw on the incident report.
- Staff told us they received feedback from incidents that had been reported. Senior staff shared lessons learnt from incidents by email, 'message of the week' and at staff meetings. The nurse in charge shared information from incidents at the safety briefing at the beginning of a shift.
- Members of the multidisciplinary team we spoke with told us they did not attend the safety briefing and did not receive feedback from incidents that had occurred on the unit. We reviewed two sets of minutes from the multidisciplinary meeting and there was no evidence that a discussion of incidents had taken place.
- Senior staff had completed training to investigate incidents and accessed support from managers and other clinicians as needed.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that

person. Staff we spoke with had not had training on the duty of candour but they demonstrated an awareness of the duty and the importance of being open and honest when delivering care.
- The electronic incident reporting system included duty of candour documentation templates.
- The service did not hold critical care specific morbidity and mortality meetings. This was not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Data for the unit from the patient safety thermometer showed the service reported 11 new pressure ulcers, one fall with harm and no new CUTI between February 2016 and February 2017.
- The unit displayed information to staff and visitors about the safety thermometer, however, the results were not dated.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to staff and visitors on the unit.
- All areas on the unit were visibly clean and tidy. All the equipment we observed was visibly clean.
- We observed staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Information provided by the trust showed that 85% of staff on the unit had completed infection control training. This was worse than the trust target of 95%.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the unit had no unit acquired infections in blood per 1000 patient bed days between 1 April and 31 December 2016. This was in line with similar units.
- Information was on display at the time of the inspection that showed it had been 11.2 days since the last reported incident of Clostridium difficile (C.difficile) on the unit.
- Information was on display at the time of the inspection that showed it had been 2012 days since the last reported Methicillin resistant Staphylococcus Aureus (MRSA) bacteraemia on the unit.
- Information provided by the trust showed the unit achieved 100% compliance with the ventilator associated pneumonia audit between December 2016 and February 2017.
- The trust provided completed monthly infection control audits. The unit's overall compliance between December 2016 and February 2017 was 97 to 99%. Areas of lower compliance the audit highlighted were the general environment, aseptic non touch technique and the patients' immediate area. The audits provided did not have an associated action plan.
- The unit had facilities for respiratory isolation.

Environment and equipment

- The unit was secure; access was by an intercom with a security camera.
- The unit provided mixed sex accommodation for critically ill patients in accordance with the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- Staff checked the emergency equipment daily. The records for this were up to date and completed in line with the trust policy.
- There was no evidence that the portable oxygen cylinders were checked regularly. Staff had completed the checklist five times in seven months.
- The unit had a difficult intubation trolley and emergency equipment was available at every bed space.
- Disposable items of equipment were in date and stored appropriately.
- We checked the service dates on 13 pieces of medical equipment; seven were past the service review date.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.
- The environment and facilities did not comply with national standards, we reviewed the critical care and corporate risk registers and could not see evidence that this was recorded as a risk or of any controls the service had put in place. This was not in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

Medicines

Critical care

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- The trust had a central system to monitor medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- We reviewed two prescription charts. The charts were completed in line with trust and national guidance.
- The critical care outreach team used patient group direction to administer fluids, nebulisers and oxygen. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.
- The unit did not have regular microbiology input. This was not in line with GPICS standards.
- Information provided by the trust showed 94% of staff in the service had completed medicines management level two training. This was better than the trust target of 85%.

Records

- Records were stored securely.
- In the three records we reviewed, the nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards.
- In the three records we reviewed, the medical documentation was complete, in line with trust and professional standards. For example, there was evidence of a consultant review on admission to critical care and of daily input from the multidisciplinary team.
- Staff completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient's stay in critical care.
- Information provided by the trust showed 85% of staff in the service had completed information governance training. This was worse than the trust target of 95%.

Safeguarding

- Staff we spoke with were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Information on safeguarding was displayed to staff on the unit.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Information provided by the trust showed 96% of staff on the unit had completed safeguarding adults level one training. This was better than the trust target of 95%. Sixty five percent of staff on the unit had completed safeguarding adults level two training. This was worse than the trust target of 85%.
- Information provided by the trust showed 96% of critical care staff had completed safeguarding children level one training. This was better than the trust target of 95%. Seventy two percent of staff on the unit had completed safeguarding adults level two training. This was worse than the trust target of 85%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training, fire safety and conflict resolution.
- Staff we spoke with told us their mandatory training was up to date and senior staff supported them to attend training.
- Information provided by the trust showed 97% of staff on the unit had completed resuscitation training and 95% of staff on the unit had completed manual handling practical training. This was better than the trust target of 85%.

Assessing and responding to patient risk

- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- The critical care outreach team supported patients stepped down from critical care and reviewed patients alerted to them by emergency department (ED) and ward staff. The outreach team was available seven days a week between 7.30am and 6pm.
- The patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.

Nursing staffing

- Nurse staffing was based on guidance and standards from D16 NHS Standard Contract for Adult Critical care and Guidance for the Provision of Intensive Care Services (GPICS).

Critical care

- The unit displayed the planned and actual staffing figures.
- Information we reviewed during the inspection, showed the unit's establishment for registered nurses was two whole time equivalent (wte) band seven, 8.2 wte band six, and 18.1 wte band five.
- The service had 15 wte vacancies cross site.
- The unit had one wte lead nurse and one wte clinical educator who worked across site. This was in line with GPICS standards.
- The establishment did not allow for there to always be supernumerary coordinator. This was not in line with GPICS standards.
- We reviewed information from the trust board papers on the fill rates for registered nurses. The fill rates on the unit were 75% in January 2017, 80% in February 2017 and 81% in March 2017.
- The trust provided the planned and actual staffing figures for registered nurses on the unit for March and April 2017. The actual number of nurses met the planned number of six on four of the day shifts and four of the night shifts.
- We reviewed the number of actual staff on duty against the dependency of the patients, although the actual number of staff was lower than the planned number the unit always met the minimum ratio of one nurse to one level three patient and one nurse to two level two patients.
- Between March 2016 and February 2017 the unit reported a sickness rate of 7.6%.
- Information provided by the trust showed the agency usage for registered nurses from December 2016 to March 2017 was between 5.5 and 13.8%. This was in line with GPICS standards.
- The unit used an agency that provided critical care trained staff. Agency staff completed a trust induction checklist; however, the unit did not have evidence that a staff completed a local induction on the unit. We reviewed 27 trust agency checklists staff on the unit had completed between December 2016 and May 2017. Twenty one of the checklists were not fully completed.
- Senior staff told us the nurse in charge considered the skill mix of staff on the unit when allocating agency staff to patients.
- Senior staff and the nurse in charge could clearly explain the escalation process they followed if they were unable to staff the unit. They reported that senior managers understood the safety issues and supported them with the escalation process.
- The critical care outreach team had a cross site establishment of 5.1 registered nurses. At the time of the inspection the team did not have any vacancies.

Medical staffing

- Critical care had a designated clinical lead consultant.
- Care was not always led by a consultant in intensive care medicine which was not in line with GPICS standards. A consultant was present on the unit from 8am to 6pm and available out of hours on call.
- Consultant work patterns did not provide continuity of care, at the time of the inspection they worked on the unit one day at a time. This was not in line with GPICS standards. The service planned to move to consultant block working to provide continuity following the acute hospital reconfiguration when all critical care services would be on one site.
- Medical staff covered critical care and ED out of hours; this was not in line with GPICS standards.
- We saw evidence in the patients' record that daily consultant led ward rounds took place which was in line with GPICS standards.
- The multidisciplinary team did not consistently attend the consultant led ward rounds which was not in line with GPICS standards.
- Staff we spoke with told us the unit had a high usage of locum medical staff. The service used regular locum doctors and they would work a day shift on the unit before working out of hours. Information the trust provided showed locum medical staff usage in anaesthetics, not critical care as a speciality; however, over 300 shifts a month in anaesthetics were filled by locums for the 12 months prior to the inspection.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans. The actions described were in line with the trust's emergency preparedness, resilience and response policy.
- Staff knew how to access the major incident and contingency plans on the intranet.

Critical care

Are critical care services effective?

Good

We rated effective as good because:

- Patient outcomes were in line with similar units.
- Care and treatment was planned and delivered in line with current evidence based guidance.
- The number of nursing staff who had an up-to-date appraisal was better than the trust's target.
- Fifty five percent of staff in the service had a post registration qualification in critical care. This was in line with GPICS minimum recommendation of 50%.
- Staff assessed patients' pain, nutritional and hydration needs and met these in a timely way.
- We observed patient centred multidisciplinary team working.

However;

- Multidisciplinary staffing was not in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standards.
- The service could not provide assurance that staff's training and competence with equipment was up to date.
- The unit used cameras to monitor patients in the side rooms. The use was not in line with trust policy.
- Some clinical guidelines were not unit or trust specific.

Evidence-based care and treatment

- The service had a generic critical care handbook which was available to all staff on the intranet. It contained some clinical guidelines and pathways but these were not unit or trust specific.
- The documentation to support end of life care had recently been updated and was in line with national guidance.
- The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital.
- The unit had a pathway to manage tracheostomies in line with the National Tracheostomy Safety Project.
- The physiotherapy delivered care in line with NICE CG83 rehabilitation after critical illness on the unit, however, they did not meet all parts of the guidance, for example, rehabilitation following discharge from hospital was not in line with the guidance.
- The physiotherapy team completed a national rehabilitation outcome measure called the 'Chelsea Critical Care Physical Assessment Tool', a scoring system to measure physical morbidity in critical care patients.
- Senior nursing staff completed the trust's front line ownership (FLO) audits monthly.

Pain relief

- The acute pain team visited the unit and reviewed patients who were receiving pain relief infusions. Staff referred other patients that would benefit from review.
- The records we reviewed showed evidence that staff assessed pain using the trust scoring system and reviewed pain relief regularly.

Nutrition and hydration

- Nursing staff assessed patients' nutritional and hydration needs using the malnutrition universal screening tool (MUST).
- The unit had a protocol for feeding patients who were unable to eat and were being fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.
- A dietitian visited the unit daily. We were informed a speech and language therapist attended the unit when staff referred patients.
- Staff on the unit were supported by a specialist nutrition nurse.
- During our inspection we observed water was available and within reach for patients who were able to drink.

Patient outcomes

- We reviewed the Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 31 December 2016 which showed that the risk adjusted hospital mortality was 1.23. This was within the expected range.
- The ICNARC data from 1 April to 31 December 2016, showed the unit had a 1.6% unplanned readmission in 48 hours rate. This was in line with similar units.

- The ICNARC data clerk worked with clinical staff to collect information the service used for research and audit.
- The critical care outreach team collected activity data and patient outcomes in an electronic database. This showed the number of referrals the team received from the wards and ED and the number of critical care patients staff followed up on discharge.

Competent staff

- Information provided by the trust showed that 93% of staff in the service had an up to date appraisal at February 2017. During the inspection we were shown evidence that this figure was 94% at May 2017. This was better than the trust target of 90%. Staff we spoke with found their appraisal a useful process.
- Information provided by the trust showed that 55% of nurses in the service had a post registration award in critical care nursing. This was better than the Guidelines for the Provision of Intensive Care Services (GPICS) minimum recommendation of 50%.
- The service had one clinical educator to cover both sites. Staff we spoke with told us the clinical educator was not as visible at Dewsbury and District Hospital.
- Nurses completed the national competency framework for adult critical care nurses. The competency framework was not mandatory for staff that had worked on the unit for more than eight years.
- Nurses in the critical care outreach team had completed training to do arterial blood gas sampling and order x-rays.
- New members of nursing staff received an induction onto the unit, were allocated two mentors and had a supernumerary period. Staff who had completed this spoke of the experience positively.
- New nurses to critical care completed a 12 week internal course led by the clinical educator. This included multidisciplinary teaching and simulation sessions.
- There was limited evidence that non-registered staff completed education or development beyond their mandatory training.
- The pain team assessed the competency of new staff using equipment to deliver pain relief infusions. An e-learning package was available for staff.
- The unit had link nurses, for example, in end of life care, equipment, tissue viability and infection prevention and control.
- Training was delivered by key trainers for new pieces of equipment, however, there was no evidence that staff's competency on pieces on equipment was reviewed regularly.
- Staff in the critical care outreach team delivered education in the trust, for example, care of the deteriorating patient, bedside teaching on the ward and provided training opportunities to student nurses, newly qualified nurses and doctors.
- Senior staff had undertaken training in relation to appraisals, sickness and performance management.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit, during the ward round and at the bedside during our inspection.
- There was a lead physiotherapist, dietitian and pharmacist for critical care. However, the level of staffing and skills for these services was not in line with GPICS recommendations.
- Staff we spoke with told us they had access to occupational therapy and speech and language therapy when required.
- We saw in records that when staff made referrals to the multidisciplinary team they responded promptly.
- The unit had a ward clerk and an ICNARC data clerk.

Seven-day services

- A consultant was available and completed a ward round seven days a week.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients' medicines. A pharmacist was available on call out of hours and staff had access to an emergency medication store on site.

Access to information

- Staff could access guidelines, policies and protocols on the trust intranet site.
- Staff we spoke with knew where to access guidelines and policies electronically and were able to demonstrate this.
- Staff were able to access blood results and x-rays via electronic results services.

- Staff completed discharge paperwork for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital.
- A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- Staff we spoke with showed an understanding of the Mental Capacity Act (MCA).
- Staff could access the MCA and deprivation of liberty safeguards (DoLs) specialist nurse for advice and support.
- There was evidence in the patient record that staff reviewed sedation regularly. All patients had a sedation score completed, where appropriate.
- Information provided by the trust showed 100% staff in the service had completed MCA and DoLs training. This was better than the trust target of 95%.
- We observed cameras were used in both of the side rooms on the unit and the images were displayed on a monitor at the nurses' station. Senior staff told us the cameras had been in use since the unit opened and were in place as a safety measure if a member of staff could not be in the room. Staff told us the monitor was turned off or covered during personal care to maintain patients' privacy and dignity. There was no information displayed to patients to inform them that a camera was in use and there was no evidence of staff obtaining consent from patients or relatives to this in the two records we reviewed.
- We informed senior staff regarding our concerns with the cameras and found the use on the unit was not in line with trust policy. Senior staff said they would address our concerns immediately.
- On our unannounced inspection on 5 June 2017 we found the unit displayed signs in the waiting area and the side rooms to inform patients and visitors that a camera was in use. Staff we spoke with told us a standard operating procedure for the use of the cameras was being written. There was no evidence in the patient record of consent to the camera being used.
- Following our inspection the trust provided information to say the need for the cameras on the unit was under review and senior staff planned to remove them from the unit.

Are critical care services caring?

Good

We rated caring as good because:

- Patients and relatives were supported, treated with dignity and respect, and were involved in their care.
- Staff received nominations for awards for their compassionate care.
- Staff provided emotional support for patients and relatives, for example, at the bereavement group and through the use of patient diaries.
- We observed all staff responded to patients' requests in a timely and respectful manner.

However;

- The unit did not have access to psychology input.

Compassionate care

- Thank you cards from patients and relatives were on display. The cards we reviewed all contained very positive comments about the care staff delivered on the unit.
- A visitor's book was available in the waiting area, we reviewed entries made in 2017, all nine comments were extremely positive about the care visitors and the patients had received from staff on the unit.
- We observed curtains being drawn around patient's beds and privacy signs in use when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- During our inspection we observed that all staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- The relatives we spoke with told us they felt patients were safe and well cared for.

Understanding and involvement of patients and those close to them

Critical care

- Relatives we spoke with told us all staff introduced themselves and explained their treatment in a way they could understand.
- Relatives told us they were grateful of the opportunity to visit patients out of hours and also stay in the overnight room if it was needed.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff explaining to patients what was happening during care delivery. Staff we spoke with felt they were able to support patients and relatives and explain their care to them.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff we spoke with told us they received excellent support from the specialist nurse for organ donation. The unit had a lead consultant for organ donation.

Emotional support

- Staff provided the opportunity for a patient diary to be kept in consultation with their relatives. Relatives made entries in the diary during the patient's stay on the unit.
- Staff we spoke with showed a good understanding of and a passion for end of life care.
- Staff invited relatives and family to a bereavement group they held twice a year. Staff read poems, lit candles and invited relatives to write in the bereavement book and share memories. Staff gave relatives a book containing the readings and details for counselling and bereavement support groups.
- The unit was looking to introduce memory boxes to use at end of life for relatives and carers.
- The critical care outreach team provided emotional support for patients on the ward following discharge from critical care.
- Information was available in the waiting area about patient and relative support groups.
- Staff we spoke with felt able to provide support to relatives and visitors as well as to patients and told us this gave them satisfaction in their role.
- The service did not have access to a psychologist.

Are critical care services responsive?

Good

We rated responsive as good because:

- The unit's out of hours and delayed discharge rates were in line with or better than similar units.
- The follow up to critical care patients following discharge from hospital was in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standard.
- The unit had introduced a critical care patient and relative support group.
- Staff took account of, and were able to meet people's individual needs.
- The service was actively involved in the regional critical care operational delivery network and the acute hospital reconfiguration.
- The service responded appropriately to formal complaints.

However;

- The unit did not collect data on admission to critical care within four hours of referral. This was not in line with GPICS standards.
- The unit's non-clinical transfer rate was worse than similar units.
- There was limited evidence the service used themes from complaints and concerns to support learning.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional operational delivery critical care network.
- Critical care provision was flexed to meet the differing needs of level two and three patients.
- The service was actively involved in the acute hospital reconfiguration plans. This involved the relocation of critical care services from Dewsbury and District Hospital to Pinderfields Hospital. At the time of the inspection staff were planning for the move to take place in September 2017.
- The critical care outreach team and allied health professionals provided support to patients on the ward following discharge from critical care.

Critical care

- The critical care outreach team held a monthly follow up clinic. Level three patients who had been on the unit for longer than three days and level two patients who had been on the unit for longer than 10 days were invited to attend the clinic six weeks after discharge from hospital. This was in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standard.
- The unit was piloting a critical care patient and relative support group. Staff involved in the group told us there was good attendance and early informal feedback from patients and relatives was positive.
- The unit had a visitors' waiting area which contained information and leaflets for visitors and drink making facilities. There was a separate room for staff to meet with relatives for private conversations.
- The unit had facilities available for overnight accommodation for relatives.

Meeting people's individual needs

- Staff we spoke with knew how to access translation services for patients whose first language was not English.
- Staff had a picture board they could use to aid communication with patients.
- Staff we spoke with felt confident to care for patients with a learning disability. They gave examples of how they had made adjustments to care and the environment for patients with learning disability. Staff would seek support from the nurse in charge on the unit or the learning disability nurse in the trust if they needed it.
- Staff we spoke with told us they could access equipment to care for bariatric patients. If the patient was undergoing elective surgery the nurse specialist would arrange the equipment preoperatively. Staff we spoke with told us of a serious incident that had occurred as a result of a delay in obtaining bariatric equipment. They were able to explain the lessons learnt from this incident and had not encountered any recent delays in obtaining equipment.

Access and flow

- The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient. The service had an operational policy that clearly explained the arrangements for the operational management of critical care beds within the trust.
- Three records we reviewed for patients showed staff did not record the time of the decision to admit the patient to critical care. The service did not collect data on if the patient was admitted to the unit within four hours of referral. This was not in line with the Guidelines for the Provision of Intensive Care Services (GPICS) standard.
- Bed occupancy had been below the England average at just over 60% occupancy from March 2016 to February 2017.
- The service did not collect information about the number of patients that were ventilated outside of critical care for more than four hours.
- Information provided by the trust showed that no elective operations had been cancelled due to the lack of a critical care bed in the 12 months prior to our inspection.
- The Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 31 December 2016 showed the unit had transferred 1.9% of patients due to non-clinical reasons. This was worse than similar units' rate of 1.2%.
- The ICNARC data from 1 April to 31 December 2016 showed the bed days of care post eight hour delay rate was 1.6%. This was better than similar units' rate of 3%.
- The ICNARC data from 1 April to 31 December 2016 showed the bed days of care post 24 hour delay rate was 0.7%. This was better than similar units' rate of 1.7%.
- The ICNARC data from 1 April to 31 December 2016 showed the out of hours discharge to the ward rate was 3.2%. This was about the same as similar units' rate of 2.9%.

Learning from complaints and concerns

- The unit displayed information on how to make a complaint.
- The unit had received two formal complaints in the 12 months prior to our inspection.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint.
- Senior staff investigated complaints, met with patients and relatives and wrote a letter. We reviewed an example of a response to a complaint and found this included an apology, met the duty of candour requirements and responded to the concerns raised in the complaint.

Critical care

- The service did not keep a log of informal complaints, this meant that themes from concerns raised or informal complaints could not be identified. Staff recorded discussions on a communication sheet in the patient's record.

Are critical care services well-led?

Requires improvement

We rated well led as requires improvement because:

- Staff were unable to tell us of a long term strategy in critical care beyond the acute hospital reconfiguration.
- We identified some risks in the service that were not recognised or recorded on the risk register, for example, the non-compliance with some of the Guidelines for the Provision of Intensive Care Services (GPICS) and non-compliance with national building guidance.
- There was no evidence that some risks and their controls had been reviewed in a timely manner.
- The service did not have an audit lead or audit strategy.
- There was limited evidence that the service measured quality, for example, an action plan from the regional network peer review had not been completed at the time of the inspection and Intensive Care National Audit and Research Centre (ICNARC) data was not routinely reviewed and shared with staff.
- The service did not have a clear approach to quality improvement, for example, informal complaints and concerns were not monitored or used to support learning.

However;

- Leadership of the service was in line with GPICS standards.
- Staff spoke of an open culture and were proud of the team work on the unit.

Leadership of service

- There was a lead consultant and a lead nurse for critical care. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards.
- Staff we spoke with told us the executive team were more visible in the trust.
- All staff we spoke with reported the senior clinical staff were visible and approachable on the unit. Staff felt supported by their team and managers.
- Senior staff had completed leadership and management courses, appraisal and root cause analysis training. They felt their development needs were met and supported by the leadership.
- Senior staff were working across site in preparation for the merge of the critical care units as part of the acute hospital reconfiguration.

Vision and strategy for this service

- The division of surgery had a business plan for 2017/18 to 2018/19; this included divisional objectives that were linked to the trust priorities.
- The senior management team told us their vision was to support services in the trust with a high quality critical care unit and to successfully merge the two critical care units as part of the acute hospital reconfiguration. They were unable to share a critical care specific longer term strategy with us, for example, they felt the vision for critical care was to support other services in the trust by providing a high quality critical care unit.
- Staff we spoke with told us they knew the future of the unit was to close and move to Pinderfields Hospital as part of the acute hospital reconfiguration. They were unable to tell us of a longer term vision or how critical care linked in to the trust's strategy.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. Examples on the unit's risk register included not meeting the standards for clinical education and lack of equipment for rehabilitation on the unit. We did not see evidence that the areas of non-compliance with GPICS or national building guidance was recognised as a risk or recorded on the risk register. Senior staff told us the risk register was reviewed at the monthly divisional management meeting. We reviewed the critical care risk register and found some of the risks were overdue for review. Senior

staff confirmed the risks had not been formally reviewed and they had not updated the controls or action plan on the risk register, however, they felt assured that the risks were mitigated and managed appropriately day to day.
- The service did not have a forum where all the senior clinical staff met to discuss operational and quality issues. Medical staff we spoke with told us they met informally at handover or at other times to share information about the service. The trust provided minutes of the anaesthesia clinical management group meeting where we saw some evidence of discussion of issues related to critical care, however, the attendance was senior management staff with limited attendance by senior clinical staff.
- The service did not have an audit lead or an audit strategy.
- There was limited evidence to show how the service monitored quality and performance, for example, the critical care outreach team did not report formally report their activity or performance outcomes to the senior management team and data from the Intensive Care National Audit and Research Centre was not discussed with senior managers or the clinical teams.
- The service had not benchmarked the critical care rehabilitation service with other units or against National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness.
- We reviewed the West Yorkshire Critical Care Operational Delivery Network peer review report dated January 2017. At the time of the inspection senior staff had not identified an action plan based on the recommendations from the report.

Culture within the service

- Staff were proud of the teamwork on the unit and of the care they were able to give to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- Senior staff were proud of the team that worked on the unit and how they had worked together during a difficult period with a high turnover of staff and changes to skill mix.
- Senior staff were proud of the quality of care staff provided and of staff's communication with patients and relatives.

Public engagement

- The unit displayed thank you cards from recent patients and relatives.
- A 'you said, we did' board was on display in the waiting area. Examples of actions staff had taken were; non-slip mats had been purchased for the bed tables, staff promoted patient diaries to relatives and made sure they were available in the waiting area. Staff in the critical care outreach team shared feedback from patients and relatives who attended the follow up clinic with staff on the unit to help improve the service.
- Staff from the bereavement group sought feedback from relatives and fed this back to senior staff and colleagues on the unit.

Staff engagement

- Staff we spoke with told us communication on the unit was good, they received information by email, at handover and through 'message of the week'.
- Senior staff told us unit meetings were poorly attended; they thought this was due to staffing pressures on the unit. Information was shared by circulating the minutes of meetings by email.

Innovation, improvement and sustainability

- The service was actively involved in the regional operational delivery critical care network.
- A relative nominated the bereavement group for a Kate Grainger award.
- Staff on the unit had been nominated for some trust awards; nominations were on display in the waiting area, one for the team and three for individuals.

Maternity and gynaecology

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides women's services over three hospital sites. Following a service re-design in September 2016, all in-patient and obstetric led maternity services were amalgamated on the Pinderfields General Hospital site from the Dewsbury and District Hospital site. There are two stand-alone midwifery led birth centres at Pontefract General Hospital and Dewsbury and District Hospital, there is also a birth centre based at Pinderfields General Hospital. The Bronte Birth Centre was a newly built facility, which opened as part of the reconfiguration of services in September 2016.

The trust offered a limited range of services for women and families at the Dewsbury and District Hospital, this included, antenatal and gynaecology clinics, antenatal day unit, the midwife led Bronte Birth Centre for women with low-risk pregnancies and planned gynaecology surgery. The trust did not undertake any termination of pregnancy services.

Between September 2016 and April 2017 there were 177 babies born in the Bronte Birth Centre.

In June 2015, CQC carried out an announced focused inspection. We rated safe as requires improvement well led as good. The service was rated good overall.

During this inspection, we visited both antenatal and gynaecology clinics, antenatal day unit, ward 14 (female surgery) and the Bronte birth centre. We reviewed three health care records, three prescription records and spoke with four patients, patient's relatives and 10 staff, including midwives, nurses, student midwives, health care assistants, ward clerks, volunteers and receptionists.

Maternity and gynaecology

Summary of findings

The overall maternity and gynaecology rating from the 2015 inspection was good. Actions the trust were told they must take were:

- Check resuscitation and emergency equipment on a daily basis in order to ensure the safety of service users and to meet their needs.
- Ensure there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

During the May 2017 inspection, we rated the service as good because :

- Following our previous inspection there were robust practices in place to check emergency equipment.
- The service had successful bid for Department of Health Safety training and had allocated the funding appropriately.
- We found good multidisciplinary working between midwifery and medical staff.
- We observed good and friendly interactions between staff, women and relatives.
- The service had a comprehensive business plan, which included plans to increase staffing levels including specialist midwifery posts.
- There was sympathetic engagement with staff and patients around the reconfiguration of maternity services.

However:

- There was a lack of assurance that staff were competent to use medical devices. There was also little assurance that electronic equipment had an annual safety check.
- We were not assured of the competence of staff with regard to basic skills such as cannulation and perineal suturing.
- Midwifery staffing was below nationally recommended levels at 1:32. Following our previous inspection the service reviewed staffing using a recognised acuity tool and this identified a shortfall of 18 whole time equivalent midwives. The service had an agreed plan to fill these posts over three years.
- Community midwifery caseload numbers were above the national recommendations.
- Attendance of community and birth centre midwives at obstetric emergency training was below the trust target of 95% at 86%.
- We found a lack of skills and drills scenarios on the Bronte Birth Centre.
- There was little information for women whose first language was not English, some staff were not aware this could be accessed on the trust intranet system.
- The risk register contained a large number of risks, and many had a review date in the past. This led to concern that the risk register was not appropriately scrutinised.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were unable to tell us where practice had changed as the result of an incident.
- There was a lack of assurance in relation to medical device competencies.
- Data provided by the service showed attendance at mandatory obstetric training for community and birth centre midwives was below the trust target.
- There had not been regular skills and drills in clinical areas including the birth centre, antenatal clinic and antenatal day unit.
- Midwifery staffing was worse than national recommendations.
- Community midwifery caseloads were worse than the national recommendations.
- There were no visual signs of electronic safety checks on equipment, there was also equipment found with exposed electrical wires, which was still in use.

However:

- There were good infection prevention and control practices observed and actions taken when the number of maternal infections increased.
- The service had plans are in place to improve midwifery staffing.
- There were robust processes in place to check emergency equipment.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. All staff we spoke with said they were aware of the process to report incidents. We saw printed information in all clinical areas, which detailed what incidents should be reported. Staff reported incidents on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported.
- There were no Never Events reported for maternity and gynaecology between March 2016 and February 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Between March 2016 and February 2016, there were no serious incidents reported by the Bronte Birth Centre.
- Between March 2016 and February 2017, there were 786 incidents reported by women's services. Of these, 732 were reported by the maternity service; of these 590 incidents were reported as no harm, 138 incidents were reported as low harm, two were reported by the service as insignificant harm and two as moderate harm. Themes identified included poor record keeping and concerns with staffing. The gynaecology service reported 54 incidents, of these 42 were reported as no harm, four were reported as low harm and eight were reported as moderate harm. The main theme for reporting was poor documentation and staffing concerns.
- Staff were unable to tell us of specific cases where practice had changed as the result of an incident, this was corroborated by the assistant director of nursing / head of midwifery who also identified this gap.
- The service used a weekly safety brief to inform staff of learning and changes to practice and keep staff informed of the risks, which faced the directorate. We observed this bulletin was displayed in clinical areas.
- Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by staff and reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from November 2016 to January 2017 included examples of the steering group reviewing cases and recommending changes to clinical guidelines and practice. Staff informed us they would like to attend these meetings held at Pinderfields hospital. However, due to the distance of travel and current staffing levels this had not been possible.
- We spoke with staff who demonstrated they were aware of the principles of duty of candour and all were able to provide examples of where it had been applied. We also found examples of duty of candour in meeting minutes and incident report outcomes. However, staff could not recall an occasion where it had been required.

Safety thermometer

- Maternity services had started using the national maternity safety thermometer. This allowed the

maternity team to check on instances of harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety**.** In addition, it identified those babies with an Apgar (a method to quickly summarize the health of the new-born) of less than seven at five minutes.

- There was only trust wide data available. We found results for combined harm-free care between April 2016 and March 2017 showed the median value was 78%. This meant that on average 22% of women experienced an element of harm during their care. This was better than the national average of 75% (25% experiencing an element of harm) for the same period. Women's perception of safety had a median level of 92% for the same period, which was consistent with the national average. However, for three months we found data for the Trust showed this was significantly below 80%.

Cleanliness, infection control and hygiene

- We reviewed the infection control policy and found this to be in date. Trust policies were adhered to in relation to infection prevention and control with arms bare below elbows observed and personal protective equipment was available.
- We observed staff who did not wear protective equipment when testing urine samples.
- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C.difficile) in 2016/2017. There was one reported case of Methicillin-Sensitive Staphylococcus Aureus (MSSA).
- We saw 'I am clean' stickers on all equipment.
- We found fully completed cleaning rotas place in clinical areas. Most clinical areas were visibly clean and well organised. However, we found the shared dirty utility room between the antenatal and gynaecology outpatient department was disorganised. There was no clear rota identifying which department was responsible for cleaning and checking.
- At 36 weeks of pregnancy, all women were screened for MRSA. If they had a positive result, they were given treatment prior to admission.

Environment and equipment

- At previous inspections in 2014 and 2015 we were concerned that checks on emergency and essential equipment were not always completed. During this inspection, we found all checks on emergency and essential equipment were complete with the exception of gynaecology and antenatal outpatients. Here we found out of date equipment and inconsistent equipment checking processes.
- We observed electronic equipment and found that a large amount of equipment showed no visible evidence of electronic safety checks. We raised this concern with staff, who were not aware of this. Information received from the trust stated all electronic equipment should have visible evidence of safety testing displayed.
- There was adequate equipment on the unit to ensure safe care – specifically, cardiotocography (CTG), resuscitation equipment and directional lights. Staff confirmed they had sufficient equipment to meet patient needs.
- The Bronte Birth Centre had six en suite rooms in total. Two rooms had a birthing pool.
- We found coagulation machines did not have visual safety equipment testing stickers and we found both machines had exposed electrical wires. We highlighted this concern with staff, who were not aware of the state of the machines.
- The service undertook annual medical devices competencies. Compliance with the completion and return of a personal training assessment was 1.3%. However, the service was confident that staff were trained in the use of medical devices and was working to improve the process to capture data to demonstrate this.
- Home birth bags were stored and collected from the birth centre. We observed community midwives checking and re stocking these bags and equipment following a home birth during our inspection.

Medicines

- We reviewed two prescription charts and found them completed in line with trust policies.
- Medicines were stored in locked cupboards and trolleys in all clinical areas.
- Medicines that required storage at a low temperature were stored in a specific fridge. Fridge temperatures were monitored remotely. We reviewed records dating back to March 2017, and found them to be complete.

- We found syntometrine, syntocinon and ergometrine stored in a home birth bag. The date on which the medications had been removed from the fridge was documented clearly.
- The Bronte Birth Centre did not stock controlled drugs. However, dihyrdocodeine was subject to a daily stock check, and this was complete for the three months prior to our inspection.
- There were processes in place to record all medications dispensed by midwives under patient group directives (PGDs) during the discharge process. This included checks by two midwives and stock control sheets for the pharmacy department. PGDs are written instructions to help supply or administer medicines to patients, usually in planned circumstances.

Records

- The service kept medical records securely in line with the data protection policy. However, we found confidential gynaecology patient outcome forms left in an open tray on the reception desktop.
- Women carried their own records throughout pregnancy and postnatal periods of care.
- We reviewed two medical records found that antenatal risk assessments were not completed.
- The service completed bi-annual record-keeping audits. We reviewed the audit undertaken from June to November 2016, in which 242 antenatal, intrapartum (labour) and postnatal records were checked. We found 17% (n29) of the areas assessed were not compliant in up to 70% of the records. These included; woman's name and unit or NHS number on each page in the postnatal record (38%); mental health risk assessment completed in second trimester (25%); and general record keeping in neonatal notes was between 36% for baby's surname and unit or NHS number on each page and 88% of all entries signed. The audit included recommendations, and plans were in place to repeat the audit in July 2017.
- Following previous audits, and following recommendations from RCAs, the service had implemented new-style records in January 2017, with the aim of improving ease of use for staff. However, we did not have any feedback from staff to corroborate this.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children. The safeguarding midwife was integrated into the safeguarding team.
- Staff demonstrated a good understanding of the need to safeguarding vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff reported they were happy to contact the safeguarding team for advice and support if required.
- Midwives received annual safeguarding level three training in line with the intercollegiate guidelines. Between April 2016 to March 2017, records showed 91% of midwives had completed this training against the trust target of 85%.
- Community midwives were required to have four safeguarding supervision sessions per year. These consisted of three group supervision sessions and at least one, one to one session, staff we spoke with informed us this was happening. Hospital based midwives were offered supervision based on need.
- Records showed 97% of midwifery staff had completed safeguarding adult's level one training. Additionally, 98% of staff had received level one mental capacity act training which was above the trust target of 95%.
- A baby abduction policy was in place at the Bronte Birth Centre. There was a video call system onto the unit with a push button exit. All paths out of the unit were in full view of manned reception desks. There was no infant alarm system in place and babies stayed with their mothers at all times.

Mandatory training

- Midwives, health care assistants (HCA) and medical staff attended a one-day Yorkshire maternity emergency training (YMET) obstetric mandatory programme, which included emergency skills and drills, human factors training and sepsis. Mangers expected staff attended the annual YMET as a priority. Data provided by the trust showed that 86% of birth centre and community midwives between April 2016 and March 2017 had attended this training.
- All attendance at training provided by the service (including CTG training, screening and safeguarding) was monitored by the midwifery clinical educator and matrons. Staff were automatically rostered to attend mandatory training. We reviewed data, which showed

88% of midwives, nurses, and HCAs attended day one of the mandatory training and 82% of staff attended day two of the mandatory training against a trust target of 85%.

Assessing and responding to patient risk

- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to Pinderfields General Hospital. All staff we spoke with were aware of these processes, they were clearly documented on the trust intranet.
- There was a robust midwifery led care policy, which identified the criteria for a women being able to deliver within the unit and at home. Staff informed us as soon as they were concerned about health of mother or baby they called for an emergency response ambulance.
- The service carried out MEWS audits, to ensure compliance with completing and escalating deteriorating patients. We reviewed the February to April 2016 audit, which showed a compliance rate of 84% to 90%. The audit clearly documented recommendations and associated action plans; this included adding the audit to the annual audit priority programme.
- There were clear guidelines for the antenatal day unit. These included the thresholds at which they could accept patients, such as cut off levels for raised blood pressure.
- Staff on the birth centre had not had any additional training over and above their mandatory training such as advanced obstetric life support (ALSO) or neonatal life support (NLS).

Midwifery staffing

- The service did not meet the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:32 across both community and hospital staff against the recommended 1:28. The service did not include maternity support workers within the establishment.
- The service used Birthrate Plus® to enable a comprehensive review of midwifery staffing numbers based on the different models of care. The review identified a shortfall of 18.42 midwifery staff and the service had plans in place to recruit to these posts between 2017 and 2020.
- Women told us they had received continuity of care and one-to-one support from midwives during labour. The trust reported the percentage of women given one-to-one support from a midwife was 100%.
- We found staffing levels displayed. We reviewed staffing rotas and found a correlation between planned versus actual staffing numbers.
- Community midwifery caseload numbers were reported as 1:113 this was worse than the national recommendation of 1:98
- The service used NHS professionals (NHSP) to fill gaps in the planned number of staff. A number of substantive staff were signed up to NHSP and the agency also provided a number of familiar staff to the maternity unit, thus providing continuity.
- Community midwives were on call for home births and for additional staffing on the birth centre. There was a clear escalation process to call in additional staff and from the community midwifery team.
- Up to 28th February 2017, the trust reported a vacancy rate of 5% in maternity and gynaecology.
- Between March 2016 and February 2017, the trust reported a turnover rate of 16%, a sickness rate of 6% and bank and agency usage rate of 8% in maternity and gynaecology.
- Between March 2016 and February 2017, the trust reported a sickness rate of 6% in Maternity and Gynaecology.
- Between March 2016 and February 2017, the trust reported a bank and agency usage rate of 8% in Maternity and Gynaecology.

Medical staffing

- There were no medical staff based at the birth centre. However, consultants attended for antenatal and gynaecology clinics.
- Staff on the antenatal day unit informed us that, if they were concerned about the health of a mother or fetus, they would contact a consultant at Pinderfields General Hospital for advice.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

Maternity and gynaecology

- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually as part of their mandatory training.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

- There was a 100% vaginal birth rate in the Bronte birth centre.
- The service had successful bid for Department of Health Safety training monies and was in the process of allocating staff to training courses.
- There was good multidisciplinary working between medical and midwifery staff.
- The service was delivering care in line with national guidance.
- Although the transfer rate was above the target all transfers were clinically appropriate.
- The service held full accreditation for the United nations children's fund breastfeeding friendly accreditation.

However:

- Data provided showed that attendance at the Yorkshire Maternity Emergency Training (YMET) was below the trust target.
- There was not a regular programme of skills and drills in all areas of the obstetric department.
- All written information we saw was in English, not all staff were aware that information in other languages was available on the intranet.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet. We observed policies were easily accessible and filed logically and were in date.
- We were told staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Some staff we spoke with said this was not the case. Policies and procedures were available on the trust's intranet and were approved by the clinical governance group. The policies we reviewed (post-partum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice.
- From our observations and through discussion with staff, care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- There was evidence to indicate NICE Quality Standard 37 guidance was being met. This included the care and support that every woman, their baby and as appropriate, their partner, and family should expect to receive during the postnatal period.
- The unit was implementing the NHS funded Saving Babies in North England (SaBiNE) which was a care bundle for still birth prevention, through improved antenatal recognition of foetal growth restriction. At the time of inspection, there was no project lead for this work stream and additional capacity was required for the additional scans required. Plans were in place to increase scanning capacity through the training of midwife sonographers.
- Following the reconfiguration of services to the Pinderfields site, we found a lack of additional audit activity. For example, there were no pain audits. We were also told that junior (e.g. band five and six midwifes and junior doctors) staff were not invited to take part in audit activity.

Pain relief

- Women received detailed information of the pain relief options available to them, which included Entonox, piped directly into the delivery rooms.
- The birth centre had two birthing pools for use in labour and birth. There was equipment to support active labour. Pharmacological pain relief options were limited to Meptazinol (Meptid) and Dihydrocodeine. Women on the birth centre who required additional pain relief for example epidural analgesia were transferred to Pinderfields General Hospital labour suite.
- The trust did not undertake pain relief audits or collect this data.

- The service did not actively promote alternative therapies for example hypnobirthing. However, we were told they supported women who chose this method of pain relief and one staff member had been trained.

Nutrition and hydration

- There was an infant feeding coordinator. Their role included training staff, division of tongue-tie clinics, supporting breastfeeding mothers on the postnatal ward and in the community.
- Breastfeeding initiation rates for deliveries that took place in the hospital for April 2016 to March 2017, were reported between 64% and 75%. This was worse than the England average of 76%.
- The trust had implemented United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved full accreditation for maternity services and at the time of inspection were awaiting assessment for reaccreditation.
- New mothers were able to attend the birth centre if they were struggling with breastfeeding and were supported by staff during the day.
- Women who chose to formula feed their baby were asked to bring their own powered formula and bottles into the unit. Women were supported to make their formula correctly during their stay on the Bronte Birth Centre.
- Women were able to have light meals and snacks during their time on the birth centre.

Patient outcomes

- Between September 2016 and April 2017 the birth centre had 100% normal vaginal delivery rate, which was better than the national average of 60%.
- The transfer rate of women to the Pinderfields General Hospital was 39%, which was greater than the target of 25%. We were told each transfer was reviewed and all were clinically appropriate such as failure to progress in the first stage of labour.

Competent staff

- Matrons and managers monitored staff training monthly. They allocated staff to training and used the appraisal system to identify the need for additional training.
- The appraisal rate up until February 2017 was 100%for medical staff and 68% other categories of staff. All staff we spoke with informed us their appraisal was up to date and found it to be a useful experience.
- Healthcare support workers attend YMET training to support the delivery of services and examples of subjects included the care of deteriorating patients and MEWS, maternal observations, skills drills, breech births, pre-eclampsia and neonatal life support.
- Staff told us that there was little skills and drills activity on the birth centre.
- We were concerned, about staff competency in basic skills such as cannulation and suturing. We were assured that the majority of the staff based in the Bronte birth centre had transferred from the consultant led unit previously based at Dewsbury hospital. We reviewed the training calendar with the education midwife and found there were limited training days for staff to learn cannulation. We were told staff could call the on call site medical team in emergencies prior to ambulance crews arriving if required.
- There was no rotation of staff around all areas of the service. We were told plans were being developed to facilitate this.
- Following the change in legislation, (April 2017) the statutory role of the supervisor of midwifery (SOM) no longer existed. The service had decided to implement a role called midwifery advisors. These previous SOMs were on call for 24 hours to provide independent advice and support as required.
- Staff on the birth centre had not had any additional training over and above mandatory update training, such as advanced obstetric life support (ALSO), or neonatal life support (NLS).
- The service had successfully bid for department of health safety training funding. At the time of our inspection, courses were being allocated to staff such as ALSO, NLS, and critical care courses. There was some confusion between staff regarding who was prioritised for training. The education midwife informed us that the staff in the stand-alone birth centres were prioritised for NLS and ALSO training.

Multidisciplinary working

- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.

- Staff confirmed there were good working relationships between the gynaecology specialist nurses and consultants.
- Antenatal day unit staff called the medical team at Pinderfields General Hospital if there were concerns about patients. On the day we visited the unit there was no medical presence or antenatal clinics in progress as the doctors were attending an audit meeting.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.

Seven-day services

- This Bronte birth centre was staffed by the midwifery team 24 hours a day, seven days a week.
- The antenatal day unit was open Monday to Friday 8.30am to 5.00pm.
- The gynaecology clinic was open Monday to Friday 8.30am to 5.00pm.

Access to information

- Women who used the maternity services had access to informative literature. We saw examples such as whooping cough in pregnancy, smoking cessation, pathway through labour and optimal infant nutrition. However, all information displayed was in English. Some staff told us foreign language information was available on the intranet. However, not all staff were aware of this.
- Blood results were available on the electronic results system.
- The service had its own dedicated area on the trust website. Pregnant women and their families could access this site. However, the information did not include information on the different units available for women to deliver. Information about gynaecology services on the website was not yet available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service carried out an audit of 20 consent forms in 2016. This identified that improvements were required in a number of areas where immediate action was required including; Responsible health professional named (Obstetrics 60% Gynaecology 15%); Responsible health professional job title (Obstetrics 30% Gynaecology 5%); Brief explanation where required and/or leaflet given (Obstetrics 40% Gynaecology 15%); Clinician contact details (Obstetrics 10% Gynaecology 0%)
- Staff had an understanding of mental capacity and described the process of caring for women who may lack capacity. Data supplied showed 98% of staff had completed Mental Capacity Act level 1 training.
- At the time of our inspection, the trust was seeking to recruit a 1.0 WTE Band 7 lead midwife specialising in mental health issues.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Most women we spoke with were positive about the standard of care they had received, as were their partners and families.
- We observed staff interacting with women and their partners and other relatives in a polite, friendly, and respectful manner.
- The trust performed similarly to the England average across all maternity aspects of the Friends and Family Test (FFT) and for all of the 16 questions in the CQC Maternity Survey 2015.

However:

- Some women who had undergone gynaecological surgery told us that staff on the ward were caring but were sometimes too busy to explain what was to happen next.

Compassionate care

- Most women we spoke with who were using the maternity and gynaecology services were positive about the standard of care they had received.
- Women using the maternity services told us they had named midwives and they received good continuity of care from community midwives. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Most women we spoke with in the maternity service described how staff took time to allow them to

understand and form choices, promoted privacy and dignity during personal care, and were compassionate when they experienced pain, discomfort, or emotional distress.

- However, one woman told us that she found her community midwife very caring but that staff at Dewsbury and District Hospital (DDH) were often impolite.
- Women admitted for gynaecological surgery were cared for on ward 14, which was a mixed specialty, surgical ward with no bays reserved for gynaecology patients. At the time of our inspection three gynaecology patients were being cared for in two separate bays. Despite being accommodated in general surgical bays, the women we spoke with on ward 14 did not express any concerns about their privacy or dignity and they described staff as caring.
- The population served by DDH was culturally and ethnically diverse. Women attending the hospital and birth centre during our inspection were from a variety of backgrounds. Most of the women we spoke with did not express any concern about staff understanding their personal, cultural, social or religious needs. However, one woman told us that her request for a female sonographer had been met with an unhelpful response and she was unsure whether it would be accommodated.
- We observed staff in the Bronte Birth Centre and the antenatal day unit interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.
- From February 2016 to February 2017, the DDH FFT (antenatal) performance (% recommended) was worse than the England average: the hospital's performance for antenatal was an average of 91%; the national average was 96%.
- From February 2016 to February 2017, the DDH FFT (birth) performance (% recommended) was 98%, which was better than the England average of 97%.
- From February 2016 to September 2017, the DDH FFT (postnatal ward) performance (% recommended) was 97%, which was worse than the England average of 98%.
- From February 2016 to February 2017, the trust's Maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average at 92% with the national average at 94%. The percentage recommended for this trust showed a decline in August 2016. However, that was rectified by September 2016.
- The trust performed about the same as other trusts for all 16 questions in the CQC Maternity Survey 2015.

Understanding and involvement of patients and those close to them

- Women were involved in their care throughout the antenatal, birthing, and postnatal periods. We observed staff involving women in the planning of their care at the Bronte Birth Centre most women we spoke with said they felt involved in their care and understood choices open to them.
- Women were encouraged to visit the Bronte Birth Centre for a tour before deciding where they wanted to give birth and/or to familiarise themselves with the facilities.
- Women we spoke with at the Bronte Birth Centre, in the antenatal day unit, and awaiting scans at the antenatal clinic told us that their partners and other family members were as involved in their care as they wanted them to be. Partners and relatives we spoke with agreed that they felt involved and that staff were caring, polite, and helpful.
- There was provision for partners to stay with women and their newborn babies in family rooms in the Bronte Birth Centre.
- We spoke with women on ward 14 who had undergone gynaecological surgery. They told us staff on the ward were caring but were sometimes too busy to explain what was to happen next. In addition, they told us that staff did not inform them when there may be delays, such as changing of the time they would be going to theatre or the time that medications would be ready.
- A range of leaflets was available for women to take away with them to help with decision-making. Women we spoke with confirmed they had been given appropriate information to take away at previous visits. There was also clear information available on the trust's website.

Emotional support

- A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss.

Maternity and gynaecology

- All women who were planning a vaginal birth following a previous caesarean section (VBAC) were seen by a consultant obstetrician and offered an appointment at a birth choices clinic.
- A specialist diabetic nurse supported the hospital's weekly diabetes antenatal clinic.
- At the time of our inspection, the trust's 1.0 WTE Band 7 lead midwife for vulnerable women post was vacant, meaning that there was no dedicated specialist support for vulnerable pregnant women, including teenagers.
- At the time of our inspection, the trust was seeking to recruit a 1.0 WTE Band 7 lead midwife specialising in mental health issues.
- The trust did not provide us with any information about its approach to antenatal and postnatal assessments for anxiety and depression, nor on the availability of counselling services for women whose assessments might indicate a need for these.
- The trust did not provide us with any information about the availability of counselling services for women undergoing gynaecological surgery or procedures.
- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death. The trust had a 0.6 whole time equivalent (WTE) Band 7 bereavement lead midwife, whose role included ensuring that pathways and processes were in place for bereaved families. It also had a 0.2 WTE Band 6 bereavement specialist midwife, who held a counselling qualification and had a special interest in caring for bereaved families.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- Women whose pregnancies were low-risk were able to choose to deliver at home, in the midwifery-led birthing centre, or in the labour ward at Pinderfields General Hospital (PGH).
- The trust had held a listening workshop for new mothers and staff, with the aim of improving the experience of all women using its maternity services. It was in the process of implementing the improvement plan generated by that workshop.
- There was a consultant midwife clinic to support women in their birth choices, including vaginal birth after caesarean.
- The service was exceeding the Newborn & Infant Physical Examination (NIPE) indicator.

However:

- There was a lack of specialist midwives in post to support vulnerable women and those needing additional support for other reasons.

Service planning and delivery to meet the needs of local people

- The maternity service at Dewsbury & District Hospital (DDH) provided an antenatal service, including pregnancy screening, clinics, and an antenatal day unit, and a midwifery-led birthing centre. The premises and facilities at DDH were appropriate for the services provided there.
- Women using the service at DDH were those assessed as having low-risk pregnancies at their booking appointment. They were then able to choose to deliver at home, in the midwifery-led Bronte Birth Centre, or in the labour ward at PGH. Those who were assessed as high-risk could continue to use the antenatal service at DDH but would travel to the labour ward at PGH to give birth.
- Partners were encouraged to stay in the birthing centre with mothers and babies following delivery, until discharge.
- Community-based maternity services were provided from a number of locations within the area; these were predominantly GPs' surgeries, children's centres, and women's own homes.
- The gynaecology service at DDH provided an outpatients clinic, with a number of nurse-led and consultant-led clinics, and planned gynaecological surgery.
- The population served by DDH was culturally and ethnically diverse. Women attending the hospital and birthing centre during our inspection were from a variety of backgrounds. Most women we spoke with did not express any concern about staff understanding their personal, cultural, social or religious needs, and staff were working with local mosques and minority ethnic groups to raise awareness of the birthing centre.

- The trust had held a workshop in March 2016 that brought together new mothers and staff, with the aim of improving the experience of all women using its maternity services. The workshop generated a list of 'always events' (experiences of care which are so important to patients and families that healthcare staff should aim to perform them consistently and reliably for every patient, every time) under the Institute for Health Care Improvement's (IHI's) Always Events Framework. These always events were then used to develop an improvement plan, which the trust was in the process of implementing at the time of our inspection.
- The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the service. The trust supported three local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

Access and flow

- From April 2016 to March 2017 the average monthly transfer rate from the Bronte Birth Centre to PGH was 39%. Staff told us that all reviewed transfers had been clinically appropriate and there had been no occurrences of women inappropriately attending the birthing centre. It was trust policy to report any inappropriate transfers or attendances as incidents using the Datix incident reporting system.
- We were told that there was ongoing review and monitoring of trends in transfer rates and any practice issues highlighted would be addressed by the consultant midwife and raised in women's clinical governance, quality, and performance meeting agendas.
- From April 2016 to March 2017, the maternity service at DDH was closed on four separate days. The closures were due to capacity issues in the neonatal unit at PGH, workload, capacity, and/or acuity issues on the labour ward at PGH. Staff told us that the service at DDH closed whenever the service at PGH was closed, to ensure there was no risk of being unable to transfer any woman for who might develop the need for consultant care.
- The hospital did not monitor the percentage of women seen by a midwife within 30 minutes of arrival during labour. However, it was normal practice for midwives to greet women immediately on their arrival at the birthing centre. None of the women we spoke with said that they had been left unattended at any time.
- The trust had set a target of 90% of pregnant women accessing antenatal care within the first 13 weeks of pregnancy. This target was not met in four of the 12 months up to and including March 2017. Nonetheless, the average monthly percentage across the trust for that year was 90.5%.

Meeting people's individual needs

- A 'Birth Matters' clinic, promoting normal birth, was available at the trust. This was held at DDH once every three weeks. The trust employed a 1.0 WTE consultant midwife for normality and a 0.8 WTE midwifery advisor specialising in normality.
- At the time of our inspection, the trust's 1.0 WTE Band 7 lead midwife for vulnerable women post was vacant. The purpose of this role when filled would be to work with the most vulnerable women using the service, including teenagers.
- Named midwives were responsible for providing support and ensuring policy implementation in areas such as substance misuse and the reporting of female genital mutilation.
- The trust had previously trialled the 'Baby Clear Initiative' to support pregnant women to give up smoking. However, it had not yet implemented the initiative following that trial. The public health midwife told us that recruitment of a 'stop smoking midwife' was planned for the summer of 2017 and the principles of the Baby Clear Initiative should therefore be implemented by the end of 2017.
- At the time of our inspection the trust was seeking to recruit a 0.6 WTE Band 7 stop smoking midwife on a one-year, fixed-term contract and had arranged mitigating actions to avoid compromising patient care during service reconfiguration and recruitment. Actions taken included arranging for the public health midwife to lead on smoking cessation and to liaise with commissioners to ensure multidisciplinary working, implementing carbon monoxide monitoring at booking and introducing an opt-out (via electronic referral) service for stop smoking services.
- The trust was achieving the quality standard of more than 90% of women being offered carbon monoxide monitoring at booking.
- There was a weekly, specialist, antenatal clinic for women with diabetes at the hospital. A midwife and a specialist diabetic nurse ran this jointly to ensure continuity of care at clinic appointments.

- The service was in negotiation with local Clinical Commissioning Groups (CCGs) to improve services for pregnant women with Body Mass Indices (BMIs) of over 35. Additionally, midwife sonographers were undertaking training to perform foetal growth scans for these women, and the service was considering the development of a specialist clinic alongside scanning, to offer specialist support and coordinate interventions.
- Staff we spoke with told us the service made adjustments women with learning disabilities in maternity and gynaecology service, for example allowing a carer to stay with a patient.
- The trust's website could be viewed in over 100 different languages.
- Staff we spoke with assured us that they would never rely upon patients' friends or family members to translate.
- Leaflets on display in the antenatal clinic and gynaecology outpatient clinic areas were in English only. The deputy manager told us that these could be requested in other languages, but there was no notice to inform patients about this.
- A small notice about the trust's complaints procedure, comprising one sentence repeated in several languages in very small print, was on display.
- A notice about women-only clinics was displayed in both English and Guajarati.
- One pregnant woman we spoke with told us that, for religious reasons, she had requested that a female sonographer perform her scan, but had been advised that this could not be guaranteed.
- The trust reported that the percentage of babies examined under NIPE criteria within 72 hours of birth was 98%, which exceeded the NIPE indicator of 95%.

Learning from complaints and concerns

- Leaflets explaining the complaints process were available in most areas. There was also information about the process on noticeboards in the antenatal and gynaecology clinics' waiting-areas. Information about how to contact the Patient Advice and Liaison Service (PALS) was included.
- The trust had received 12 complaints relating to maternity services at DDH from March 2016 to March 2017 inclusive. Of these, four were upheld, six were partially upheld, and two were not upheld.
- The service responded to complaints in a timely manner, with responses provided within the timescales set out in the complaints policy.
- Learning from complaints about the maternity service was disseminated by a weekly, trust-wide, maternity service safety briefing, which was read out at each staff handover session for a week, emailed to all staff and displayed in clinical areas.
- Trust policy stated that one-to-one feedback should be given to staff who had been directly involved in any matter triggering a complaint.
- The head of midwifery told us that, although learning from complaints was disseminated amongst staff, the trust did not necessarily make it clear when practice had changed following the addressing of a complaint.

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- The service had successfully reconfigured services to one consultant let site and two standalone birth centres.
- There was a clear business plan for women's services, which was aligned to the corporate priorities.
- There were good processes in place to monitor clinical governance, risk management, performance and quality.
- There were clear and defined roles within the senior leadership team. Staff were aware of these roles and knew who the senior leadership team were.
- The service actively engaged with women through the maternity services liaison committee based in Kirklees.
- The service had fully engaged with staff during the acute hospitals reconfiguration including preferred hospital base.
- The service had benchmarked against the national maternity review and had a clear action plan in place to achieve compliance.

However:

- The head of midwifery was rarely seen on the birthing centre.

- Lack of assurance the risk register was managed robustly owing to the number of risks on it and the number of review timescales that had lapsed prior to our inspection.

Leadership of service

- Maternity and gynaecology formed part of the Women's Services Directorate. There was a clear managerial structure, which included clinical engagement.
- The triumvirate consisted of the Deputy Director of Operations, head of clinical services (one each for obstetrics and gynaecology) and Assistant Director of Nursing and Midwifery for Women's Services.
- The leadership team had successfully reconfigured women's services from two consultant led maternity units and one standalone midwifery led unit; to one consultant led maternity unit with an alongside midwifery led unit, two standalone midwifery led units.
- Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through 1:1 meetings with managers.
- We observed a cohesive senior leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in discussions around the development of the unit and the recent reconfiguration of services.
- The assistant director of nursing and midwifery was also the head of midwifery (HOM) was not often seen on the birth centre, staff told us her focus appeared to be on the consultant led unit at Pinderfields Hospital.
- The matron was visible and the senior midwife service manager was a daily presence. Staff were clear about who their manager was and who members of the senior team were.

Vision and strategy for this service

- The service had a clear business plan for women's services. The business plan included the recent acute hospital review and the maternity improvement plan.
- The service business plan had strategic objectives, which were aligned to the trust priorities. Strands included growth in targeted areas, building capacity and improving efficiency and midwifery supervision.
- All staff we spoke with were aware of this vision.

Governance, risk management and quality measurement

- There was a defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. Staff were aware of their roles and responsibilities in relation to governance
- The women's clinical governance meeting occurred monthly at Pinderfields General Hospital to monitor safety and risk throughout the directorate. We reviewed meeting minutes and found focused and detailed discussion with clear outcomes and actions.
- The quality and performance group meet monthly to discuss outcome and performance data. The service had a comprehensive dashboard, which enabled them to monitor performance and identify any trends and concerns.
- Risk registers assisted the management team and senior staff to identify and understand the risks. The risk register was a live document and all staff were able to access it through the trust intranet.
- The service provided a copy of the risk register were 67 risks identified for maternity and gynaecology. All had risk levels attached to them and were ordered in the level of the risk (highest to lowest) existing controls and gaps, and action necessary. For example, the risk of obstetric antenatal clinics running late or cancelled at last minute due to the complexities of the obstetric rota achieving the 98 hours a week labour ward cover. All risks had a review date next to them. However, 70% (47) of the review dates were prior to our inspection.
- All staff we spoke with had an awareness of the duty of candour regulations that came into effect on 27 November 2014. Policies on being open were in use and an open culture was observed.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). All identified gaps had clear actions documented against them. We reviewed evidence that the directorate had reviewed the actions since the initial analysis.
- The service had benchmarked themselves against the Better Births - National Maternity Review (2016). All identified gaps had clear actions documented against them. We reviewed evidence which demonstrated the service had updated this analysis.

Culture within the service

- We found an open culture with the emphasis on the quality of care delivered to women. Staff told us there was a 'no blame' culture where staff could report when errors or omissions of care without fear. For example, staff we spoke with informed us they were encouraged to reflect on adverse incidents as soon as possible, this included staff with minimal involvement in a woman's care.
- We observed strong individual and team working.
- Staff told us about the 'open door' policy at department and board level. This meant they could raise a concern or make comments directly with senior management, which demonstrated an open culture within the organisation.

Public engagement

- The service actively sought the views of women and their families through the maternity services liaison committee (MLSC) for Kirklees. This was a functional group, which met bi-monthly.
- The service had also developed a patient experience action plan with measurable goals and was red amber green (RAG) rated.
- The service had undertaken a local health needs assessment to identify the hard to reach communities and working with local partners such as commissioners to support them effectively.
- The service consulted with women during the reconfiguration of the services. Women were invited to walk round the birthing centre when they attend the hospital for routine appointments and also visits to the day assessment unit.

Staff engagement

- There were no directorate specific results in the 2016 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.57. This score placed worse than trusts of a similar size.
- We spoke with staff and in all areas staff were very engaged and felt involved in service throughout the reconfiguration of maternity services. A consultation asked staff to identify the area and hospital they would like to work in order of preference.
- There was a weekly staff bulletin to inform staff of up to date with guidance, changes to practice and updates of information within the trust.
- We observed staff being read the weekly safety brief, which informed them of changes to guidelines within maternity services.

Innovation, improvement and sustainability

- The service has successfully reconfigured services at the Dewsbury site to ensure the sustainability of maternity services on this site.
- This included developing, building and opening the purpose built midwifery led birth centre.
- Transferring care of women to the new units without service disruption.

Services for children and young people

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

Information about the service

The acute hospital reconfiguration had seen children's inpatients moved from Dewsbury Hospital to Pinderfields Hospital in August 2014. The neonatal unit had moved in September 2016.

Services for children and young people at Dewsbury Hospital consisted of an eight bedded assessment unit and an outpatients department. Some children's day case surgery took place in a joint adult day care ward.

During our inspection, we visited the children's assessment unit, children's outpatients and the day care ward, which admitted children and young people for minor day case surgery.

We spoke with 14 members of staff including nursing staff, medical staff, health care assistants and the service leads. We spoke with two parents and reviewed three sets of records. We also examined data provided to us by the trust.

Summary of findings

In a follow up inspection carried out in June 2015, children's services were rated as good overall. Responsive was rated as requires improvement, because there were no formal transition arrangements in place for adolescents moving to adult services.

At this inspection, we rated safe, effective, responsive, and well-led as good. We did not rate caring as we only saw care of one patient on the assessment unit and one patient in outpatients.

At this inspection, we rated this service as good because:

- Staff understood their responsibilities for reporting incidents. There were incident reporting mechanisms in place and staff received feedback.
- Care was planned and delivered in line with evidence-based practice.
- Staff had the skills required to carry out their roles effectively. Children's services had employed advanced nurse practitioners.
- Children and young people could access the right care at the right time.
- There were processes in place for the transition in to adult services, although they were not as well developed as at Pinderfields, due to commissioning arrangements. A lead nurse for the trust had recently been appointed.
- There were effective governance processes and the leadership team understood the risks to their service.

Services for children and young people

However:

- Staffing for children's day case surgery did not meet Royal College of Nursing (RCN) guidance and there were no specific plans in place if the staff member on duty called in sick at the start of a shift.
- Although there were safeguarding systems and processes in place, staff were not meeting the trust target for safeguarding training and did not receive regular safeguarding supervision.
- Equipment had no indication of when electronic testing was due and relied on staff contacting medical physics. Service leads told us that there had been a decision to reintroduce the labelling of equipment.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Staffing for children's day case surgery and in the assessment unit did not meet RCN guidance, which says a minimum of two registered children's nurses must be available at all times. One registered nurse covered day case surgery and in the assessment unit, there was only one registered nurse until 11am when a second nurse would start a shift.
- Children were not cared for in a child friendly environment for day case surgery. The day care unit was shared with adult patients and children were recovered alongside adults.
- Staff were not meeting the trust target for safeguarding training and did not receive regular safeguarding supervision as recommended in the Royal College of Nursing (RCN) guidance, although it was offered on a case need basis.
- Equipment had no indication of when electronic testing was due and relied on staff contacting medical physics. Service leads told us that there had been a decision to reintroduce the labelling of equipment.
- There were no records to indicate that checks had been made on the transfer bags in the assessment unit. After the inspection, service leads told us a process would be put in place.

However:

- Staff understood their responsibilities for reporting incidents and raising concerns. Staff received feedback about incidents and they were discussed at governance meetings.
- Staff assessed, monitored and managed risks to children and young people on a day-to-day basis. Staff recognised and responded appropriately to changes in risks.
- All areas were visibly clean and monthly infection control audits were completed. There had been no cases of MRSA or clostridium difficile in the last 12 months.

Incidents

- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- Between March 2016 and February 2017, the trust reported no incidents which were classified as Never Events for children's' services.
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children's services at Dewsbury hospital, which met the reporting criteria set by NHS England between March 2016 and February 2017.
- Children's services reported 49 incidents at Dewsbury hospital between March 2016 and February 2017. Five incidents occurred in the A&E department and 19 occurred on the neonatal unit, which moved to the Pinderfields site in September 2016. The remaining 25 incidents were reported by the children's assessment unit and were classified as no or low harm. One was classed as moderate harm. There were no particular trends.
- Staff were aware how to report incidents using the electronic reporting system. Staff told us, and we saw evidence in meeting minutes, that they received feedback about incidents that had taken place. Medical staff said they received regular feedback at governance meetings and grand rounds.
- Staff we spoke with could not tell us about any recent incidents or changes that had been made because of an incident. This could be due to the low number of incidents reported at Dewsbury hospital.
- Paediatric significant events meetings were held regularly and incidents were a standing agenda item along with discussions of morbidity and mortality. We reviewed minutes from these meetings and found there had been case discussions, which included any learning points and action to be taken.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with told us about the need to be open and honest with patients and their parents. There had been no recent incidents requiring the duty of candour to be implemented.

Cleanliness, infection control and hygiene

- There had been no cases of MRSA, methicillin-sensitive Staphylococcus aureus (MSSA) or clostridium difficile (C difficile) between March 2016 and February 2017.
- Staff completed monthly infection control audits. These looked at 10 key elements, which were general environment, patient's immediate area, dirty utility and waste disposal, linen, storage areas and clean utility/ treatment room, patient equipment, sharps safety, hand hygiene facilities, isolation of infected patients and clinical practice. Hand hygiene and bare below elbows audits were also completed.
- Data provided by the trust showed that in February 2017, the children's assessment unit's overall compliance with the 10 key elements was 99%; hand hygiene was 100% and bare below the elbows was 100%. There had been no data received for the children's outpatient department.
- All areas we visited were visibly clean and equipment looked clean.
- All areas we visited had suitable hand washing facilities and wall mounted hand gels. We saw staff washing their hands and using the hand gel.
- We observed staff to be arms bare below the elbows and using personal protective equipment, such as gloves and aprons, when required.
- On the children's assessment unit, we saw an infection prevention and control board, which provided information for patients and parents.

Environment and equipment

- The children's assessment unit was located next to the accident and emergency department.
- The children's outpatient department was situated in an old ward area. A four-bedded bay was used for investigations and treatments, such as certain endocrine tests and for patients receiving blood transfusions. Plans were in place for redesign of the environment.
- A staff member told us they were concerned about plans for an adult discharge lounge to be located next to the children's outpatients. When we spoke with service leads, they explained that the discharge lounge would be located in a ward area opposite the children's outpatients. A lock was to be fitted to the outpatient's door and access would be secure via an intercom.

- Children's day case surgery took place in a joint adult day care surgery ward. The children were nursed in a separate bay to the adult patients, however, children were recovered in the same area as adult patients and this area was not child friendly. The Children's Surgical Forum, Standards For Children's Surgery (2013) and The Royal College of Anaesthetists, Guidelines for the Provision of Anaesthetic Services (2015) say that children should be separated from, and not managed directly alongside adults, whether in the operating department (including reception and recovery areas) or the day ward.
- Resuscitation equipment was available in all areas and we saw records to indicate regular checks had taken place. However, we saw transfer bags on the children's assessment unit that staff told us were regularly checked but we could find no evidence of checklists having been completed. We were told after the inspection that a new process would be put in to place to ensure checks were recorded.
- During our inspection, we noted that equipment did not have any indication of when electrical testing was next due. Staff had to ring medical physics in order to verify that testing had taken place. Service leads told us they were assured that equipment was regularly checked and there were plans to reintroduce service labels on equipment.

Medicines

- We saw a copy of the Standard Operating Procedure for Ward Management of Medicines Storage Temperatures. This was up to date and contained the required action to take if the temperature went too high.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored with access restricted to authorised staff who maintained accurate records. Staff performed balance checks regularly in line with the trust policy.
- On the children's assessment unit, we saw completed records to show that daily temperature checks were undertaken and recorded of drug fridge and drug cupboard temperatures.
- In the children's outpatient department, we saw completed checklists to indicate that daily checking of the fridge temperature took place. However, the precise temperature and minimum and maximum temperatures could not be recorded as the fridge thermometer only indicated if it was in a safe or danger zone.

Records

- We reviewed three sets of records. Overall, they were clear and legible, however, in two of the records, the time and date of when the patient had been seen had not been completed and the medical staff had not signed and dated each time they had seen the patient.
- We reviewed a record keeping audit done by the service for 2016/2017. This showed a comparison with a previous record audit done in 2015/2016. The results showed a significant decrease in the number of records with a legible patient name and unit number on every page. The GMC number was documented in 66% of the records, an increase from 39% the previous year. An action plan was included with the audit. Actions included incorporating a space on both sides of the clinical record for the patient's name and unit number to be recorded. It was planned for the paediatric team to complete a further audit in December 2018.

Safeguarding

- Staff knew how to report concerns and told us the procedure they would follow. All staff we spoke with told us that they could access support from the safeguarding team at any time and their contact details were available on the trust intranet.
- Staff had access to a safeguarding children policy, which was written in 2015 and referred to Working Together to Safeguard Children (2013). However, the 'Working Together to Safeguard Children' guidance had been updated in 2015. Although this was not a major review, it did include some changes, such as how to refer allegations of abuse against those who work with children. There is therefore a risk that staff were not working to current guidance.
- The intercollegiate document, Safeguarding Children and Young People: Roles and competencies for Health Care Staff (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to Level 3 in safeguarding. Training data for Dewsbury hospital showed that 94.4% of relevant staff on the assessment unit had completed safeguarding children level 1 and 90% had completed

level 3. The outpatient figures were trust wide and showed 75% had completed safeguarding children level 1 and 66.6% had completed level 3. The trust had a target of 95% for level 1 training and 85% for level 2 and level 3 training.
- Medical staff compliance with safeguarding level 3 training was 95%, therefore meeting the trust target.
- Staff were aware of female genital mutilation (FGM) and child sexual exploitation (CSE) and told us these subjects were covered in their safeguarding training.
- Nursing staff did not have regular safeguarding supervision, but the safeguarding nurse would provide it on a specific case need basis.
- The Royal College of Nursing Guidance: Safeguarding children and young people – every nurse's responsibility (2014) states that regular high-quality safeguarding supervision is an essential element of effective arrangements to safeguard children. We were told that nurse managers and the safeguarding team were working towards developing more meaningful supervision for staff.
- Access to the children's assessment unit was secure with entry intercoms for patients and visitors.
- Children's day case surgery took place alongside adult day care surgery. There was not secure access to this area although the bay that children were nursed in was separate from the adult bay. Staff told us that they would try to ensure there was always a member of staff present in the bay with the children and parents would normally be with their child.

Mandatory training

- Mandatory training was available in subjects such as fire safety, diversity awareness, infection control, manual handling, mental capacity, health and safety and information governance.
- Data provided showed that children's services at Dewsbury were meeting the trust target of 95% for diversity awareness, health and safety, mental capacity and manual handling. Compliance with fire safety training was 88% for staff on the assessment unit, information governance was 83% and infection control was 83%. Data provided for the outpatients department was trust wide and showed compliance with fire safety training was 77%, information governance was 37% and infection control was 75%.
- Service leads told us they were planning to start staggering the training so all staff did not have to complete it at the same time, making it easier for staff to get time to do the training. Feedback we received from staff suggested that there was a delay between staff attending training and attendance been reported.

Assessing and responding to patient risk

- The service used a paediatric advanced warning score (PAWS), to help with the detection and response to any deterioration in a child's condition.
- A PAWS audit carried out in March 2017 showed a need for improved documentation and recommended the development of guidelines for prescribing the frequency of observations, and the escalation of PAWS scores and how these should be documented. Staff training was ongoing.
- We saw appropriately completed PAWS charts in the three records we reviewed. Staff told us that a sepsis score was in development.
- All staff were paediatric intermediate life support (PILS) trained. Band 6 staff had completed the European paediatric life support course (EPLS) and band 5 staff were in the process of doing the course.
- The assessment unit was open until 10 pm so did not take any referrals after 8pm. If children required overnight admission, they were transferred to Pinderfields General Hospital. Between 10 pm and midnight, there was one trained nurse and one health care assistant based on the unit. Any children still waiting for transfers at midnight were sent to the A&E department. A paediatric nurse was available in the A&E department 24 hours a day.
- Staff had access to Practical Guidance for Managing Transfers, which guided staff in the process to follow for transferring patients within the Mid Yorkshire Trust or for specialist care within other Trusts.
- The regional retrieval team transferred patients requiring paediatric intensive care facilities at other hospitals.

Nursing staffing

- Since June 2015, an acute matron and two practice educators had been appointed. There had been an increase in nurse staffing numbers, with successful recruitment programmes.
- Between March 2016 and February 2017, the trust reported a vacancy rate of 5% in children's services. At the time of our inspection, service leads told us they had no nursing vacancies.

Services for children and young people

- Agreed staffing levels for the assessment unit were one trained member of staff and one health care assistant from 9am until 10pm, and one trained member of staff and one health care assistant from 11am until midnight. Staff told us that the number of patients admitted to the unit before 11am was minimal, staff would get support from A&E if required before the second trained member of staff arrived at 11am.
- One trained member of staff and one health care assistant normally covered children's outpatients. The advanced nurse practitioner based at Pinderfields hospital outpatients worked at Dewsbury when they had patients who were undergoing endocrine testing.
- Royal College of Nursing (RCN) guidance (2013) suggests a minimum of two registered children's nurses at all times for day surgery. This staffing requirement was not met as there was only one registered nurse covering the paediatric day surgery theatre lists, supported by a health care assistant. There were no specific plans in place for what would happen if this nurse called in sick at the start of a shift at 7am. Service leads told us that cover would be provided from elsewhere in the children's service, however, we were not assured that this would provide a staff member for the start of the theatre list.

Medical staffing

- Medical staff rotated between Dewsbury Hospital and Pinderfields Hospital.
- Consultant cover was between 10am and 10pm. We spoke with a consultant who told us that they worked one in four weekends and one in four at Pinderfields.
- Outside of these hours, staff in A&E would contact the consultant at Pinderfields for advice. A standard operating procedure (SOP) was in place, which detailed when medical staff were expected to stay on the unit for longer hours. Ambulance services were informed of which patients should be taken to Pinderfields Hospital A&E rather than Dewsbury A&E out of hours.
- Service leads told us there were ongoing issues with the middle grade staffing with three vacancies, however, things had improved over the last year and they were filling gaps with internal locums and advanced nurse practitioners.
- Plans had been looked at for the next five years and an advertisement for a specialist middle grade post had gone for executive board approval.

Major incident awareness and training

- The trust had in place an Emergency Preparedness, Resilience and Response Policy, which set out the responsibilities of key staff when dealing with a major incident. This had a due date for revision of March 2017.

Are services for children and young people effective?

Good

We rated effective as good because:

- Children and young people's care was planned and delivered in line with evidence-based guidance. This was monitored to ensure consistency of practice.
- There was participation in relevant local and national audits. Outcomes for children and young people were in line with the England average.
- Staff were qualified and had the skills required to carry out their roles effectively.
- Staff understood Gillick competency when obtaining consent, and staff had attended Mental Capacity Act training.

However:

- Staff appraisal rates were low. However, service leads acknowledged this and had plans in place to increase compliance.

Evidence-based care and treatment

- Staff had access to policies, procedures and guidelines on the intranet.
- Policies and procedures were evidence based and based on national guidance including National Institute for Health and Care Excellence (NICE) guidance.
- Audits were undertaken to ensure compliance with guidelines, for example, this year there was a plan to look at intravenous fluid therapy in children and young people in hospital, based on NICE guidelines.
- Children's outpatients used evidence-based protocols, provided by another trust, when carrying out endocrine tests.

Pain relief

- Children's services used a paediatric pain-scoring tool. This was incorporated within the PAWS charts.

- Children were prescribed appropriate pain relief.

Nutrition and hydration

- Staff had access to dieticians if required. The children's outpatient department contained a dietician's room.
- A family we spoke with on the assessment unit told us they had been offered a drink and a sandwich.
- The assessment unit kept emergency dietary requirement information for those patients with a metabolic condition.

Patient outcomes

- The trust took part in a number of national audits, including the British Thoracic Society paediatric pneumonia audit, national neonatal audit programme (NNAP), national paediatric diabetes audit and the British Thoracic Society asthma audit.
- HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".
- Data shows that in the 2015/2016 diabetes audit Dewsbury Hospital had similar results to the national average. The national average for patients having an HbA1c of less than 58 mmol/mol was 26.6% and for Dewsbury hospital it was 25.5%. The average mean HbA1c nationally was 68.3 mmol/mol and for Dewsbury hospital it was 66.5 mmol/mol.
- Between December 2015 and November 2016, the trust performed similar to the England average for the percentage of patients, with asthma, epilepsy and diabetes, aged 1-17 years old who had multiple emergency readmissions within 12 months.

Competent staff

- The trust employed one advanced paediatric nurse practitioner (APNP). This nurse practitioner supported medical staffing at the middle grade level.
- There were specialist nurses employed for diabetes, asthma, epilepsy, continence and neuro-disability.
- All staff attended the trust induction programme upon joining the trust.
- Staff appraisals had been identified by the trust as an area for improvement. Appraisal rates for the assessment unit were 33.3%. Service leads told us the manager for the unit had been off sick and there were plans in place for the completion of appraisals.
- Medical staff told us they received regular supervision. Data showed that in February 2017, 100% of medical staff had received an appraisal.

Multidisciplinary working

- The trust benefitted from a play team, which consisted of six play staff, who ensured that every area of the children's services received play support.
- Staff on the assessment unit told us that they accessed support from the child and adolescent mental health service (CAMHS). They found that this worked well during the week but was poor at weekends or on bank holidays.
- Medical staff liaised with radiology staff and had weekly radiology meetings.

Seven-day services

- Consultants were available 10am to 10pm Monday to Sunday.
- Children's services had access to diagnostic services, such as x-ray and laboratory services.

Access to information

- Staff had access to policies and guidance on the trust intranet.
- Staff in outpatients told us they always had access to the child's records for appointments.
- Discharge summaries were routinely sent to GP's and other relevant professionals.
- We observed a consultant in clinic using the child's personal child health record.

Consent

- Staff we spoke with understood Gillick competency and could give examples of when they had applied it in practice. Gillick competency helps staff assess whether a child has the maturity to make their own decisions and to understand the implication of those decisions.
- The trust reported that between April 2016 and March 2017, Mental Capacity Act (MCA) and Deprivation of Liberty training had been completed by 95% of staff within children's service.

Services for children and young people

Are services for children and young people caring?

Good

We rated caring as good because:

- Feedback from parents and the Friends and Family Test was positive.
- We observed parents being given good explanations about their child's care.
- Staff were described as supportive and nice.
- Play specialists were available to help alleviate children's anxieties.

Compassionate care

- Parents we spoke with said staff were supportive and nice.
- We saw children and their parents being spoken to in a compassionate manner.
- Friends and Family test responses were consistently positive. Results for February 2017 showed that 100% of respondents would recommend the assessment unit to friends and family.

Understanding and involvement of patients and those close to them

- A parent that we spoke with on the assessment unit told us the nursing and medical staff had discussed the plan of care with them.
- Staff allowed parents to be involved in their child's care.
- Parents we spoke with in the outpatient department told us that the consultant answered all their questions and they both felt included in the discussion.
- We observed parents being given good explanations of their child's condition and given time to ask questions.

Emotional support

- Play specialists were able to provide support to children and young people to alleviate their anxieties.
- We observed a consultant providing reassurance to parents and allowing them time to discuss their child's plan of care.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- The assessment unit was open for 12 hours a day, service leads had worked out the peak hours of use from a period of opening for 24 hours.
- Average waiting times did not exceed 18 weeks, therefore children and young people could access the right care at the right time.
- There were processes in place for transition from children's to adult services, although specialist nurses were not able to do home visits due to commissioning arrangements.
- Information was available to parents on how to make a complaint. Staff could tell us about changes they had made in response to complaints.
- At our previous inspection, it was found that there were no effective processes in place for the transition to adult services. At this inspection, we found this had improved but was not as well developed at Dewsbury Hospital as at Pinderfields Hospital.

Service planning and delivery to meet the needs of local people

- As part of the service reconfiguration, inpatient services had moved to Pinderfields hospital and the Dewsbury site retained a children's assessment unit.
- The assessment unit had had a period of opening for 24 hours to allow service leads to work out the peak hours of use and staffing requirements. The business plan had always been to reduce the opening hours to 12 hours a day as agreed with the clinical commissioning group. The unit had reduced its opening hours to 12 hours a day from September 2016.
- Medical staff we spoke with told us that the opening times of the assessment unit were a challenge at times and felt they were not beneficial for the children in the local area, however, service leads told us that they had worked out the best opening hours for the unit based on when there were the most attendances.
- Low risk day case surgery took place three times a week on the day surgery unit. More complex and emergency surgery was carried out at Pinderfields Hospital.

Access and flow

Services for children and young people

- The children's assessment unit accepted referrals from GPs, accident and emergency and direct from families. Paediatric consultants took phone calls from GPs to determine whether the child needed to be seen.
- Children were seen in the outpatient department for blood tests. GPs gave the blood request form to the parents and the parents rang the outpatient department directly, to book an appointment.
- All children and young people from across the trust that required endocrine testing would attend the outpatients department at Dewsbury. This meant that those patients were not taking up an inpatient bed as had previously happened.
- Waiting times for paediatric outpatients varied between specialities, but the average of total weeks waiting for all specialities, between April 2016 and March 2017, did not exceed 11 weeks.
- A parent we spoke with in the outpatients department felt they had a long wait for an appointment as they had to wait 10 weeks to see a doctor and their child was only a month old when first seen by the GP.
- A rapid access clinic ran on three days a week and patients were booked in to this on a weekly basis.

Meeting people's individual needs

- Children's services employed a specialist nurse for neuro-disability and complex needs. Staff could contact the specialist nurse if any support was needed.
- Although there was a transition lead nurse in post, transition services at Dewsbury were not as advanced as at Pinderfields. The lead nurse told us this was due to the commissioning arrangements, which meant specialist nurses did not visit children and young people at home. However, the specialist nurses would see these children in clinic. The lead nurse had been in post since the beginning of April 2017 and was in the process of developing the transition services.
- Play staff worked with children with special needs to ensure care was individualised.
- The assessment unit had a direct access file, which contained information on those patients with certain medical conditions that were admitted via self-referral.
- Staff had access to interpreting services and employed family support workers, part of whose role was to interpret when needed.

Learning from complaints and concerns

- Between March 2016 and February 2017, there were 10 complaints. Issues raised included staff attitudes and delays related to referrals and treatment.
- We saw leaflets available for patients/carers informing them how to make a complaint.
- Staff in the outpatient department told us that they had received complaints about waiting times. They had introduced a new system, which had improved this.

Are services for children and young people well-led?

Good

We rated well-led as good because:

- Children's services had a strong, effective leadership team. However, staff at Dewsbury said they did not see them regularly and felt a bit isolated at times.
- Governance meetings were held monthly and there was a comprehensive risk register, which was regularly updated. There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.
- Service leads had a clear strategy for children's services, which aligned with the trust strategy.
- Staff were positive about working for the trust. However, they said that they would like more staff forums to be held at Dewsbury.

Leadership of service

- Children's services were part of the family and clinical support services division. Each division had a deputy director of operations and a divisional clinical director.
- A group manager, head of clinical services and assistant director of children's nursing led the children's services.
- Staff were positive about their leaders at Dewsbury Hospital. However, staff we spoke with said they did not see the service leads or the executive team and could feel isolated at times.

Vision and strategy for this service

Services for children and young people

- The trust had a quality strategy, which focused on reducing mortality, reducing harm, continuous improvement and quality improvement. Children's services had a clear strategy and operational plan, with a focus on staffing, safety and cost improvement.
- Staff were aware of the trust vision and values.

Governance, risk management and quality measurement

- The divisional clinical director was the divisional governance lead.
- A paediatric governance group fed in to divisional management and governance groups, which in turn fed in to the trust quality committee. The quality committee, along with a resource performance committee and audit and governance committee fed in to the trust board.
- Each area had a governance lead nurse who attended the governance meetings. Governance files were kept in all clinical areas for staff to access.
- Service leads identified their top three risks as staff training, nurse staffing and medical staffing. These were reflected on the risk register; measures put in place to mitigate the risks and were regularly reviewed.
- Team leaders and managers reviewed their own risks at a local level. The risk register was reviewed monthly at divisional governance meetings.

Culture within the service

- Staff within the service had a focus on improving child health outcomes. They spoke positively about the service they provided for children, young people and their families.
- Staff felt morale was good and that they worked well as part of a team.
- Staff were encouraged to be open and honest. They felt respected and valued.

Public engagement

- Patients and their families were able to provide feedback through the NHS Friends and Family Test.

Staff engagement

- Staff received weekly emails that kept them up to date with what was happening and the chief executive wrote a blog.
- A dedicated email address had been given to staff where they could send in any concerns they had.
- Staff told us that there was a freedom to speak up guardian available in the trust and they felt encouraged to speak about any concerns.
- Staff told us that they would like to have regular staff forums but would prefer them to be held at Dewsbury rather than Pinderfields all the time.

Innovation, improvement and sustainability

- The outpatient department was to be redesigned to make better use of the space they had. Plans had been approved for this.

End of life care

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

Information about the service

The Specialist Palliative Care service (SPC) works across The Mid Yorkshire Hospitals NHS Trust on two main hospital sites at the Pinderfields Hospital and the Dewsbury Hospital.

Patients at the end of life were nursed on general hospital wards. Between December 2015 and November 2016 the trust had 2,099 deaths.

The same period there had been 1,209 referrals to the specialist palliative care team (SPCT). Of these referrals, 905 (75%) were cancer related and 304 (25%) were non-cancer related. The end of life care service is operationally managed by the Specialty Medicine directorate within the Division of Medicine. The service is made up of the specialist palliative care nursing team supported by a team of four consultants. Palliative care education has been introduced as part of mandatory training for all nursing staff at the trust.

We inspected the acute end of life care service only and did not inspect the community end of life service.

The trust had a bereavement team which consisted of a bereavement nurse and a bereavement officer at both Pinderfields and Dewsbury Hospital.

During this inspection we visited a number of areas including stroke, acute medical unit, elderly care, general medicine and general surgery. Also, we visited the chapel, multi-faith room, the bereavement office, and the hospital body store.

We viewed twelve care records including two where patients were being cared for using the care of the dying patient (CDP) care plan. We spoke with three patients and three relatives.

We spoke with members of the SPC service, SPC consultant, ward based staff including a consultant, nursing staff, health care assistants and medical staff. In addition we spoke with the chaplain, bereavement office staff, discharge team and body store staff and porters.

In total, we spoke with 23 staff members. We looked at policies and procedures and reviewed performance information about the trust.

We viewed 24 DNACPR forms and they were generally completed well.

End of life care

Summary of findings

During our last inspection of End of Life Care Services at Dewsbury Hospital, in July 2015 we rated requires improvement overall.

During that inspection we found concerns regarding staffing levels within the specialist palliative care team, a lack of strategic vision for the service, unnecessary delays to the rapid discharge of patients at the end of life and not all ward staff trained to use or using the end of life care plan.

We rated this service as good because:

- Nurse and consultant staffing levels for the specialist palliative care team were at full complement and reviewed daily to keep people safe at all times. Any staff shortages were responded to quickly and adequately.
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- We viewed body store protocols and spoke with body store and porter staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient including hospital staff, community staff and most GPs. They also had access to EPaCCS (Electronic Palliative Care Coordination System), which enabled the recording and sharing of people's care preferences and key details about end of life care.
- We observed the use of syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.
- For those palliative care patients who were already known to the service and admitted to the hospital for care and treatment, 93% were followed up by contacting the ward within 24 hours to assess the need for specialist palliative care assessment.
- Staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. Body store staff told us there was always a member of staff on call out of hours. This service was available for families who requested to visit during an evening or a weekend.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- The quality of leadership for end of life care had improved since the last inspection. Structures, processes and systems of accountability, including the governance and management of joint working arrangements were clearly set out, understood and effective.
- The establishment of the end of life project group had led to a number of projects being undertaken to improve the quality of care for end of life patients.
- The chaplaincy service provided spiritual support for patients and their families.

However:

- Staff we spoke to were not all familiar with the Duty of Candour and when it was implemented.
- An end of life care plan had been introduced, but there was no regular audit to determine what percentage of end of life inpatients had the care plan in place.

End of life care

- The weekly specialist palliative care team (SPCT) multidisciplinary meeting included SPCT nurses and palliative care consultants but no other discipline such as allied health care professionals, pharmacy or the chaplaincy.
- We were unable to assess the level of performance in achieving fast track discharges for end of life patients due to lack of evidence; no audit work had been done to measure performance in this area since the last inspection.
- The service reported that 73% of all new referrals were seen within 24 hours of being referred to the team.
- There was no regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients.

Are end of life care services safe?

Good

We rated safe as good because:

- There were no serious incidents reported between March 2016 and February 2017.
- Staff were aware of reporting procedures and the importance of thorough analysis of incidents, duty of candour and sharing lessons learnt.
- Clinical areas were visibly clean, personal protective equipment and hand sanitiser was readily available and used.
- The body store was secured, monitored and accessible only to relevant staff. Body store records were complete and accurate.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust were making use of audits and learning from incidents to drive improvements.
- Appropriate anticipatory prescribing of medicines was used at the end of life. There was evidence of good initial care provided by nursing staff working across the trust, supported by specialist palliative care input from qualified and skilled nurses and doctors.
- Equipment was available for the care of patients at the end of life.
- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient including hospital staff, community staff and most GPs. They also had access to EPaCCS (Electronic Palliative Care Coordination System) which enabled the recording and sharing of people's care preferences and key details about end of life care.
- Staff assessed and responded to patient risks.

However:

- An end of life care plan had been introduced, but there was no regular audit to determine what percentage of end of life inpatients had the care plan in place.

Incidents

- Between March 2016 and February 2017 the trust reported no Never Events for end of life care. A never event is a serious incident that is wholly preventable, as

guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The SPCT could explain their responsibilities for reporting incidents. Staff told us that when an incident happened they recorded it on an electronic reporting system.
- Staff told us any incident relating to a patient at the end of life they involved the palliative care team in the investigation and subsequent learning as a result.
- Staff spoke with some understanding about the duty of candour regulations. They understood their responsibility to be open and transparent with patients and carers.
- The service reported 17 incidents between March 2016 and February 2017. There were 15 no harm incidents and two low harm incidents. Trends resulting from incidents were monitored and discussed at the divisional governance group. There were no clear themes identified from the incidents; four of the 17 incidents involved various aspects of the discharge process. Discharge management was listed on the palliative care risk register with actions in progress to improve the process.
- Mortality and morbidity reviews were included in the weekly multidisciplinary meetings and any issues arising were escalated to the directorate governance meeting.

Environment and equipment

- There was a body store at the hospital. We viewed body store protocols and spoke with body store and portering staff about the transfer of the deceased. The body store was manned by two staff with support as needed from porters within the hospital. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- We saw that the body store fridges were checked every day to ensure no leakage of bodily fluids had occurred. We inspected the fridges and saw that these were visibly clean. If a patient was identified as an infection control risk, an alert notice was placed on the fridge door and we saw this being followed during the inspection.
- The body store was secured to prevent inadvertent or inappropriate admission to the area. The temperature of the body store fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.
- The body store staff told us that they had not experienced any difficulties involving capacity.
- We were shown records of the fridge temperature audits and there was full compliance with these. We also saw the Frontline Staff Ownership (FLO) environmental audit results, which showed 100% compliance for infection control and management of sharps safety, waste disposal and patient equipment.
- There was standardised use of one model of syringe drivers. We saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged. Records showed equipment had been safety tested and serviced where required.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and facilities.
- We saw there were hand wash basins, liquid soap, paper towels, hand gels and protective equipment available.

Medicines

- The trust had produced guidelines for medical staff to follow when prescribing anticipatory medicines. These were available on the intranet.
- Medicines for use at the end of life, including those for use in a syringe driver were readily available on the wards. Nursing staff said that end of life care medicines were accessible, including outside of normal working hours.
- Anticipatory end of life care medication (medication that patients may need to make them more comfortable)was appropriately prescribed. We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines.

Records

- Staff used a community-wide electronic patient record system accessible to the multidisciplinary team caring for the patient including hospital staff, community staff

and most GPs. Hard copy records were kept on the wards and these were updated by visiting specialist palliative care nurses. The electronic records were updated as required.
- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We saw this had recently been introduced across the trust. We did observe the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- Care plans reflected national guidance and included risk assessments such as those for the risk of falls or pressure area damage.
- We viewed 24 DNACPR forms and they were generally completed well. All forms were kept at the front of the patient's notes, included clear documentation and clinical reasoning for the DNACPR decision. Decisions were appropriately recorded as approved by a senior clinician.
- Records within the body store were comprehensive and included processes for appropriate checking.
- We looked at nine case notes on the wards and these were organised with information easy to access. There was evidence in the records of the discussions that had taken place about the patient's condition, resuscitation status and care planning. We saw evidence of completed assessments for pain, falls, pressure areas, nutritional status and moving and handling.
- The bereavement office kept records of all hospital deaths and funerals, which had been arranged by the hospital when there was no next of kin or no means for families to arrange a funeral.

Safeguarding

- Policies were in place and accessible to staff and the director of nursing and quality was the board lead for safeguarding. Staff we spoke to were aware of how to escalate safeguarding concerns. There was a safeguarding team in place, which was led by the head of safeguarding and included a named nurse and midwife for safeguarding children, a named professional for adult safeguarding, a learning disability lead and a Mental Capacity Act and Deprivation of Liberty Safeguards lead.
- We spoke with staff around safeguarding. Staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the unit.
- The trust set a target of 95% for completion of safeguarding training Level 1 and 85% for Level 2. Training for safeguarding adults and children was mandatory for all staff. The training levels for the specialist palliative care team for April 2016 and March 2017 were adult safeguarding Level 1 (91%) and Level 2 (77%); safeguarding children Level 1 (93%) and Level 2 (75%).

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%.
- The compliance level for the specialist palliative nurse team trust-wide between April 2016 and March 2017 was 91% for diversity awareness, infection control, manual handling theory, Mental Capacity Act and Deprivation of Liberty Level 1, fire safety, health and safety and information governance. Compliance with annual resuscitation training was 73%.
- All qualified nurses in the end of life services were trained in syringe pump training.

Assessing and responding to patient risk

- Patients who were known to the specialist palliative care team (SPCT) were given a green card on their initial visit. They were advised to show this to the healthcare professionals if they were admitted to hospital to alert them of palliative care input. The card highlighted the patient was on the Gold Standards Framework and the EPaCCS (Electronic Palliative Care Coordination System). EPaCCS enabled the recording and sharing of people's care preferences and key details about end of

life care. This record was accessible on the hospital electronic patient record system for staff to view if a patient was admitted and helped alert them about end of life preferences.

- Patients were referred to the SPCT by staff on the wards by telephone or paper based referral. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.
- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- We saw an early warning score (NEWS) which highlighted if escalation of care was necessary. Additionally, the SCPT used the trust's electronic system for recording patient's clinical observations. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.
- Ward staff provided care to patients requiring palliative and end of life care. Should a patient experience complex symptoms or additional support be required to meet patient needs, then ward staff would refer to the SPCT.
- Ward staff told us the SPCT team had a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes recorded clearly.
- Members of the SPCT held a daily review meeting and weekly multidisciplinary meeting during which the condition and symptom management of each patient on the caseload was considered and frequency of patient visits were determined.
- We saw that seven-day out-of-hours medical palliative care input was available via the consultant on-call rota. Specialist palliative care nursing input was available Monday to Friday and not at weekends or out-of-hours; however the gap in service was recognised as a priority to resolve and service leads were planning to introduce a seven-day service when possible.
- Community SPCT and hospice staff ensured handover was given to the acute team when patients were admitted to hospital. In turn, a handover was given between teams when patients were discharged.
- We saw that risk assessments were completed in the nursing records including those related to skin integrity, nutritional needs, falls risk and pain assessments.

Nursing staffing

- The catchment area for the trust has a population of approximately 500,000. The Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives (2012) recommends that the minimum requirements per 500,000 people are ten WTE specialist palliative care nurses.
- Specialist palliative care nurse staffing met the national guidance with 10.8 whole time equivalent (WTE) Macmillan specialist palliative care nurses. Staffing included one WTE end of life care facilitator / team leader, five WTE Macmillan Nurse band 7 and 4.8 WTE Macmillan Nurse band 6. Of these, three WTE specialist palliative care nurses were hospital-based to manage end of life patients while inpatients at the trust. This also met national guidance.
- In addition, there were three part-time administrators and a part-time education facilitator supporting the team. The service was in the process of recruiting a discharge facilitator (funded for two years) to manage and improve the discharge process for end of life patients.
- The Specialist Palliative Care Team delivered an 8am – 6pm service Monday to Friday for face-to-face and telephone consultations. The service was provided 9am - 5pm on bank holidays and there was a 24 hour telephone advice service available for out of hours' needs.
- EOLC was provided by all ward staff, with specialist support from SPCT.
- Staff told us they prioritised care for patients at the end of life as much as possible.
- Specialist palliative care and chaplaincy staff regularly attended ward rounds to provide support to ward staff around end of life care issues.
- Link nurses had been identified for most wards with an emphasis on medical wards.

Medical staffing

- The Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives (2012) recommends the minimum requirements of four whole time equivalent (WTE) consultants in palliative medicine for a population of 500,000. The specialist

palliative care team included four full-time palliative care consultants, one of whom led the service. The consultants divided their time between serving the local hospices, community end of life care and acute end of life care. 1.5 WTE of consultants were designated to acute end of life care in the trust and resources were flexed as required to meet the need of patients during annual leave and unplanned absences.

- There was a clear rota in place to manage out-of-hours access to the consultants including weekends and nights. Nursing staff confirmed they had access to consultant advice out-of-hours
- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals.

Major incident awareness and training

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency. Staff could access this on the intranet.
- Business continuity plans were in place to address such issues as staffing shortages and bad weather affecting services. Managers were aware of how to access these and the expected actions.

Are end of life care services effective?

Good

We rated effective as good because:

- The trust included a session on end of life care in the core mandatory training programme for ward nursing staff. The training included a video on the 'five priorities of care' for end of life care patients. The service was planning to introduce the Gold Standard Framework to hospital staff on eleven wards in 2017.
- Evidence based care of the dying patient (CDP) document had been developed and was starting to be implemented throughout the hospital.
- There was good evidence of multi-disciplinary working and involvement of the specialist palliative care team throughout the hospital.
- The trust had participated in the National Care of the Dying Audit (NCDAH) and performed better than the England average for three of the five clinical indicators. The trust scored particularly well for KPI3 'is there any documented evidence that the patient was given an opportunity to have concerns listened to', scoring 98% compared to a national result of 84%.
- There was evidence of end of life care training and support for ward based staff.
- Specialist palliative care nurses were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Each ward had an end of life link nurse and there was evidence that this was an active role to improve the quality of care for end of life patients. Link nurse meetings were held quarterly for updates and education.
- For those palliative care patients who were already known to the service and admitted to the hospital for care and treatment, 93% were followed up by contacting the ward within 24 hours to assess the need for specialist palliative care assessment.
- There was a 24-hour seven-day rota for palliative care consultant cover and this was accessed by nursing staff in the hospital when palliative care specialist advice was required out-of-hours. Access to specialist palliative care nurses was Monday to Friday at the time of inspection, but recruitment was underway to expand to a seven-day service.

However:

- The weekly specialist palliative care team (SPCT) multidisciplinary meeting included SPCT nurses and palliative care consultants but no other discipline such as allied health care professionals, pharmacy, or the chaplaincy.

End of life care

- The service did not report or monitor the number of patients referred to the end of life services who achieved their preferred place of death.

Evidence-based care and treatment

- The trust had introduced a 'caring for the dying patient' (CDP) care plan. The plan had been adapted from strategic clinical network guidance and was based on national guidance. Sources included the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- The plan was based on recommendations in the national guidance on end of life documentation, What's important to me. A Review of Choice in End of Life Care, The Choice in End of Life Care Programme Board (2015) and the five priorities of care identified in the report, One Chance to Get it Right, Leadership Alliance for the Care of Dying People (2014). It also complied with the NICE quality standard QS 144: Care of dying adults in the last days of life.
- Symptom control guidelines for use in the trust were included in the end of life plan. These were based on guidelines agreed by regional palliative care and end of life care groups.
- The service was planning to introduce the Gold Standard Framework to hospital staff on eleven wards in the trust during 2017. The Gold Standard Framework is a provider of quality improvement, accredited, evidenced based end of life care training for health and social care staff.

Pain relief

- Members of the specialist palliative care team had attained courses and qualifications in symptom control and pain management.
- Doctors we spoke with were aware of the guidance around prescribing for key symptoms at the end of life. They knew they could access the guide on the intranet and also seek support from the specialist palliative care team.
- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for the symptoms sometimes experienced at the end of life, including pain.
- Anticipatory end of life care medication (medication that patients may need to make them more comfortable) was appropriately prescribed. We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- We found that patients received good pain relief. Patients and relatives told us that their pain was under control and we saw that pain relief was administered in a timely manner. We did not observe any patients in pain during our inspection.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain.
- Care plans included pain assessment prompts and clear records of pain assessments.
- 'Just in case' medicines were prescribed appropriately for patients at the end of life.

Nutrition and hydration

- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care.
- Patients were encouraged to eat and drink as and when they were able to and for as long as they were able to in their last days of life.

- Staff told us that snacks were available for patients throughout the day and night.
- An audit of 18 end of life care plans was conducted in April 2017; 50% of care plans documented an agreed and individual plan for food and nutrition. An action plan was in place to increase education for nurses on the use of the plan.

Patient outcomes

- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and performed better than the England average for three of the five clinical indicators. The trust scored particularly well for KPI3 'is there any documented evidence that the patient was given an opportunity to have concerns listened to?' scoring 98% compared to a national result of 84%. Scores for the remaining two indicators were slightly worse than the England average score. These related to documented evidence that the needs of the person important to the patient were asked about, and that a holistic assessment of needs and individualised plan was completed in the last 24 hours of life.
- An audit of 18 end of life care plans was conducted in April 2017 to assess compliance with the five priorities of care. This found that there was documentary evidence that 94% of patients had been assessed by a doctor as likely to die within the next few days or hours and 78% of the patients and / or family members had been informed of the decision. It found 67% of patients and / or family members were involved in the decision of care and 72% of patients had an individualised care plan. A re-audit of the care plans was planned for July 2017.
- However, 50% of care plans documented an agreed and individual plan for food and nutrition and 44% documented that the needs of families and others important to the patient had been discussed and respected. Additional areas of poor documentation in the care plan included completion of the patient's diary, daily medical review, spirituality and emotional needs section and care after death section. A video of how to complete the end of life care plan was being developed for use during the mandatory end of life care education sessions for nursing staff.
- Between April 2015 and March 2016, the hospital reported that 1,209 trust-wide referrals were made to the Specialist Palliative Care Team. Of these referrals, 905 (75%) were cancer related and 304 (25%) were non-cancer related. The service submitted annual data to the National Council for Palliative Care national minimum data set project on specialist palliative care hospital support.
- A local audit of the response to end of life alerts on the patient administration system was completed in September 2016. It found that for those palliative care patients who were already known to the service and admitted to the hospital for care and treatment, 93% were followed up by contacting the ward within 24 hours to assess the need for specialist palliative care assessment. Of these, 33% of patients received a face-to-face visit.
- The service did not report or monitor the number of patients referred to the end of life services who achieved their preferred place of death.
- The service was in the process of introducing training for the Gold Standard Framework (GSF) across the trust. GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life.

Competent staff

- The trust included a session on end of life care in the core mandatory training programme for nursing staff. Many of the ward staff we spoke to told us about the training and that they had attended. We saw core competencies in providing end of life care and providing personal care after death for nursing staff. As part of the skills in practice programme, health care assistants and Band 5 nurses received sessions on end of life care and 'last offices'.
- The SPCT had secured funding for end of life care education from the local education and training board and used a collaborative approach with the two local hospices to use hospice staff to deliver education in the hospital.
- Medical staff varied in their responses when asked about their education in palliative care. The palliative care lead consultant and the SPCT team leader were involved in education sessions for junior doctors but it was acknowledged that palliative care education opportunities for more senior doctors would be helpful.
- In the national End of Life Care Audit – Dying in hospital report (2016), the trust answered yes to four of the eight organisational indicators. The trust performed worse

than average for KPI8A and KPI8C, both of which refer to in-house training including communication skills for care in the last hours or days of life for medical staff and for nursing (non-registered) staff.

- The palliative care link nurse scheme was re-launched in September 2015. All settings across the trust and local care homes were asked to identify nurses who had a specific interest in palliative care and who would be happy to fulfil this role. The nurses were asked what relevant subject they would like to be covered in the both years of this program and a schedule was developed around their requests.
- Line managers were asked to support the link nurses by allowing them to attend four forum sessions per year and by giving the link nurse the opportunity and resources to disseminate the information in their clinical areas. We saw evidence of information boards on wards disseminating information about end of life care, which were managed by the ward link nurse. Staff also told us that the link nurses had supported the implementation of the end of life care plan.
- Link nurses from all three hospital sites, community teams, care homes and local hospices were joined together for the sessions to share information and learn from each other's experiences. Sessions included an introduction to the specialist palliative care team and the role of the link nurse, advanced care planning and pain assessment, end of life care plan and use of anticipatory medications, breaking bad news and management of breathlessness. Feedback from staff was positive on the value of the programme.
- Two members of the specialist palliative care team (SPCT) had master's degree level specialist training in palliative care, one was awaiting results of their completed master's degree course, two were on the course at the time of inspection and two were scheduled to start the course in 2017 and 2018. Eight members of the team had completed a post-graduate certificate in palliative care.
- The SPCT were qualified as non-medical prescribers and had completed an advanced communications course.
- The appraisal rate for the service was 100% for medical staff and 86% for nursing staff. Staff we spoke to confirmed that they received an annual appraisal.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- Porters received training on induction and on an ongoing basis from body store staff around the transfer of the deceased to the body store.

Multidisciplinary working

- The SPCT attended weekly meetings with two local hospices to discuss referrals, inpatients and deaths.
- The palliative care consultants attended other specialty multidisciplinary (MDT) meetings for haematology, lung cancer, cancer of unknown primary and the hospice MDTs. A member of the SPCT nursing team attended the lung cancer, heart failure and upper gastroenterology MDT meetings.
- We observed the weekly SPCT MDT meeting attended by the SPCT nursing and medical staff. There was thorough discussion of existing patients, deaths in the past week, new referrals and new inpatients identified as known to the palliative care team by the alert system. Notes on their current condition and any care or treatment plan changes were recorded on the electronic record management system. There was no representation from other disciplines such as allied health care professionals, pharmacy, discharge planning or the chaplaincy. We were told that these disciplines were invited but rarely attended due to time constraints.
- The SPCT worked with the ward staff, specialist nurses, physiotherapy, occupational therapy, the chronic pain team and discharge liaison coordinators to arrange for safe discharge home.

Seven-day services

- The palliative care nursing team at Dewsbury was available 9am to 5pm Monday to Friday. The team could be accessed via telephone and access details were available on the website and provided to patients and families by the team. The nursing team was not available out-of-hours or at the weekend. There was no single point of access for the palliative care services across the community served by the trust.
- There was a 24-hour seven-day rota for palliative care consultant cover and this was accessed by nursing staff in the hospital when palliative care specialist advice was required out-of-hours.
- Out-of-hours imaging, pharmacy, occupational therapy and physiotherapy were available within the hospital as required by the patient.

End of life care

- The chaplaincy service provided pastoral and spiritual support, and was contactable out of hours on a 24 hour basis.

Access to information

- The CDP document provided a guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that staff had access to up to date clinical records when caring for and making decisions about patient care.
- Staff had access to a number of resources through the trust intranet. Staff we spoke with said this information was accessible and easy to use.
- The service used an electronic record management system that was used by multidisciplinary healthcare professionals across the hospital and community services although not all members of the healthcare community used the same system. This system was used to inform the multidisciplinary meetings held weekly and used daily to access information about palliative care patients.
- The trust had implemented the Electronic Palliative Care Co-ordination Systems (EPaCCS). EPaCCS enable the recording and sharing of people's care preferences and key details about their care with those delivering their care. This record was accessible on the hospital electronic patient record system for staff to view if a patient was admitted and helped alert them about end of life preferences.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place relating to consent. This included advance decision making, mental capacity guidance and best interest decision making and the use of Independent Mental Capacity Advocates (IMCAs).
- Staff we spoke with had a clear understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.
- We reviewed 24 DNACPR forms in patient records across the hospital. These were all placed at the front of the patient record. All 24 forms were kept at the front of the patient's notes, included clear documentation and clinical reasoning for the DNACPR decision. Decisions were appropriately recorded and approved by a senior clinician. All forms were authorised by a medical staff member of appropriate seniority.
- The resuscitation team carried out an annual audit of 120 DNACPR forms trust-wide in September 2016. Documentation to evidence the reasons why the patient was not involved in decision-making had improved from the previous year's audit from 57% to 78%. Evidence of documentation of a capacity assessment where required, had improved from 50% to 67%. An action plan was in place and included disseminating the results to the consultant body and to improve education of patients and relatives to increase understanding of DNACPR orders and to promote active and early engagement in the decision making process.

Are end of life care services caring?

Good

We rated caring as good because:

- Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff and they were involved with their loved ones care and felt supported in making decisions as a family.
- The body store department provided out of hours support for families who requested a viewing of their relative.
- Staff were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance.
- Care and support was clearly a priority for patients and relatives.
- In all interactions, staff were seen to treat patients and relatives with dignity and respect.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by people and their families.
- Patients and their relatives had good emotional support from the specialist palliative care team, chaplaincy, and bereavement office and ward staff.
- We saw staff maintained the privacy and dignity of patients. They took opportunities to further inform the patient and their family of the situation.

End of life care

- Drop-in services were accessible to palliative care patients and families for emotional support and therapies.

Compassionate care

- Staff at the y the hospital provided compassionate end of life care to patients.
- The body store department provided an out of hours support for families who requested a viewing of their relative.
- We saw a dedicated chaplain team as well as access to chaplaincy volunteers who demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect.
- We saw that privacy and dignity was maintained and opportunities were taken to further inform the patient and their family of the situation. We observed that patients and relatives were central to this process.
- All patients admitted to the hospital were given the opportunity to discuss their wishes for their future care with staff.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death café's' where issues relating to death and dying were talked about openly.

Understanding and involvement of patients and those close to them

- The Hospital operated an open visiting policy for patients friends, relatives and carers
- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- A survey of patients seen by palliative care consultants found that 34 (92%) rated the doctor as very good at explaining their condition and involving them in decisions. All respondents rated the doctor as very good at listening to them.

Emotional support

- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- The hospital provided Christian and Muslim prayer facilities and a point of contact with the appropriate faith community for patients and families. They offered a variety of services to patients including confidential listening, bereavement support and regular ward visits. Spiritual needs were assessed as part of the end of life care plan and the chaplaincy was accessible 24 hours a day if required out-of-hours.
- Chaplains would sometimes accompany relatives to the body store and we saw that chaplaincy support was a part of the trust major incident plan. Chaplaincy staff told us they were available to provide emotional support to patients, relatives, visitors and staff alike.
- The chaplaincy service provided spiritual support for patients and their families together with the Bereavement Team.
- The specialist palliative care team, the chaplaincy staff and ward based staff provided emotional support to patients and relatives.
- Patients with life-limiting illnesses could access the Rosewood Centre based at Dewsbury Hospital, which is a palliative day support and therapy unit. It aimed to enhance the quality of life of those struggling with the physical and mental impact of their illness. Services included a palliative pulmonary rehabilitation programme to help patients with progressive lung disease and primary or secondary lung cancer, manage chronic breathlessness.
- End of life patients and their carers could also access a drop-in service at the local hospice for supportive services including music therapy, benefits advice and complementary therapies.

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The trust was required to improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis following the previous inspection. We were unable to assess the level of performance in achieving fast track discharges for end of life patients due to lack of evidence. There was no trust definition of a fast track discharge for end of life care patients and no audit work had been done to

measure performance in this area since the last inspection. Management recognised that end of life patients needed a dedicated resource and had recently had an end of life discharge facilitator role approved and funded for the next two years.
- The service reported that 78% of all new referrals were seen within 24 hours of being referred to the team in February 2017. This is being confirmed
- The service did not collect data on preferred place of death and the percentage of people who achieved this.

However:

- The trust was working to create a local end of life care strategy with the clinical commissioning group and other stakeholders.
- There were clinical networks in place linking the hospices, hospital and community services to ensure effective communication as the patient moved between services.
- Facilities such as palliative care beds and overnight stay rooms for relatives were received positively by patients and families.
- Arrangements were in place for people to complain or raise a concern and there was openness and transparency in how complaints are dealt with.
- Discharge liaison capacity had increased since the last inspection.

Service planning and delivery to meet the needs of local people

- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- The hospital had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.
- We also noted that wards allowed open visiting times for relatives of end of life care patients. Pull out beds and comfortable chairs were available for visitors to stay the night. This ensured family and friends could spend unlimited time with the patient.
- There were clinical networks in place linking the hospices, hospital and community services to ensure effective communication as the patient moved between services. Weekly meetings were held at the local hospices to discuss referrals, inpatients and deaths. The palliative care consultants worked across the two trust sites and provided clinical care to the local hospices as well community services
- The end of life care plan was developed jointly with the SPCT and the local hospices. This meant that one form of documentation was used wherever the patient chose to have end of life care. Secondment opportunities had been implemented between the hospital and community SPCTs and the local hospices to improve seamless working for the benefit of patients and allow professional development.
- The trust-wide end of life care project group met monthly and was chaired by one of the deputy directors of nursing. It was attended by representatives from the SPCT, patient experience, nursing education, the local hospice and senior nurses. The group reviewed progress with various projects to improve the quality of end of life care in the local community. These projects included bedside care, care of personal belongings, end of life education and bereavement care.
- Interpreters were available within the trust and a nurse told us the system worked well and would be available to attend meetings.

Meeting people's individual needs

- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs.
- The chaplaincy team engaged with other faith leaders to ensure that the needs of patients from different faiths would be met. This work included formalising links with key faith groups through service level agreements.
- The chapel also had a multi-faith prayer room and there were plans in progress for extending the prayer room and improving facilities for patients, staff and visitors of multi-faiths.
- The SPCT provided phone advice and also frequently visits to ward.
- The chaplaincy delivered staff training in spiritual, religious and cultural awareness; spiritual aspect of palliative care; understanding and dealing with grief and loss to staff.
- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.

End of life care

- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible, with staff reporting that they would respond on the same day for urgent referrals.
- Discharge coordinators were available to support the process of getting people home, including for those patients at the end of life.
- The SPCT had improved early access to palliative care services for patients with Stage IV lung cancer. In collaboration with the lung cancer specialist team, an appointment with the palliative care consultant was offered to patients when appropriate.
- The SPCT also had increased involvement with patients with motor neurone disease. Following the initial appointment with a neurologist, a palliative care consultant took over all further medical reviews and led the MND multidisciplinary meetings. This was to allow for greater opportunities for symptom management and advance care planning.
- The life care project group was developing an end of life care box to be placed on the wards as a resource for ward staff when patients in the last stage of life were admitted. These included 15 end of life care plans, mouth care plans, mouth ease tissues, shampoo caps, ring pouches, syringe driver bags, bereavement booklets, last offices documents and car parking permits. A pilot was being planned at the time of the inspection.
- The needs of patients with learning disabilities were monitored and facilitated by the learning disabilities lead nurse. The SPCT sought support from the lead nurse when required to assist with end of life care planning.
- The wards had a relaxed visiting policy for relatives to visit patients.
- Family members who wished to stay with their relatives were encouraged to do so.

Access and flow

- Face to face palliative care was available Monday to Saturday 9am to 5pm including bank holiday Mondays. At other times a hospice telephone advice was provided on an on call basis.
- The SPCT worked closely with the specialist discharge team to discharge people to their preferred place of dying.
- Referrals to the specialist palliative care team came through by phone and in writing and were picked up through routine ward visits.
- Ward staff told us they had referred patients to the team, both reported that the response was prompt and the support from the team had been valuable and beneficial to patients.
- The service reported that 78% of patients were seen within 24 hours of being referred to the team. Staff told us that the electronic patient administration system was checked several times a day for new alerts or referrals and urgent referrals were seen the same day. If this could not be achieved, the team called the ward to check on the patient and saw them within 24 hours.
- The key performance indicator for urgent referrals was for all to be seen within 24 hours during the working week. The service met this 100% target for February to April 2017.
- From the minimum data set submitted by the trust for April 2016 to March 2017, the total number of patients seen by the service was 1714. Of these 822 (48%) were new referrals, 32 were the existing caseload and 860 (50%) were re-referred during the year. There were 359 deaths and 1,225 discharges from the service.
- The service did not collect data on preferred place of death and the percentage of people who achieved this.
- Staffing levels within the SPCT had significantly improved and were at full complement at the time of this inspection. An SPCT nurse attended daily 'board rounds' on two wards in the hospital where most palliative care patients were inpatients. This provided an update on potential discharge plans for end of life patients and the team took any action necessary to facilitate this, such as ensuring that anticipatory medicines were available and handover to the community palliative care team was completed. A community prescription chart and checklist was used to improve the process. Team members received referrals from the emergency department and were able to review and advise on symptom control to avoid hospital admission for patients where this could be resolved quickly.

Learning from complaints and concerns

- Between April 2015 and March 2016 there were no complaints about end of life care services.

End of life care

- Members of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.
- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- The Head of Patient Experience triangulated complaints with other data such as incidents, PALS data, Family and Friends data and claims to identify clinical areas where support and education was required to improve patient experience.

Are end of life care services well-led?

Good

We rated well-led as good because:

- The quality of leadership for end of life care had improved since the last inspection. Structures, processes and systems of accountability, including the governance and management of joint working arrangements were clearly set out, understood and effective.
- Leadership within the end of life specialist palliative care team was clear.
- There was a commitment by the trust and this was underpinned by staff that end of life care patients were cared for in a timely and appropriate manner
- The establishment of the end of life project group had led to a number of projects being undertaken to improve the quality of care for end of life patients.

However:

- There was no regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients.

Leadership of this service

- The end of life care lead on the trust board was the director of nursing and quality. The clinical lead for specialist palliative care and the specialist palliative care team (SPCT) leader had bimonthly meetings with the director of nursing and quality to provide updates and discuss current issues within end of life care. There had been a nominated non-executive member of the board for end of life care; this role was in the process of being reassigned.
- End of life care was managed within the specialist medicine directorate and the SPCT reported to the directorate clinical director. The clinical lead for the service was a palliative care consultant who was active in local and regional end of life care groups, including the strategy group for developing an integrated service across the local community.
- The specialist palliative nursing team were led by the end of life facilitator. SPCT members described management as professionally and personally supportive and they felt well-informed by the service leadership.
- End of life care on the wards was led by the SPCT and supported by link nurses on each ward. We saw evidence that link nurses were active as a resource for end of life care. Ward staff were uniformly positive about the accessibility of the SPCT and the level of support received in managing end of life care patients.

Service vision and strategy

- The service had a draft end of life care strategy 2017-2019, which was for review in April 2019. The document referred to key priorities including “each person is seen as an individual”, “each person gets fair access to care” and “care is coordinated”. There was no action plan attached to the strategy to indicate the timeline to achieve the key priorities.
- The specialist palliative care (SPCT) team participated in the local multiagency project board working on the end of life care strategic outline case. This was sponsored by the local clinical commissioning group (CCG) to support the development of an integrated and comprehensive end of life care service for local communities including those in hospices, care homes and prisons. The board was led by the CCG and was in the process of developing a business case describing the long-term vision and steps required to achieve this. Two of the SPCT palliative care consultants were on the project board and other members of the team had attended project workshops.
- Staff told us they were aware of these end of life strategic developments, which were communicated in the monthly joint operational meeting.
- The trust had made a commitment to the roll-out of the GSF framework.

End of life care

Governance, risk management and quality measurement

- The Mid Yorkshire palliative care joint operational meeting was held monthly and attended by nursing and consultant members of the SPCT. We reviewed three sets of minutes; there was a set agenda, which included operational and business matters, risk management, complaints, incidents, patient experience, education, and service improvement.
- The trust-wide end of life care project group met monthly and was chaired by one of the deputy directors of nursing. Representatives attended it from the SPCT, patient experience, nursing education, the local hospices, and senior nurses. We reviewed three sets of minutes; the group reviewed progress with various projects to improve the quality of end of life care provided by the trust. There was a project plan that was monitored and progress recorded.
- The SPCT held monthly governance meetings which, reviewed patient safety incidents, complaints, risk management, new NICE guidance, the clinical audit programme and mortality and morbidity. The service also reported into the directorate of medicine governance meetings.
- The end of life service risk register recorded one risk, which was the inability to provide an efficient fast-track discharge for end of life patients. The service had submitted a bid to Macmillan to fund a discharge project and recruit a discharge facilitator to focus on the discharge of end of life patients. This bid was successful and recruitment was taking place at the time of the inspection. The end of life project group planned to act as the steering group for the discharge project. The corporate quality committee raised fast-track discharge for end of life patients as a key message to the trust board.
- There were no performance reports produced by the SPCT on the quality of service that were submitted at directorate or board level.

Culture within this service

- Staff on the SPCT were passionate about the service they provided and the quality of care they gave to patients and their carers. The SPCT facilitator told us that since the increase in staffing and interaction with the hospices including secondment of staff and sharing education, morale had improved. Team members gave increased positive feedback to the facilitator since these changes took place.
- Staff were positive about the educational opportunities available. Several of the SPCT staff either were in the process of studying for a master's degree or planned to start the course in the near future.
- One team member positively described how supportive the team and management were in cases where members of the team were personally affected by bereavement or by complex and demanding cases of end of life care.
- The culture encouraged staff to be open, honest and transparent when things went wrong. There was a policy for Duty of Candour and training was included in patient safety mandatory training modules.

Public engagement

- The SPCT were involved in engaging the public and raising awareness about end of life care through various activities including Macmillan coffee mornings.
- The trust had a Patient, Family and Carer Experience Strategy. The programme plan included a project to co-design improvements in end of life care using the national Always Events methodology. Interviews were being held with patients, relatives and carers to establish 'what matters most' to identify aspects of the patient experience that are so important to patients and families that trust staff must perform them consistently for every patient, every time.
- The trust had a Facebook page that communicated a range of information to the public about the hospital and staff. For example, the recent upgrade to the bereavement suite at Pinderfields Hospital with photos and information about the staff and improvements made.
- The SPCT ran a quarterly 'users and carers' group meeting which included staff and individuals who had palliative care issues or had been seen by the SPCT.

Staff engagement

- Staff we spoke with on the wards were well-informed about the specialist palliative care team, the support they offered and the importance of high quality end of life care. There were end of life care link nurses on each

ward promoting end of life care and acting as a support to staff. End of life care was actively supported by the director of nursing and quality and seen as an area of priority for continuous improvement.

- The 2016 trust-wide staff survey identified that the trust needed to improve in a number of areas including staff recommending the trust as a place to work or receive treatment, staff motivation at work, staff satisfaction with the quality of work and patient care they were able to deliver and recognition and value of staff by managers and the trust.
- The trust had an action plan in place to respond to areas in the 2016 staff survey where staff engagement needed to improve. This included establishing a range of activities and events to show staff how the trust recognised and appreciated them such as celebrating International Nurses' Day, long service awards, team of the week and MY star of the month awards. The action plan also addressed the workforce strategy, health, and well-being of staff.
- The chief executive sent out a monthly team brief to update staff on the latest news about the organisation and at a local level, the SPCT received updates at the joint operational monthly meeting and during daily handover.

Innovation, improvement and sustainability

- The SPCT team participated in the local multiagency project board working on the end of life care strategic outline case for the local community.
- The palliative care consultants were involved in a wide range of specialist multidisciplinary meetings to provide expertise for symptom control and facilitate early access to advance care planning for patients with life-threatening conditions.

Outpatients and diagnostic imaging

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provided a range of outpatient and diagnostic imaging services from three hospitals, Dewsbury and District Hospital, Pinderfields Hospital and Pontefract Hospital.

Between December 2015 and November 2016 there were 506,250 first and follow-up outpatient appointments at the trust. There were 182,758 appointments between December 2015 and November 2016 at Dewsbury and District Hospital.

We visited the main outpatient departments, dermatology, phlebotomy and diagnostic imaging.

The service had an access, booking and choice directorate which was responsible for outpatient services managers and was part of the surgical directorate. The booking centre was based at Pinderfields Hospital.

Diagnostic imaging services were mainly provided from three locations: Pinderfields General Hospital, Pontefract General Infirmary and Dewsbury General Hospital. Diagnostic imaging at Pinderfields General Hospital provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. The acute clinical work including fluoroscopy was concentrated at Pinderfields General Hospital. The service offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures.

Diagnostic imaging services were available for inpatients 24 hours a day, every day of the year. Outpatients and those referred by their GPs could access plain film services seven days a week between 8am and 8pm and for CT there were appointments from 8am to 8pm on weekdays. MRI was available for outpatients, in patients and emergency department patients every day from 8am to 8pm. After these hours patients requiring urgent MRI scans were transferred to Pinderfields General Hospital. Ultrasound services ran from 8am to 6pm on weekdays for outpatients. Sessions were set aside for inpatients and emergency department patients from 10am to 3pm on Mondays, and 11am to 3pm on Tuesdays to Fridays. The service provided extra appointments for evenings and weekends to meet demand. Diagnostic imaging services booking team organised and booked appointments for procedures and follow-ups for all hospital sites from the radiology booking centre at Pontefract General Infirmary.

During the inspection of diagnostic imaging services at Dewsbury District Hospital, we spoke with two patients, one relative, and six staff including managers, doctors, radiographers, and nurses, all of whom worked across the three hospital sites. We observed the diagnostic imaging environments, checked five electronic records, equipment in use and looked at information provided for patients. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Records we reviewed confirmed that there continued to be a steady increase in demand for diagnostic services.

During our inspection we spoke with 15 staff, eight patients and visitors and we looked at 12 patient records in outpatients.

Outpatients and diagnostic imaging

Summary of findings

The Mid Yorkshire Hospitals NHS Trust was inspected previously between the 23 and 25 June 2015 as part of a follow up inspection. The previous inspection rated safe as good, effective as not sufficient evidence to rate, responsive as requires improvement and well led as good. Previous issues identified included capacity issues, cancellation of appointments and not consistently achieving referral to treatment indicators.

Overall we rated this service as requires improvement because:

- Managers told us clinical validation had occurred on some waiting lists, for example in areas of ophthalmology. However, this had not occurred on all backlogs or waiting lists for appointments across the trust.
- There were issues regarding referral to treatment indicators and waiting lists for appointments. There was an appointment backlog which had deteriorated since the last inspection and was at 19,647 patients waiting more than three months for a follow up appointment.
- No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks). The trust had a trajectory to be achieving the indicators by March 2018.
- Although senior managers could describe the duty of candour, it was not well understood across all staff groups.
- Appraisals completion rates did not always achieve the trust target.
- In main outpatients, team meetings did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.
- The trust did not measure how many patients waited over 30 minutes for imaging within departments.

However:

- A trust incident reporting system was used to report incidents and staff we spoke with were aware of how to report incidents. There had been no never events or serious incidents between March 2016 and February 2017. Staff were aware of how to report safeguarding concerns
- Areas we visited were visibly clean and tidy. Medicines checked were stored securely and medicines checked were in date. Staff told us records were available for clinics when required.
- Actual staffing levels were in line with the planned staffing levels in most areas. There had been issues with staffing levels in main outpatients; however managers told us they had recruited to assist in addressing the issues.
- Staff provided compassionate care to patients visiting the service and mostly ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff. The Did Not Attend (DNA) rate was lower than the England average.
- Managers were able to describe their focus on addressing issues with the referral to treatment indicators and reducing waiting times. There were referral to treatment recovery plans in place for various specialties.
- Risk registers were in place and managers took risks to the divisional governance meetings. Management could describe the risks to the service and the ways they were mitigating these risks.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was effective teamwork within teams and there was a culture of openness and honesty.
- Diagnostic imaging leaders encouraged and enabled staff to develop their own skills and knowledge, share good practice nationally, and improve the service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Managers told us clinical validation had occurred on some waiting lists, for example in areas of ophthalmology. However, this had not occurred on all backlogs or waiting lists for appointments across the trust. This did not provide assurance that the risk to patients waiting for follow up appointments was being mitigated or clinical validation was being completed across specialities.
- The outpatient daily monitoring cleaning chart was not consistently completed or up to date during our inspection. This did not provide assurance cleaning had been completed.
- Although senior managers could describe the duty of candour, it was not well understood across all staff groups.

However:

- There was a trust incident reporting system which was used by outpatients and diagnostic imaging services. Staff we spoke with were aware of how to report incidents. There had been no never events or serious incidents between March 2016 and February 2017.
- Areas we visited were visibly clean and tidy. Radiology departments were clean and hygiene standards were good.
- Patient records were completed and available. Records were stored securely in electronic format. Medicines checked were stored securely and medicines checked were in date.
- Actual staffing levels matched the planned staffing levels in general across radiology modalities and staff worked across all sites to ensure continuity of the service at times of greater demand.

Incidents

- The trust had an incident reporting system used for reporting incidents in outpatients and diagnostic imaging. Managers told us these were investigated by service leads and where a serious incident had occurred, managers appointed a member of staff to investigate the incident.
- Between March 2016 and February 2017, the trust reported no incidents which were classified as Never Events for outpatients and diagnostic Imaging.
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The trust reported no serious incidents (SIs) in outpatients and diagnostic imaging which met the reporting criteria set by NHS England between March 2016 and February 2017. However the service had an incident categorised as severe by the trust which occurred in ophthalmology. The information provided by the trust highlighted delay in treatment and lack of capacity to meet demand as a contributory factor to the incident. The trust had completed a summary review which included information such as contributory factors, root cause, lessons learnt and recommendations.
- Staff we spoke with were able to describe the incident reporting system and how they would report incidents in the electronic incident reporting system.
- Managers told us that if a serious incident occurred, this would be discussed at local team meetings and the local governance meeting. Managers told us they would conduct a 72 hour report on the incident and the risk committee would then decide if further investigation was required.
- Staff told us that learning from incidents was discussed at team meetings across outpatients; however, team meetings were not held regularly and there were not always minutes from the meetings, which could be disseminated to staff. This did not provide assurance that learning from incidents was shared with all staff.
- The eye centre held team meetings monthly and team leaders told us this was where they would share learning from incidents. A team meeting agenda for April 2017 showed that clinical incidents and complaints were part of the agenda for this meeting.
- Staff understanding of duty of candour varied across the services, however staff could describe being open and honest.

Outpatients and diagnostic imaging

Diagnostic imaging:

- The services reported no serious incidents (SI's) in outpatients between March 2016 and February 2017.
- There had been twelve recent radiological incidents reported under ionising radiation medical exposure regulations IR(ME)R at the trust. These were attributed across all modalities and most were not thought to have been caused by referrer errors. The diagnostic imaging safety team had carried out investigations and implemented a new process where operators could reduce the occurrence of human error.
- All managers and most staff we spoke with were aware of duty of candour, their responsibilities and its requirements. Staff at all levels were able to explain their departmental culture of being open, honest and transparent when things go wrong.
- Radiology discrepancy incidents were discussed by case review with radiologists. Reporting radiographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care.
- Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean and tidy. Hand gel was available in areas visited and personal protective equipment such as gloves were available. Managers told us departments were cleaned daily.
- Managers in main outpatients showed us a frontline ownership audit (FLO) they completed monthly. Results for April 2017 showed that 92% was achieved for the general environment, 100% for the patient immediate area, 100% for dirty utility and waste disposal, 100% for hand hygiene facilities and 100% for bare below the elbows adherence. Results for March 2017 showed 100% for dirty utility and waste disposal, 100% for general environment, 100% for patient immediate area, 89% for patient equipment, 100% for hand hygiene audit and 100% for bare below the elbows.
- Outpatients had a daily monitoring cleaning chart; however this was not consistently completed. For example, one out of the five charts on display was up to date during our inspection, one was out of date and three were blank. This did not provide assurance that cleaning of areas and toys for example had been completed.
- Dermatology outpatients achieved 97% in the environment audit in January 2017.

Diagnostic imaging:

- Personal protective equipment (PPE) such as gloves, masks and aprons was provided and used appropriately throughout the imaging department and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- Specialist diagnostic imaging protective equipment including lead aprons were provided and were clean and free from cracks. Staff explained the safety procedures undertaken to ensure aprons were checked for wear and tear or damage.
- The department was cleaned daily by domestic staff who took responsibility for cleanliness of the department. All areas we observed were clean.
- The department's different areas such as changing rooms and reception were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment between patient use, reducing the risk of cross-infection or contamination.
- Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly.

Environment and equipment

- The trust undertook an outpatient survey in 2016. The survey had a response rate of 42%. The survey showed that 100% of respondents highlighted the toilets were clean and 99% reported that the environment was very or fairly clean.
- Dermatology outpatients had two treatment rooms and four consulting rooms in the department. There was carpet in main corridors; however clinic rooms were laminate flooring. Toilets were available and a disabled toilet was available in the department. There was a height and weight area in the department. A recovery room was available next to the treatment room for patient use after minor operations in dermatology.
- We looked at equipment, such as resuscitation trolleys and found this to be checked daily.

Outpatients and diagnostic imaging

- Main outpatients had one main waiting area and four sub waiting rooms in the department. Toilets were available and there was access to a wheelchair accessible toilet. A privacy room was available in main outpatients.

Diagnostic imaging:

- Check in was by receptionist at the main entrance to the department with a further reception for patients with direct access from the Emergency Department. The reception desks provided enough space between the desk and the people waiting to ensure patients could not be overhead speaking.
- X-ray equipment was well maintained and quality assurance (QA) checks were in place for all equipment. QA checks are mandatory and based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These regulations protect patients against unnecessary exposure to harmful radiation.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range as set by IRMER.
- The department provided local rules for each piece of equipment and we saw a user guide for each room.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- Crash trolleys throughout the departments were all locked and tagged. We saw checklists to show staff made regular checks of contents and their expiry dates and all stock we checked was within its use by date.
- There was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces. There were separate areas for inpatients and outpatients. This made sure that the privacy and dignity of patients was preserved. The department had recently reorganised space so that an inpatient waiting area had been developed. The waiting area ensured inpatients were offered privacy before and after imaging and no inpatients in beds, trolleys or chairs waited in public areas or corridors.

Medicines

- Medicines checked were stored securely and staff told us they stock rotated medicines as they replenished stock. Medicines checked were in date. We found one medical gas cylinder in Dermatology outpatients was out of date and when notified staff of this, this was replaced immediately.
- Refrigerator temperatures were checked and documented on a daily log within the services; these were checked when clinics were taking place.

Diagnostic imaging:

- We found medicines were managed securely. The medicines refrigerators were locked and the medicines we checked were in date.
- Records provided by the trust showed that only 52% of all diagnostic imaging staff had attended Medicines management level two training. No staff in CT had attended medicines management level one training. However, records showed that 31 staff had been identified as needing this training.

Records

- Records were written during clinics and scanned onto the electronic patient system. Staff told us there were no current concerns with record availability in outpatients. Records seen were completed appropriately.
- As of April 2017 the trust reported there were no known instances of patients seen in Outpatients without their full medical record being available. The trust has reported that they mitigated this risk by having a standard operating procedure in place.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via electronic records systems.
- We looked at five electronic patient records and all were completed correctly.

- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. Risk assessments were stored electronically and were easily accessible to all diagnostic imaging staff.

Safeguarding

- The trust target for completion of mandatory safeguarding training was 95%.
- Medical and Dental staff within the Outpatients and Diagnostic core service, did not reach the 95% compliance rate for mandatory safeguarding courses.
- Nursing and Midwifery staff within the outpatients and diagnostic core service achieved the 95% compliance rate for safeguarding adults level one, safeguarding children level one. They also achieved the 85% target for safeguarding children and adults level 2.
- Physiotherapy team leads we spoke with had knowledge of safeguarding and were able to describe safeguarding procedures.
- Staff in dermatology outpatients told us they had level two safeguarding training. Staff told us they would contact the safeguarding team for advice if required.

Diagnostic imaging:

- Staff we spoke with had an understanding of safeguarding vulnerable adults or children principles and processes. Staff we spoke with knew that there was a policy on the intranet and staff within the organisation who they could speak with for advice.
- Safeguarding training compliance for diagnostic imaging staff fell below the target of 95%. Radiology training compliance for all staff across the trust was close to the trust target at 92% for Safeguarding adult's level 1 and above the 85% target for level 2. For safeguarding children training the compliance rates were 92% for level 1 and 90% for level 2.

Mandatory training

- Staff told us they were up to date with mandatory training and managers told us where staff were not up to date with mandatory training, they were booked onto the course.
- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%.
- Nursing and midwifery staff within the outpatients and diagnostic imaging core service achieved the target for five of the seven core training modules; they did not reach the target of 95% for Infection control and fire safety.
- Medical and dental staff within outpatients and diagnostic imaging core service achieved the target for three of the seven core training modules; they did not reach the target of 95% for infection control, fire safety, health and safety and information governance.

Diagnostic imaging:

- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and used this system to ensure staff had completed or were booked on mandatory training.
- However, managers we spoke with told us, and records showed, mandatory training compliance rates did not achieve the trust target of 95%.

Assessing and responding to patient risk

- There were backlogs in ophthalmology outpatients for first and follow up appointments. Managers told us that Glaucoma patients had an administrative validation to check they were on the correct waiting list followed by a consultant validation. The glaucoma service had two forms, one was the partial booking referral form, which went to reception staff and the booking centre to book an appointment and there was another referral form, which was used for appointments which needed to be booked in the following 12 weeks. The 12 week form for appointments was used to ensure the appointment was booked within the required timeframe. There was no clinical validation in other ophthalmology appointment backlogs for patients awaiting appointments. Ophthalmology clinical governance meeting minutes for May 2017 highlighted patients not receiving appointments for requested time due to ongoing capacity issues as a risk.
- Managers told us some waiting lists had been clinically validated, however not all had been. The planned care

improvement programme plan had clinical validation and review of follow ups as part of the plan and stated that review and validation of follow up patients was in progress as at February 2017.
- The follow up project plan highlighted review and validate follow up backlog. Most actions were in progress.
- The trust provided a document which was an update on the management of patients waiting for follow up in April 2017 and this highlighted the trust could not provide assurance that clinical validation had or was taking place across specialities.
- Dermatology minor operations had taken into account the local safety standard for invasive procedures. Staff told us these were completed for all minor operation dermatology procedures in the clinic.
- Staff in physiotherapy told us they carried out an initial assessment, for example in the MSK clinic which identified risks.

Diagnostic imaging:

- Diagnostic imaging policies and procedures were written in line with IR(ME)R to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holder for the Medical Physics elements of diagnostic imaging was employed by the trust within the Medical Physics department at Pinderfields General Hospital. The role of the ARSAC advisor is to be contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were employed by the trust. They visited the departments, attended meetings and provided advice as required.
- There were named certified Radiation Protection Supervisors (RPS) for each modality to give advice when needed and to ensure patient safety at all times.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000. Local rules for each piece of radiological equipment were held electronically and available to all operational staff within the immediate vicinity of the equipment.
- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure they were given an early appointment. All other requests were triaged and appointments were allocated accordingly.
- We observed and records showed diagnostic imaging staff used the world health organisation (WHO) safer surgical checklist for all interventional procedures. The latest audit of WHO checklist compliance for February 2017 showed 100% compliance for fluoroscopy, angiography and cardiography. A wider audit carried out at the same time for all procedures within diagnostic imaging showed 89% compliance.
- Managers told us that the WHO safer surgical checklist process had been adopted and embedded by all staff carrying out interventional procedures and we saw an audit carried out in April 2017 showed compliance rates between 85% and 90%. Staff told us checks were always completed in practice and full compliance would be achieved with improved documentation.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients. Electronic records we saw showed that staff had checked no woman of childbearing age was at risk of having an x-ray taken if there was a chance she may be pregnant. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not.
- Resuscitation training compliance for all diagnostic imaging staff across the trust was only 68%.

Nursing staffing

- As at March 2017, outpatient's whole time equivalent (WTE) staffing establishment at Dewsbury and District Hospital was 15.99 WTE. There were 14.71 WTE in post.
- As at 28 February 2017, the trust reported a vacancy rate of 11% in Outpatients for qualified and unqualified nursing staff. Dewsbury and District Hospital had a vacancy rate in outpatients of 7%.

Outpatients and diagnostic imaging

- Between March 2016 and February 2017, the trust reported a turnover rate of 10% in outpatients for qualified and unqualified nursing staff. Dewsbury and District Hospital had a turnover rate in outpatients of 10%.
- Between March 2016 and February 2017, the trust reported a sickness rate of 7% in outpatients. Dewsbury and District Hospital had a sickness rate in outpatients of 4%.
- There was no data available for bank and agency use within outpatients and diagnostic imaging across the trust.
- Managers told us recruitment to administrative posts was difficult and they had previously held a recruitment drive to try and address this issue.
- Managers told us there were no vacancies in dermatology outpatients. Ophthalmology staff told us there were no current concerns with staffing levels.
- There had been recent staff issues in main outpatients at Dewsbury Hospital where the service had been three WTE staff members below the planned number. Staff from other sites at the trust had sometimes worked at Dewsbury Hospital main outpatients to assist in dealing with staffing shortages. During our inspection we were told the service had been recruiting and had appointed to the vacant positions. Managers told us this would assist in ensuring the department was at almost full establishment staffing levels.
- Managers told us they considered skill mix and the type of outpatient clinic being provided when managing staffing requirements for the clinics. Teams were generally a mixture of registered nurses, administrative staff and healthcare assistants in the department.
- Team leads in physiotherapy outpatients told us they were currently around 50% staff lower than the planned level, which was being covered by staff working additional shifts. Staff told us there was a recovery programme in place and they expected to be back to full establishment by September 2017.
- Dewsbury Hospital planned staffing requirement for phlebotomy of three WTE staff and they had an actual WTE staffing level of three.
- Physiotherapy staffing levels provided by the trust for April 2017 showed there was a planned WTE staffing level of 61.92 for qualified staff and the service had an actual WTE staffing level of 59.18.
- The trust provided information showing that Audiology outpatients had a planned WTE of 24.84 and an actual WTE of 23.67; however the information provided by the trust stated it had recently recruited and had full establishment as at June 2017.
- The trust provided information about ophthalmology outpatient staffing vacancies. This showed that the trust had in place one WTE Band six Nurse Practitioner, 43 hours Band five and 1.7 WTE Band three staff. There was one consultant post vacancy and two specialist optometrist post vacancies.

Diagnostic imaging:

- The trust had appointed a radiology matron who acted as direct line manager for radiology nurses.
- There was a Band six radiology sister and a team of specialist nurses to support interventional radiology procedures. There were four WTE nursing vacancies. However, one Band five nurse had been recruited and was due to commence shortly after our inspection.
- Interviews for Bands two and three support staff were planned for early June 2017.
- Most interventional work was carried out at Pinderfields General Hospital but nurses travelled between hospitals to support interventional procedures.

AHP Staffing

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely.
- Between March 2016 and February 2017, the trust reported a sickness rate of 3.6% for radiology staff.
- There had been difficulties in recruitment of qualified radiographers in the past. This was in line with the national picture regarding radiographer recruitment. There had been significant vacancies across the team and managers told us these had improved significantly. The establishment figure for radiographers across the whole trust was 169 WTE staff and at the time of our inspection there were 149 in post. The vacancy rate was 7.5% and these posts were being recruited to following successful recruitment open days targeted at final year students. Staff we spoke with were able to corroborate this.

- Managers were planning for new staff to be trained to specialise in modalities including CT.
- The departments had three agency staff and only five bank staff across the whole trust. Bank and agency staff completed the same induction processes as substantive staff.
- The radiology department had nurses and clinical support workers who assisted with interventional procedures.
- Sonographers reported their own ultrasound scans at the time of each procedure. A lead sonographer was responsible for ultrasound across all sites.

Medical staffing

- Between March 2016 and February 2017, the trust reported a turnover rate of 17% in Outpatients for permanent medical and dental staff.
- Between March 2016 and February 2017, the trust reported a sickness rate of 1% in Outpatients for permanent medical and dental staff.
- There was no data available for bank and agency use for medical staff within outpatients and diagnostic imaging across the trust.
- Medical staffing in outpatients was organised and managed by individual specialties.

Diagnostic imaging:

- The trust had experienced no difficulties in recruitment to consultant radiologist or specialty training grade posts.
- There was consultant cover across the trust out of hours and at weekends.
- There were 28 WTE consultant posts across the trust and 27 of these were filled.
- At the time of this inspection there were sufficient staff to provide a safe and effective service.
- The trust employed ten specialist radiology trainees who were completing placements with the trust. There was only one vacant post.
- The department contracted the reporting of some overnight plain film X-rays to external organisations to enable it to meet the demands on the service. There were formal service level agreements (SLA) in place for this process. Trust radiologists followed the quality assurance process to report discrepancies back to external organisations.

Major incident awareness and training

- The trust had a major incident procedure in place.
- The access, choice and booking centre had business continuity plans in place in the event of information technology failure within the booking centre.

Diagnostic imaging:

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The diagnostic imaging department had business continuity plans in place. There were maintenance contracts in place to ensure that any mechanical breakdowns were fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate effective in outpatients and diagnostic imaging, however we found:

- Staff we spoke with were able to describe the guidelines they used and departments visited such as diabetes and physiotherapy outpatients used goal setting for patients.
- Diagnostic imaging staff we spoke with could describe the national guidance they used. Staff had undertaken extensive further training and development to develop further competency and skills in their work.
- Radiologists, radiographers and specialist nurses undertook clinical audits to check practice against national standards and to improve working practices.
- Main outpatients had water available for patient use in the department and departments such as diabetes outpatients provided food and drinks if requested to patients waiting for transport.
- Between December 2015 and November 2016, the follow-up to new rate for Dewsbury and District Hospital was lower than the England average.
- The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberties level 1 training had been completed by 100% of staff within Outpatients. Staff we spoke with could

describe how and when they obtained consent, for example when they obtained verbal consent. Staff understood about consent and followed trust procedures and practice.

However:

- Appraisals completion rates did not always achieve the trust target.

Evidence-based care and treatment

- Staff in physiotherapy outpatients were able to describe the guidelines used in their practice, for example back pain treatment guidelines. Staff told us protocols and standard operating procedures were accessible through the systems used.
- Goal setting was in use in services such as diabetes outpatients and physiotherapy service for patients receiving care.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the trust was as safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.
- Consultant radiologists told us and we observed audits to show they used a WHO checklist for every interventional radiology procedure.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact local practice and processes had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Nutrition and Hydration

- Some areas visited had water available in waiting areas for patient use, for example in main outpatients and ear, nose and throat outpatients.
- Areas we visited such as diabetes outpatients provided food and drinks if requested to patients waiting for transport.

Diagnostic imaging:

- Water fountains were provided for patients' use in waiting areas and there was a café nearby where people could purchase drinks and snacks.
- Nurses could provide hot and cold drinks and snacks or small meals for patients undergoing interventional procedures and for those with long waits for transport.

Pain relief

- Pain scores were used in physiotherapy outpatients and staff completed checklists for equipment where required to help with pain relief.

Diagnostic imaging:

- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures.

Patient outcomes

- Between December 2015 and November 2016, the follow-up to new rate for Dewsbury and District Hospital was lower than the England average.
- Physiotherapy outpatients used a questionnaire to assess patient outcomes and collected this data quarterly. This was in progress during our inspection. Staff told us they provided a back to activity exercise class and patient outcomes were reviewed when patients were discharged.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- The radiology quality assurance programme including radiology audits were led by lead radiographers for each modality across the trust.

Outpatients and diagnostic imaging

Competent staff

- Data provided by the trust on appraisal completion rates could not be split by hospital site level. All staff groups were below the trust target of 85% for appraisal completion except for medical and dental staff groups which were at 92.6% against a target of 91.5%. Additional clinical services were at 84% against a target of 85%, allied health professionals were at 83% against a target of 85%, nursing and midwifery staff group was at 82% against a target of 85%. Scientific and technical group were at 50% against a target of 85% and administrative and clerical were at 71% against a target of 85%.
- Staff told us they had annual appraisals and that these were an opportunity to discuss training and development.
- The access, booking and choice directorate had a team leader programme available for staff to attend to develop team leading skills and knowledge. Managers told us this enabled staff to develop within the service. The directorate also had access to a trust programme to help leaders and managers develop in their roles.
- Dermatology outpatient managers told us the service had a dermatology learning group where they could complete learning relevant to the role.
- Staff in ophthalmology were able to describe the competency checks they undertook before being able to complete certain treatments with patients, for example staff had to complete 50 supervised injections before being signed off as competent.
- The ophthalmology service had converted some posts in the service into nurse specialist's posts and a specialist optometrist post to assist in addressing medical staffing challenges in the speciality. Ophthalmology held nurse led clinics. Some staff had completed an ophthalmology nursing qualification and completed further in house training, for example in nurse specialist injections.
- Some staff we spoke with had been able to attend further training, relevant conferences and study days to develop additional skills and knowledge. Staff told us that new starters in the departments received a trust induction and there was a workbook for local induction and training. Staff also told us that there were link nurses in the departments, for example for mandatory training and infection, prevention and control.
- Team leaders in physiotherapy outpatients told us they completed supervision with staff and that staff rotated through different areas to gain experience in other areas. When new starters arrived in the department, they were assigned a mentor after their trust induction and clinical supervision was undertaken every two weeks. Team leaders told us they carried out regular internal training with staff.

Diagnostic imaging:

- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuous professional development.
- Radiology staff were assessed against radiology competencies and training for working with equipment was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they had recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers had been trained for lead roles in each modality including CT and MRI.

Multidisciplinary working

- Physiotherapy outpatient staff told us of the multi-disciplinary working in their services. Team leads told us staff attended a regional multi-disciplinary team (MDT) meeting every six months and staff from the upper limb clinic met every two weeks. Rheumatology had a MDT meeting each month.
- Staff worked with different professions such as doctors, registered nurses, specialist nurses and healthcare assistants to provide care and treatment to patients.

Diagnostic imaging:

- There was evidence of multidisciplinary working in the imaging department. For example, nurses, radiographers and medical staff worked together in interventional radiology within the department, other specialty clinics and in theatres.

Outpatients and diagnostic imaging

- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example the radiology department worked with the emergency department to ensure that X-rays, CTs and other scans were carried out and reported in a timely manner.
- Radiologists attended multi-disciplinary meetings across several specialties to discuss diagnosis and treatment plans for patients including those with suspected cancer.

Seven-day services

- Outpatients offered appointments on Monday to Friday between 08:30am and 5pm. There were additional clinics during weekends where there was demand for the services.
- Orthopaedic outpatients provided some services during weekends.

Diagnostic imaging:

- Diagnostic imaging services including plain film, CT, MRI and ultrasound were available 24 hours seven days a week for trauma and inpatients radiographers and clinical support workers on site providing overnight cover, with further on-call support available if necessary.
- Outpatients and GP patients could attend for x- rays seven days a week and up to 8pm on weekdays. When demand increased the department could flex staffing to provide sufficient imaging sessions.

Access to information

- Staff had access to computers and a trust intranet. The electronic reporting systems could be accessed from the intranet and staff told us they had access to records as required through the computer systems.
- Staff told us that guidelines and policies were available on the trust intranet.
- Staff we spoke with told us they received regular communication bulletins.

Diagnostic imaging:

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, and medical records appropriately through electronic records.
- Diagnostic imaging departments used a picture archive communication system and a computerised radiology information system to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.
- Diagnostic results were available through the electronic system used in the department. These could be accessed through the system available in wards and clinics throughout the trust.
- Senior staff organised daily huddles to ensure all staff were available to discuss the day ahead and raise anything that would benefit staff and managers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between April 2016 and March 2017 Mental Capacity Act (MCA) and Deprivation of Liberties level one training had been completed by 100% of staff within Outpatients.
- Staff we spoke with could describe how they obtained verbal or written consent from patients. Consent given by the patient was recorded and we saw examples of consent recorded in patient records.

Diagnostic imaging:

- Diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. Staff were able to describe to us the various ways they obtained consent from patients. Staff told us consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.

Outpatients and diagnostic imaging

- Audit of the WHO safer surgical checklist carried out at all interventional procedures across the trust showed good compliance that was consistently improving. The current compliance rate was 90%.
- Training compliance rates for diagnostic imaging staff across all modalities for Mental Capacity Act and Deprivation of Liberty Safeguards level 1 training was 93% and but was lower, at 80% for level 2.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We found staff provided compassionate care for patients in outpatients and diagnostic imaging and provided additional support where required. Chaperones were available to support patients in outpatients and diagnostic imaging.
- Privacy and dignity was maintained by staff in areas visited.
- Friends and family test (FFT) data was positive for outpatients.
- Specialist registered nurses were available in a number of services visited. This enabled services to provide further support and care to patients.

Compassionate care

- Staff provided compassionate care to patients and provided additional support to patients where required in clinics. Chaperones were available in clinics.
- Patients we spoke with were positive about the services they had visited.
- Managers in main outpatients told us one of the department risks was lack of privacy between sub-waiting areas and consulting rooms as people could be overheard. Managers told us they had attempted to address this by moving consultations to different rooms and moving patients to wait for their appointment in the main department waiting area. Consulting rooms did have signs outside which highlighted whether these rooms were in use.
- A privacy room was available in main outpatients which could be used for patients to provide further privacy and dignity.

Diagnostic imaging:

- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the departments.
- Staff ensured that patients felt comfortable and safe in the department and we observed them putting patients of all ages at ease.
- There were gowns available to patients to maintain their dignity and, although these were always offered, we observed some patients preferred not to use them.
- There were designated areas for patients on trolleys to maintain their privacy.
- The department had been designed to provide as much privacy and dignity as possible with changing rooms and toilets close to procedure rooms and away from public thoroughfares. However staff working in the recovery area told us the environment did not always allow for total privacy and confidentiality but staff worked carefully to maintain this as much as possible.
- We spoke with two patients and one relative and each person told us that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Understanding and involvement of patients and those close to them

- Friends and family test data for October 2016 for the outpatients department showed that 97.1% were likely to recommend and in November 2016, 96.6% were likely to recommend the service. The response rate was below the 20% target during these months.
- Dermatology outpatient's friends and family tests results showed that 97% of patients were likely or extremely likely to recommend the service to friends and family. The response rate was 28%.
- Ophthalmology provided further information to patients on the different services available. Staff told us friends and family test results for ophthalmology showed negative points with delays in clinics. Staff were monitoring the situation.
- Staff provided patients with information on their medicines where required, discussed patient goals and provided further support to patients where required.

Diagnostic Imaging:

Outpatients and diagnostic imaging

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by staff. All those we spoke with told us that they knew why they were attending for a procedure or scan.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment. We observed examples in diagnostic imaging where staff gave patients and families time and opportunities to ask questions.
- Radiology reception was situated near to the department entrance and staff frequently checked the entrance areas for trauma and inpatients to greet people and assist them where required. Staff we spoke with described examples where they would provide further support to patients if required.

Emotional support

- Clinical nurse specialists were available in a number of clinics. Ophthalmology had nurse led minor operation clinics.
- Staff offered patients a separate room to wait for appointments where required.

Diagnostic Imaging:

- Staff told us that on request, if someone was anxious about a procedure such as a scan, they could visit the department first to look at the equipment and understand what to expect. This was also available for patients living with a learning disability.
- There was a process in place to support patients living with dementia or a learning disability who needed extra support in the scanning or x-ray room. A carer or relative could be in the x-ray room, protected by a lead apron to ensure that the patient felt safe

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- No specialties were above the England average for non-admitted referral to treatment (RTT) (percentage within 18 weeks).
- Between February 2016 and January 2017, the trust's referral to treatment time (RTT) for incomplete pathways had been worse than the England overall performance and worse than the operational standard of 92%.
- The trust has performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral since Q1 2016/17.
- Follow up appointment dates to be seen were not always met by the services in outpatients. There were patients waiting for appointments past their see by date.
- There were 19,647 patients in the trust backlog waiting for appointments which included first and follow up. This backlog of patients waiting for appointments had deteriorated since the last inspection.
- The trust measured turnaround times in a different way from Keogh standards. They measured time taken from referral to report rather than referral to image and a separate measurement of image to report. Although measured differently, trust and national targets were not consistently met.

However:

- The trust did have referral to treatment recovery plans in place for specialities at the trust which were used to highlight current performance data and the current position of the speciality in relation to the RTT indicators, along with actions being taken and an action plan tracker. These plans had been developed to address the current issues with waiting lists and referral to treatment indicators.
- The trust had a trajectory to be achieving the indicators by March 2018.
- The Did Not Attend (DNA) rate was lower than the England average.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust was performing slightly better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).

Service planning and delivery to meet the needs of local people

- Managers told us that capacity and demand in the service was planned within the services and as part of the annual planning cycle. Team leaders in the

physiotherapy outpatient department told us they used a capacity and demand matrix to plan the services and this allowed for 15 new patients a week for 42 weeks annually.

- The booking centre was responsible for booking outpatient appointments in a number of services such as medicine and surgery. Partial bookings were also made by the booking centre and the booking centre took calls from patients regarding outpatient appointments. Ophthalmology outpatients partial bookings were carried out by the booking centre and all other appointments were booked by the ophthalmology outpatient clinic.
- Outpatients offered appointments between 8:30am and 5pm, Monday to Friday and arranged clinics on Saturday where there was demand. There had recently been weekend clinics to assist in addressing backlogs in waiting times.
- Staff in a number of services were able to work across sites in outpatients. For example ophthalmology staff worked across the different hospital sites where required.
- Staff in main outpatients told us they had completed an audit with regards to clinics starting late. The results from this audit were communicated to staff in the department and feedback was provided which staff told us had led to improvements in clinics starting on time.
- Dermatology outpatients held a nurse led "suspected skin cancer clinic" every Thursday afternoon and Friday morning. This had been a trial from November 2015 and became permanent from September 2016. The clinic was held mainly at Dewsbury Hospital and Pinderfields Hospital on Thursday and Friday.
- Physiotherapy provided back to activity exercise classes for patients. Staff in physiotherapy outpatients supported patients through the exercise classes they provided to complete their exercises. Staff provided patients with contact numbers if they needed to contact the service.

Diagnostic imaging:

- The diagnostic imaging department had processes in place and the capacity to deal with urgent referrals and scanning sessions were arranged to meet patient and service needs.
- Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements. Urgent reports were flagged for prioritisation.

Access and flow

- The backlog of patients waiting for first and follow up appointments across the trust outpatient departments had increased since the last inspection and information provided by the trust showed at the end of March 2017 there was a backlog of 19,647 patients who had waited over three months for a follow up appointment.
- There were patients overdue their appointment by three months in different specialities across outpatients. Ophthalmology had the largest backlog of patients overdue their appointment by three months with 6942 patients waiting; this was followed by trauma and orthopaedics with 2512 patients and gastroenterology with 1382 patients overdue for their appointment.
- Ophthalmology outpatient managers told us they had a backlog of patients waiting to be seen in outpatients. Managers told us there were no current issues with the macular clinic and first appointments followed by the first 12 months treatment; however after the first 12 months there was a delay in follow up appointments of about six weeks. Ophthalmology was at 68.1% for non-admitted RTT (percentage within 18 weeks) against an England average of 92.1%. Ophthalmology was at 79.6% for incomplete pathways RTT (percentage within 18 weeks) against an England average of 92.3%.
- Managers told us there were particular challenges for first appointments, follow up appointments and appointments in the surgery directorate. Managers told us that a number of specialities had long waits for appointments. Each speciality had an action plan to address waiting lists and referral to treatment indicators. Managers told us demand was high and there had been consultant vacancies across different specialities. The services were trying to address this by working with other qualified providers, arranging extra clinics and job planning. Managers also told us of their aim to make the services sustainable.
- The trust provided us with RTT recovery plans for specialities including rheumatology, dermatology, ENT and ophthalmology. These recovery plans included performance information such as the current position of

speciality and the action being taken along with an action plan tracker. These RTT recovery plans had been developed to address the current issues with waiting lists and RTT indicators.

- There was an improvement plan from the previous inspection. This included addressing the backlog of outpatients appointments, including follow ups and ensuring clinical deteriorations in a patient's condition were monitored and acted upon for patients who are in the backlog of outpatient appointments. However the improvement plan was still in progress during the inspection.
- Managers told us there had been no 52 week breaches for waiting times and the maximum wait for a first appointment was between 28 and 38 weeks in some specialties.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance. The figures for January 2017 showed 76.9% of this group of patients were treated within 18 weeks versus the England average of 89.3%. There has been a downward trend in performance over the last 12 months.
- No specialties were above the England average for non-admitted RTT (percentage within 18 weeks). Data showed that the lowest percentage was ENT with 64.8% for non-admitted RTT against an England average of 90.3% and the highest percentage was rheumatology with 89.2% performance for on-admitted RTT against an England average of 92.1%.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for incomplete pathways had been worse than the England overall performance and worse than the operational standard of 92%. The figures for January 2017, showed 80.0% of this group of patients were treated within 18 weeks compared with the England average of 89.7%.There has been a downward trend in performance over the last 12 months.
- No specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks). Data showed that the lowest percentage was ENT with 72.8% for incomplete pathways RTT against an England average of 89.6% and the highest percentage was geriatric medicine with 93.8% performance for incomplete pathways RTT against an England average of 96.9%.
- The trust was performing better than the 93% operational standard for patients being seen within two weeks of an urgent GP referral.
- The trust was performing slightly better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- The trust has performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral since quarter 1 2016/17. Managers told us the 62 day operational standard performance was variable; the trust met the standard in February 2017, did not meet it in March 2017 and met the standard in April 2017.
- The percentage of clinics cancelled within six weeks in November 2016 was 4.9%, in December 2016 was 5.3%, in January 2017 was 5.8% and in February 2017 was 5.4%.
- The percentage of clinic cancelled over six weeks in November 2016 was 6.3%, in December 2016 was 6.4%, in January 2017 was 7.8% and in February 2017 was 6%. The main reason(s) for cancellations as reported by the trust are: Over six weeks: annual leave, on call, study leave and Under six weeks: sickness, non-compliance with process by specialty resulting in late notification. Managers told us clinics were sometimes cancelled within six weeks.
- The service did not monitor the length of time patients waited in clinics once they had arrived for their appointment. However on a daily basis staff highlighted in clinic waiting times on the waiting room information boards and informed patients as to delays in the service. Staff informed patients of delays after 30 minutes of delay in clinic.
- Outpatients had an outpatient follow up procedure in place with a review date of February 2019.
- Staff told us they would communicate delayed appointments to patients once they were in clinic.
- Managers told us the booking and call centre had a target of 95% to answer calls within three minutes. Data from the booking centre between 6 and 10 March 2017 showed that 97% of calls were answered within three minutes.
- The trust undertook an outpatient survey in 2016. The survey had a response rate of 42%. The survey showed that 29% of respondents highlighted that the appointment started more than 15 minutes after the stated time. The survey showed 49% of respondents

stated that nobody apologised for the delay when waiting to be seen. The survey report provided by the trust showed that 99% of people were able to find a place to sit in the waiting room.
- The survey highlighted that patients not being told what would happen next had worsened since the last survey in 2011 with 13% of patients not told what would happen next in 2016.
- Between December 2015 and November 2016, the 'did not attend rate' for Dewsbury and District Hospital was lower than the England average. Main outpatients were to trial using text reminders to assist in managing and reducing the number of patients who 'did not attend' (DNA).

Diagnostic imaging:

- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and seven day working arrangements. They monitored waiting times and were able to identify any possible breach dates. This enabled the team to take action such as adding extra appointments. They organised imaging sessions and staff to accommodate urgent diagnostic imaging requests.
- Patients referred by their GP for plain film x-rays could attend without an appointment. GP patients made up 29% of all patients attending for x-rays.
- Managers told us that they worked closely with staff from other departments and specialties to manage their performance in providing a prompt service to meet targets. Departments included accident and emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets and urgent cancer referrals.
- The trust performance dashboard showed that compliance for diagnostic results exceeding referral to test six week target ranged from 0% and 0.04% in the six months from August 2016 to January 2017. However, national data showed that between February 2016 and January 2017 the percentage of patients waiting more than six weeks for a diagnostic test was generally higher than the England average. The figures for January 2017, showed 2.9% of patients waited six or more weeks compared with the England average of 1.7%. There has been fluctuation in performance over the last 12 months; figures were higher than the England average between February 2016 and July 2016, lower than the England average between August 2016 and November 2016 before rising back above the England average for the latest two months (December 2016 and January 2017).
- Radiology managers told us, and the quality dashboard confirmed, diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals for inpatients and emergency department referrals met national targets. Compliance for inpatient and emergency department referrals was met in 99.98% of instances in the last 12 months.
- The percentage of images taken and reported across all modalities for the two week cancer target was 76% and a trust based target of three weeks from referral to report was 85%. This included CT, MRI, ultrasound and plain film x-rays, which did not meet national standards for reporting times. However, staff told us that the demand for urgent cancer referrals had doubled since June 2016 and one third of all CT referrals were 'fast track' requests which meant they were given priority over all other requests.

Meeting people's individual needs

- Staff told us interpreter services were available.
- The trust used VIP cards which held information about the patient and could be presented to staff upon arrival at clinics. These cards could be used by patients with a learning disability attending the services. Additional communication cards such as yes and no cards were available for staff to use to assist patients attending the services.
- Staff in the booking centre told us letters that were sent to patients included the contact details of the booking centre staff they could contact for further information and advice.
- A number of services visited had patient information leaflets on display, for example ophthalmology had patient information leaflets in waiting areas. Dermatology outpatients provided education about eczema to patients on a Monday afternoon.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.

- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provision was made to ensure that patients were seated in quiet areas and seen quickly.
- Bariatric equipment was available and accessible.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a range of information. Information was available on notice boards and in leaflets. Patient information leaflets were plentiful, of good quality, and up to date.
- There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Staff told us interpreter services were available across outpatients and diagnostic services. Staff gave an example of how an interpreter had provided a flexible service when an appointment had to be rearranged.

Learning from complaints and concerns

- Between March 2016 and February 2017 there were five complaints about Outpatients. The trust graded all five as 'Low'.
- In the same time period there were 40 complaints about Radiology, there were graded High (One), Medium (Nine) and Low (30).
- Managers in Dermatology outpatients told us there had been no recent formal complaints. Physiotherapy outpatients had not received any formal complaints in the 12 months prior to the inspection.
- The trust provided seven access, booking and choice complaint action plans. These highlighted the complaint, action and the person responsible for completing the action along with due dates for completion.

Diagnostic imaging:

- Staff in diagnostic imaging told us that informal comments and complaints were rare and none of the patients we spoke with had ever wanted or needed to make a formal complaint.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at team meetings, actions agreed and any learning was shared.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Managers were able to describe their focus on addressing issues with the referral to treatment indicators and reducing waiting times. Managers told us they had recovery plans in place and attended weekly performance management meetings for RTT and waiting lists. Managers told us they were able to escalate any issues from the performance management meeting directly to senior management at the trust.
- The services had risk registers in place which were reviewed monthly. Managers were aware of the risks across the service such as RTT issues. Risks were escalated to divisional governance meetings which could then be escalated further if required.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Managers told us they had an open door policy. Staff told us communication had recently improved. Staff told us there was good teamwork within teams and there was a culture of openness and honesty.
- The services had carried out engagement with staff and the public through staff surveys and the friends and family test. Staff bulletins were in use across the services to improve engagement.
- Diagnostic imaging leaders encouraged and enabled staff to develop their own skills and knowledge, share good practice nationally, and improve the service.

However:

- In main outpatients, team meetings did not always happen monthly. Managers were aware of this and told us they were addressing consistency of team meetings in main outpatients.

Leadership of service

Outpatients and diagnostic imaging

- Services were managed by local service managers. There had been a recent change in structure to the directorates and outpatients had a new senior role managing across the service which had been implemented to assist in developing professional support to the services.
- The access, booking and choice directorate managed most outpatient services, however ophthalmology and physiotherapy outpatients were part of their own directorate.
- Most staff we spoke with told us managers and team leaders were available, supportive and visible. Managers told us they had an open door policy. Staff told us communication had recently improved
- Team meetings were held intermittently and minutes were not always disseminated to staff in main outpatients. Main outpatients at Dewsbury Hospital had not held a team meeting since January 2017. Minutes from these meetings were not always sent to staff in the department. Staffing issues within the department had made arranging team meetings difficult. Managers told us they were aware team meetings needed to be more consistent and were planning to address this. Dermatology outpatients had three-monthly meetings.
- Staff in main outpatients told us information from the organisation was provided to staff and was displayed in the staff room for staff to view.

Diagnostic imaging:

- Staff were very positive about local leadership and we were told managers made themselves available and approachable.
- The trust had employed lead radiographers for each modality to lead the teams across all sites to ensure safe and effective working practice, a skilled workforce, and quality assurance.
- Staff told us diagnostic imaging department leadership felt stable, reliable, and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train staff.
- Departmental managers were supportive in developing the service and practice, and the trust as a whole valued its staff. Staff felt that they could approach managers with concerns and felt listened to. We observed positive and friendly interactions between staff and managers.
- Staff told us they saw the group management team regularly.
- Managers told us that IR(ME)R incidents were looked on as an opportunity to learn.
- The radiology matron provided nursing leadership for interventional radiology and the wider team. They took responsibility for infection control and medicines management within all radiology departments and modalities across the trust.
- Clinical leads and radiology managers collaborated to achieve shared goals including research and learning, development of advanced practitioners, and direct access pathways.

Vision and strategy for this service

- Outpatient managers told us their focus was on addressing the issues with referral to treatment indicators and this was being actioned through the joint planned care improvement group. The joint planned care improvement group was formed in November 2016 and the group aimed to improve performance in the key performance indicators (KPI's) relating to planned care and to implement transformational schemes.
- Diagnostic imaging services had a vison for the service. This was to deliver a nationally recognised excellent radiology service of a high quality exceeding national targets.
- The access, booking and choice service managed the outpatient services and the service was part of the surgical directorate.
- Trust values were on display in the dermatology department.

Diagnostic imaging:

- Diagnostic imaging services were provided across the three hospital sites at the trust.
- The diagnostic imaging department staff at all levels told us they were kept informed and involved in strategic working and plans for the future.
- The management team were working on ensuring that the department was able to cope with current and future demands on services. This involved the purchase of further MRI and CT machines.
- Improvements to the service were made to improve timely access for patients through radiographer vetting of referrals. Staff told us this practice saved one WTE consultant radiologist time across the trust.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- The outpatients department had a risk register which contained a number of identified risks to the services. Managers told us the risk register was reviewed monthly and the main risks identified were referral to treatment indicators, cancer appointment indicators and follow up appointments, administrative staffing, the environment in some areas along with space issues and IT equipment. The risk register had one identified major category logged risk which related to ophthalmology and meeting the four week standard for seeing patients. This risk was to be reviewed in March 2017.
- Managers we spoke with were aware of issues with referral to treatment targets and capacity and demand issues across the outpatients departments. Each week a performance management meeting was held to discuss waiting times and RTT. Managers told us they escalated any issues from the meeting directly to senior management at the trust.
- Managers told us governance and risk issues were escalated through different meetings to board level if required. There were divisional governance meetings which were able to escalate risks to the surgical directorate and risks identified were escalated to the quality committee. Managers in outpatients told us they attended governance meetings.
- There was an access, booking and choice governance group and the agenda from January 2017 showed that patient and public experience, safety and quality were on the agenda. The meeting minutes for December 2016 showed that the access, booking and choice governance meeting included complaints and action plans, compliments and patient stories, risks, clinical incidents and root cause analysis and serious incidents.
- The access, booking and choice directorate held a governance meeting and presented quarterly to the surgical meeting. The surgical meeting presented at the trust quality committee which could escalate governance issues to the trust board.

Diagnostic imaging:

- The department had a risk register. Risks were rated high, moderate and low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Diagnostic imaging had a separate and additional risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads and radiology protection specialists.
- Serious incidents were discussed at clinical governance meetings and where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Where necessary, policies and procedures were updated in line with guidance received.
- There were governance arrangements which staff were aware of and participated in. Staff told us they understood the management and governance structure and how it reported up to the executive board and back down to staff with lessons learned across the trust.
- Consultants told us they took part in radiology reporting discrepancy meetings. These were held to discuss the quality of images and reporting. This forum was used to promote learning.
- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the group manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included guidance around specialist interventional and biopsy procedures.

Culture within the service

- The services used staff surveys to gather feedback from staff and managers told us they had increased engagement with staff to assist in improving morale in the service.
- Staff told us there was teamwork within teams and there was a culture of openness and honesty.

Diagnostic imaging:

- All staff we spoke with told us they felt respected and valued. Staff we spoke with enjoyed their role and were proud of the service they provided. Staff told us there was good team work and that teams were supportive. Morale had improved significantly with improved trust senior leadership.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.

- Staff were passionate about their work, and in particular about patients, and felt that they did a good job. Staff we spoke with in all the diagnostic imaging departments said that they felt part of a team and were empowered to do the job to a high standard.
- Diagnostic imaging staff told us there was a positive working relationship between all levels of staff. We saw that there was a friendly and professional working relationship between managers, consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice at any level within their individual modalities.
- Staff were proactive and innovative in terms of presenting new ideas for practice locally and nationally.
- Department managers told us that there were formal team meetings as well as informal meetings and team leaders walked around departments every day to speak with staff.

Public engagement

- Staff told us where improvements had been made from the 'you told us' board which sought the views of service users and feedback.
- Ophthalmic outpatients had an eye clinic liaison officer who was able to provide information and referral to other services.
- Ear, nose and throat outpatients used a 'you told us' board to seek to the views of service users across the services.
- Dermatology outpatients carried out patient satisfaction surveys. The most recent survey showed 100% positive feedback with a 78% response rate to questionnaires.

Staff engagement

- Staff we spoke with said communication had improved across the services.
- Staff bulletins were provided to staff within the organisation. Services such as dermatology operated a staff award scheme.
- The outpatient 2016 staff survey showed the positives and areas for improvement in outpatients. For example a highlighted positive was staff having access to all of the materials and supplies to carry out their role and confidence to approach the senior management team. Areas for improvement included training and development needs not discussed in appraisal and where training or development was not provided in the previous 12 months. The survey poster developed by the outpatients department highlighted that managers intended to set up a staff health and wellbeing group. The poster also highlighted that volunteers from each team would be involved to represent their team.
- An access, booking and choice staff bulletin from May 2017 showed the suggestions made and what the service did regarding the suggestion.

Diagnostic imaging:

- Staff told us diagnostic imaging managers shared new information and news with staff through team meetings.
- Staff told us they met informally with team leaders each morning.
- A daily staff huddle was carried out in the diagnostic imaging departments. This allowed staff to discuss any issues related to their work and plans for the day ahead or issues identified from the previous day. Staff could discuss concerns they may have or receive and share important information. Staff told us the huddles provided for regular updates about the service and for them to receive information from other areas of the trust.
- Policies and procedures were available to staff via the trust intranet and lead radiographers supported staff to access information.
- Departmental staff liaised with specialists from other hospitals, teams within the trust, and neighbouring trusts as well as through national groups and panels to keep updated with new practices and developments. This helped ensure that services offered were in line with current practice and effective.

Innovation, improvement and sustainability

- The access, booking and choice division had an improvement action plan. This had 14 actions included, six of these were complete, and eight of these were not complete at the time of the inspection. One action had not been completed within the target date; all other actions were within the target date.
- We spoke with managers in various areas of outpatients and diagnostic imaging and some had attended an improvement workshop at the organisation.

Diagnostic imaging:

Outpatients and diagnostic imaging

- Staff were proactive and innovative in terms of presenting new ideas for practice locally and nationally.
- Radiographer discharge had been developed for patients with normal x-rays under an emergency department prescribed development plan. Staff told us this reduced patient journey times and therefore improved patient satisfaction.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The department had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The trust had a new electronic process with remote monitoring to alert staff to fridge temperatures being below recommended levels to store drugs.
- Panic buttons had been installed for staff to use if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department.
- We saw evidence of the risk assessment in patients` notes and falls bands were visible on patients. This enabled all staff in the hospital to identify patients at risk of fall no matter where they were in the hospital.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are suitably skilled staff available taking into account best practice, national guidelines and patients' dependency levels.
- Ensure that there is effective escalation and monitoring of deteriorating patients.
- Ensure that there is effective assessment of the risk of patients falling.
- Ensure that the privacy and dignity of patients being nursed in bays where extra capacity beds are present is not compromised.
- Ensure that there is effective monitoring and assessment of patient's nutritional and hydration needs to ensure these needs are met.
- Ensure that there is a robust assessment of patients' mental capacity in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Ensure that mandatory training levels are meeting the trust standard.

Action the hospital SHOULD take to improve

- Ensure appropriate precautions are taken for patients requiring isolation and that the need for isolation is regularly reviewed and communicated to all staff.
- Ensure reported incidents are investigated in a robust and timely manner and the current backlog of outstanding incidents are managed safely and concluded.
- Ensure staff are informed of lessons learnt from patient harms and patient safety incidents.
- Ensure work is undertaken to reduce the number of patients requiring endoscopies being cancelled on the day of their procedure.
- Ensure staff in maternity services are trained and competent in obstetric emergencies, to include a programme of skills and drills held in all clinical areas.
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians.
- Ensure the end of life time provide regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, preferred place of death, referral management and rapid discharge of end of life patients.
- Ensure VTE risk assessments are completed and the target of 95% is achieved.
- Ensure that records are completed fully and that records are stored securely.

Outstanding practice and areas for improvement

- Ensure care plans are individualised and reflect the needs of their patients.
- Continue to address issues of non-compliance with referral to treatment indicators and the backlog of patients waiting for appointments.
- Ensure that families who had been discussed at the multi-agency risk assessment panel. (MARAC) are flagged on the electronic system so they can be identified as being at risk of domestic abuse.
- Ensure that there is a specific mental health assessment room that meets the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983.
- Ensure staff are aware of the NHS Protect guidance on distressed patients to ensure that patients with mental health problems would be treated appropriately.
- Ensure a risk assessment is undertaken with regards to access to the staircase via the fire exit on ward 2.
- Consider relocating the resuscitation trolley on ward 4 to ensure it can be easily access in an emergency.
- Ensure that staff are following the medicines management policy and that fridge and room temperatures are appropriately recorded.
- Improve the rate of missed medicines doses.
- Ensure the use of cameras in critical care is reviewed and in line with trust policy and national guidance.
- Ensure that children are recovered from day case surgery in a child friendly environment.
- Ensure there are systems in place for the recording of transfer bag checks.
- Ensure work to improve the completion of consent forms in line with trust expectations.
- Review the risk registers and remove or archive any risks that no longer apply.
- Increase local audit activity to encourage continuous improvement.
- Ensure it continues to address capacity and demand across all outpatient services.
- Consider ways of ensuring team meetings in main outpatients are regular and consistent.
- Consider ways of ensuring environmental compliance issues with carpets in departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include— (2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. • Staff continued to fail to meet the trust mandatory training standard of 95% • Lack of training across the departments in triage/IAT. This means that potentially less experienced staff are triaging/IAT patients. This occurred in both adults and children. • Staff attendance at other statutory training such as life support skills were not meeting the trust standard. This was a compliance action at our last inspection.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services 17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) • Local audit activity was not always embedded. • National guidance was not always adhered to.

This section is primarily information for the provider

Requirement notices

(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

- There was a lack of assessment, monitoring and mitigation of the health, safety and welfare of service users within the medicine division.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **10(1) Service users must be treated with dignity and respect.** • Transfers after 10pm occurred frequently medical wards. • During care observations, we found the privacy and dignity of patients being cared for in wards where extra capacity beds were situated was compromised. There were 63 additional beds at Dewsbury. • It was difficult for staff to deploy the correct and appropriate use of curtains to ensure privacy and dignity when delivering care, and there were insufficient nurse call bells for all patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **11(1) Care and treatment of service users must only be provided with the consent of the relevant person.** • We identified a number of records across the Trust where capacity assessment documentation was incomplete. • It was acknowledged by the Safeguarding leads that there was a gap in the knowledge and understanding of some staff regarding the legislative process, documentation and trust procedures in relation to Mental Capacity Act and Deprivation of Liberty Safeguards.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include— 2(a) assessing the risks to the health and safety of service users of receiving the care or treatment 2 (b) doing all that is reasonably practicable to mitigate any such risks • We reviewed 15 patient records across the medical wards at Dewsbury and District Hospital for patients who had a NEWS score of 4 or greater. Of these, ten out of 15 did not have evidence of appropriate escalation. • We reviewed care plan documentation and risk assessments of 12 patients on various medical wards at Dewsbury and District Hospital. In seven sets of records (58%), we found the falls risk assessment and/or care bundle documentation to be incomplete, inaccurate or absent. • Twenty two falls with harm had been reported as serious incidents since April 2016. Of these, two resulted in patient deaths.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs 14(1) The nutritional and hydration needs of service users must be met. • We reviewed 17 patients on a number of wards at Dewsbury and District Hospital. We found 14 out of 17 records (82%) where fluid, food and/or intentional rounding charts were absent, incomplete or only partially completed. • We observed that staff could not focus on feeding due to work pressures; some food and drinks were left out of the reach of patients who required assistance.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

- All medicine divisional wards at Dewsbury reported nurse staffing vacancies.
- Nurse to patient ratios did not comply with national guidance on a number of medicine wards.
- Nursing fill rates were below trust establishment on many medicine wards.