The Mid Yorkshire Hospitals NHS Trust

Pinderfields Hospital

Quality Report

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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)	Inadequate
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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 Pinderfields, the trust had approximately 643 general and acute beds, 58 beds in Maternity and 17 in Critical care. The trust also employed 7,948 staff, of which 5,295 were based at Pinderfields. This included 629 medical staff and 2,045 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. We rated Pinderfields Hospital as requires improvement, because;

- 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. There were a number of senior medical vacancies and a heavy reliance upon locum staffing. There were regular rota gaps, a number of which went unfilled or were backfilled by 'other' grades.
- We found examples of patient safety being compromised as a direct result of low staffing numbers. This was compounded by current demand and extra capacity being staffed from within the existing nurse compliment. 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. Patients had long waits in the emergency 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.
- 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.
- The ward environment did not lend itself to additional patient beds in non-designated bed spaces. Privacy and dignity of patients being cared for in extra capacity beds was compromised. Staff commented how utilisation of extra capacity beds on wards restricted space to deliver care, impinged on neighbouring patients bed areas and was hazardous due to a lack of nurse call bells and inadequate screening. Divisional leaders recognised this affected the quality of the patient experience.

Summary of findings

- 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. Recording of pain scores and National Early Warning Scores (NEWS) was not consistent and some audits identified a deterioration in compliance with recording NEWS scores.
- 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.
- Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable. There was confusion around the internal processes and in the completion of the associated documentation. Patients were subject to restrictions of liberty. There was an inconsistent assessment of patient capacity and therefore uncertainty in assurances around patient ability to consent to care and treatment decisions.
- 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.
- The emergency department was failing to meet the majority of national standards relating to Accident and Emergency performance. However, recent information showed that this was improving.
- 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.
- Divisional managers in medicine recognised the additional beds currently in use across the division compounded by staffing shortages caused dissatisfaction with staff and destabilised ward leadership. Staff morale was variable across the division.
- 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 register contained risks with review dates in the past or unidentified risks. This led to concern that the risk registers were not always appropriately scrutinised.
- The critical care service was not compliant with the Guidelines for the Provision of Intensive Care Services (GPICS) standards in a number of areas.

However;

Summary of findings

- 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. Staff were passionate and driven to deliver quality patient care that they considered a priority. We observed kind, compassionate and caring interactions with patients and they commented positively about the care they received. There were positive and dynamic initiatives to support vulnerable patients living with dementia and for those with additional needs because of learning difficulties. 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. Staff were also able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.
- The medicine division had appointed Safety Support Workers to support the existing nursing compliment. A number of additional registered nurse appointments had been made and were due to commence in the summer 2016.
- There had been a reduction in some patient harms reported, namely category three and four pressure ulcers and falls with harm. The division had reinforced their objective to reduce patient harms further with the appointment of a Falls Lead.
- 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.
- 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.
- During 2015/16, 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.
- 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 emergency department was aware of its problems and risks and had changed practice and processes in an attempt to tackle them, such as by the introduction of new nursing roles to support ambulance handovers and manage the flow of patients through the department.
- 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. Between December 2015 and November 2016 the average length of stay for surgical elective patients was lower than the England average. Readmission rates had reduced and improved.
- The maternity service had successfully reconfigured to provide consultant-led maternity care on one hospital site. The community midwifery caseloads were the same as national recommendations, and the services had plans in place to improve midwifery staffing by 2020.
- 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 and they had recently appointed a lead nurse for transition services.

Summary of findings

- 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.
- Leadership of the critical care service was in line with GPICS standards. The service was actively involved in the regional critical care operational delivery network and the acute hospital reconfiguration.
- 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. Management could describe the risks to the services and the ways they were mitigating these risks.
- Staff praised the executive management team of the trust. Staff were positive about the future and felt that problems were now more open and being addressed.

We saw several areas of outstanding practice including:

- The emergency department had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The facilities on the spinal unit for rehabilitation and therapies were modern, current and progressive.
- The cardiology e-consultation service which provided a prompt and efficient source of contact for primary care referrers who sought guidance on care, treatment and management of patients with cardiology conditions;
- The proactive engagement initiatives used by the dementia team involving the wider community to raise awareness of the needs of people living with dementia. The use of technology to support therapeutic engagement and interaction with patients, stimulating activity and reducing environmental conflict.
- The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience 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. Faster pre-theatre assessment was provided which helped ensure treatment was delivered quicker. The surgical division had reduced pressures on Surgical Assessment Unit (SAU) by taking the bulk of ambulatory plastics patients out of SAU.
- The burns unit play specialist ran a burns club, which provided psychological support to children and their families. This included an annual camp and two family therapy weekends a year.
- The maternity service had implemented the role of 'Flow Midwife', a senior member of staff who had oversight of the service during the day. The aim of this role was to ensure a smooth flow of patients throughout the unit; this included the risk of transfers from the stand-alone birth centres and concerns with the discharging of patients from the postnatal ward and labour suite.

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.

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- Ensure that mandatory training levels are meeting the trust standard.

In addition the trust should:

- Ensure that all staff have annual appraisals.
- Ensure staff are aware of the duty of candour regulations.
- Ensure prescribers detail the indications for antimicrobials and ensure review dates are adhered to.
- Ensure it reviews the compliance with Guidelines for the Provision of Intensive Care Services and the plans to meet the standards.
- 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 quality and performance is measured effectively.
- Ensure it develops and shares with staff a longer term critical care strategy beyond the acute hospital reconfiguration.
- Ensure risks are identified and reviewed appropriately.
- 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 visible assurance that all electronic equipment has been safety checked and assurance that staff are competent in the use of all medical devices.
- Continue to focus on achieving A&E standards and ensure that improved performance against standard is maintained.
- Ensure that records are completed fully and that records are stored securely.
- Ensure that all appropriate staff have undergone APLS training.
- Work with the trust's non-medical prescribing governance group to ensure that all non-medical prescribers are supported to prescribe within their competencies.
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians.
- Ensure patients have access to leaflets in alternative formats such as large print, Braille or other languages.
- Ensure it completes the outstanding actions remaining from RCEM audits to ensure the quality of care in the department is meeting the RCEM standards.
- Ensure that the cross site governance processes introduced in January 2017 become embedded in practice.
- Consider an analysis of the increased reporting of clostridium difficile cases across the division.
- Ensure all relevant staff are informed of oxygen prescribing standards.
- Apply the trust wide pain assessment documentation consistently on wards.
- Ensure whiteboards being used at the patient bed head contain the correct information.
- Ensure all patients and family members are fully informed and involved in all discharge arrangements and future care discussions at the earliest opportunity.
- Consider an analysis of the processes involved in obtaining timely social care assessments for patients on divisional wards.
- Consider a review of the current governance processes for the Regional Spinal Unit.
- Continue with improvement in staff engagement activity specifically around the acute healthcare reconfiguration and current service demands.
- Ensure divisional meetings are quorate and all agenda items are discussed/minuted accordingly.
- Improve the proportion of patients having hip fracture surgery on the day or day after admission.
- Continue to monitor and improve compliance with the 'Five steps to safer surgery'.
- Reduce the management of medical patients on surgical wards.

Summary of findings

- Reduce the number of patients boarding on PACU and discharging home directly from PACU.
- Reduce the usage of extra capacity beds on surgical wards.
- Ensure there is evidence of appropriate local induction for agency staff.
- Ensure their safeguarding children policy is up to date.
- Ensure that staff have regular safeguarding supervision.
- Ensure that children have access to child friendly menus.
- Consider limiting access to their milk rooms and fridges, to prevent unauthorised access to feeds.
- Ensure that staff are following the medicines management policy and that fridge and room temperatures are appropriately recorded.
- Ensure that resuscitation equipment is checked daily and appropriately recorded.
- Ensure plans for clinical validation across specialties where there are waiting list backlogs are progressed and risks are managed and mitigated.
- Audit and report the implementation of the end of life care plan and performance in fast track discharge.
- Ensure regular internal performance reporting on End of Life care 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.

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 	The department was failing to meet the majority of national standards relating to Accident and Emergency performance including: four hour waits, re-attendance rates, time from decision to admit to admission, median time to treatment and ambulance handover times. However, recent information showed that this was improving. Staff were not meeting the trust's mandatory training and appraisal targets. We had concerns about the robustness of the triage training process because relatively inexperienced nurses were being trained to carry out triage. Recording of pain scores and NEWS was not consistent. 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 and there were concerns about the long term sustainability of consultant cover. 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. Although there was a newly implemented governance process, this was yet to be embedded in practice. Information for patients in alternative formats such as large print or Braille and other languages was not available. However: There were governance processes in place to assess the quality of care patients received. The department took part in national and clinical audits to provide assurance of the quality of care provided. The department was aware of its problems and risks and had changed practice and processes in an attempt to tackle them, such as by the introduction of new nursing roles to support ambulance handovers and manage the flow of patients through the department.

Summary of findings

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.
Staff praised the executive management team of the trust and the department and told us since our last inspection the atmosphere of the trust felt different. Staff were positive about the future and felt that problems were now more open and being addressed.

Medical care (including older people's care)

Inadequate

Divisional wards were consistently understaffed. The division failed to meet safe registered nurse staffing ratios and actual nurse staffing figures were significantly below establishment planned numbers, evidenced by poor fill rates. There was a reported and identified correlation between deficient nurse staffing and patients suffering harm. The effect of the current nurse staffing situation impacted in all clinical areas. This was compounded by current demand and extra capacity being staffed from within the existing nurse compliment.
There were a number of senior medical vacancies and a heavy reliance upon locum staffing. There were regular rota gaps, a number of which went unfilled or were backfilled by 'other' grades.
There had been an increased incidence of clostridium difficile infections reported across the division. These figures were significantly above the annual threshold.
The divisional wards were ill equipped to deal with the addition of extra capacity beds above the ward bed base. The ward environment did not lend itself to additional patient beds in non-designated bed

Summary of findings

spaces. Patients in extra capacity beds (and neighbouring patients) had personal care space compromised, did not always have access to suitable furniture and to nurse call bells.
Antimicrobial prescribing standards and antibiotic administration required improvement to ensure patients received safe treatment in a timely manner for the right reasons and for the correct duration.
Nursing documentation standards were variable. We found deficiencies in risk assessment completion for falls and pressure ulcers. There were also significant omissions on fluid, food and intentional rounding documentation.
Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable. There was confusion around the internal processes and in the completion of the associated documentation.
Patients were subject to restrictions of liberty. There was an inconsistent assessment of patient capacity and therefore uncertainty in assurances around patient ability to consent to care and treatment decisions.
The meal time initiative to support patient nutrition and hydration was not robust. Patients did not always have ease of access to drinks and the use of the 'red jug, red tray' was inconsistent. Nursing documentation to support nutrition and hydration was poor. Fluid charts, food diaries and intentional rounding documentation was absent, incomplete or partially completed.
Privacy and dignity of patients being cared for in extra capacity beds was compromised. Staff commented how utilisation of extra capacity beds on wards restricted space to deliver care, impinged on neighbouring patients bed areas and was hazardous due to a lack of nurse call bells and inadequate screening. Divisional leaders recognised this affected the quality of the patient experience.
Due to limitations in patient flow across the division, there was a considerable number of patient moves after 10pm.
There were high numbers of 'on the day' cancellations across endoscopy services causing inconvenience to patients and delay in patients receiving necessary investigations.

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Divisional managers recognised the additional beds currently in use across the division compounded by staffing shortages caused dissatisfaction with staff and destabilised ward leadership. Staff morale was variable across the division.
Governance and assurance processes for the care and management of patients in extra capacity beds did not support the provision of safe care, quality outcomes and positive patient experience on divisional wards.
However:
Staff were passionate and driven to deliver quality patient care that they considered a priority. We observed kind, compassionate and caring interactions with patients and they commented positively about the care they received. There were a number of considered and thoughtful examples of staff engaging with patients and their family members to improve the quality of care received.
There were positive and dynamic initiatives to support vulnerable patients living with dementia and for those with additional needs because of learning difficulties.
The division had appointed Safety Support Workers to support the existing nursing compliment. A number of additional registered nurse appointments had been made and were due to commence in the summer 2017.
There had been a reduction in some patient harms reported, namely category three and four pressure ulcers and falls with harm. The division had reinforced their objective to reduce patient harms further with the appointment of a Falls Lead.
Staff responded proportionately to clinical indicators suggesting patient deterioration. They had a good understanding of escalation triggers and processes underpinned by clinical judgment and recognition of the National Early Warning Score tool.
There was a real recognition of the value and importance in multi-disciplinary team working across the division. All disciplines acknowledged pressures colleagues faced and all worked together in a coordinated and cohesive manner to support patient outcomes.

Summary of findings

Staff delivered evidence based care and treatment underpinned by national guidelines, quality standards and best practice standards. The division had developed a number of local care pathways to standardise care and improve patient outcomes.
The division planned services to meet the needs of the local population and were actively involved in the on-going acute healthcare reconfiguration across the trust.
The division involved commissioners and network colleagues when reviewing service delivery.
There were clearly defined leadership structures across the division with a vision and strategy aligned to the trust agenda. The division had clear governance channels into the wider organisational executive management structure. Divisional meetings considered safety, risk and quality measures. The division had a live risk register, which was reflective of real issues faced across divisional services impacting on patient care, staff wellbeing and service quality. There was evidence of positive progression being made within the divisional ethos underpinned by a number of public and staff engagement projects.

Surgery

Good

We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection.
There were systems in place to identify themes from incidents and near miss events. The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed, and changes to practice identified.
During 2015/16, 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.
Between December 2015 and November 2016 the average length of stay for surgical elective patients at trust level, as well as at Pinderfields General Hospital, was lower than the England average at 3.1 days and 2.6 days respectively, compared to 3.3 days for the England average.
For the period Q4 2014/15 to Q3 2016/17, the trust cancelled 726 surgeries. Of the 726 cancellations,

Summary of findings

1% were not treated within 28 days. The trusts performance has been consistently better than the England average for the period. Across the trust, there were 54,683 surgical admissions from December 2015 to November 2016. Readmission rates had reduced and improved.
There were clear and embedded governance processes in place to monitor the service provided. A clear responsibility and accountability framework had been established. Leadership at each level was visible. Staff had confidence in the new leadership and felt they were be listened to. Complaints were responded to in a timely manner and learning was taken forward to develop future practice.
However:
National Early Warning Score (NEWS) audits in March 2017 showed that 59% of observations were recorded which was down from 67% in the previous audit cycle.
The qualified nursing staff levels required across all surgical wards at Pinderfields General Hospital was 335.9 whole time equivalent (WTE) for March 2017. The number of qualified staff in post were 309.87 WTE. The areas with the largest staffing vacancies were in theatres (16.2 WTE), the plastics and burns surgical services (6.23 WTE) and gate 33 (4.17 WTE).
Nursing staff had not met all mandatory training targets. Medical staff did not reach the 95% target for any of the trusts core training, including safeguarding.
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, continuity of care from consultants and multidisciplinary staffing. 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.

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Mandatory training was worse than the trust target in a number of areas. 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.
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. There was no evidence that senior staff had reviewed some risks and their controls had been reviewed.
However:
Leadership of the service was in line with GPICS standards. 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.
Staff received a trust award for their high quality and compassionate care. 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.

Maternity and gynaecology

Requires improvement

Midwifery staffing was below nationally recommended levels, at 1:31. Following our previous inspection the service reviewed staffing using a recognised acuity tool and this identified a shortfall of 18 whole time equivalent midwives.
Attendance of midwifery and medical staff at obstetric emergency training was below required levels.
Since the reconfiguration of services at the Pinderfields site, staff told us there had not been any skills and drills in clinical areas namely the birth centre and ward 18. There was also a lack of clinical audit since the reconfiguration of services. Staff voiced concern about the monitoring of vulnerable women on the antenatal and postnatal ward; this was due to a lack of ward rounds by some consultants.

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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 there was a lack of oversight by senior managers.
However:
The service had successfully reconfigured to provide consultant-led maternity care on one hospital site. The community midwifery caseloads were the same as national recommendations, and the services had plans in place to improve midwifery staffing by 2020.
Following our previous inspection there were robust practices in place to check emergency equipment.
The service had successfully bid for Department of Health Safety training and had allocated the funding appropriately.
We found good multidisciplinary working between midwifery and medical staff. Women were positive about the care they received; 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.

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.
There were safeguarding systems and processes in place and staff were accessing the required level of training.
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, young people and their parents were involved with their care, given information in a way they could understand and allowed time to ask questions.

Summary of findings

Staff were friendly, caring, helpful and provided emotional support. Services were planned and delivered in a way that met the needs of the children and young people.
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 and they had recently appointed a lead nurse for transition services. There were effective governance processes in place and the leadership team understood the risks to their service.
However:
Staffing numbers did not meet national recommendations on a number of occasions. Staffing levels and patient acuity were reviewed twice a day and staff were moved between the different children's areas to provide support where needed. However, although this provided support to some areas it meant that other areas were not meeting the national recommendations
Staff 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.
The menus provided were not child friendly and staff had difficulties accessing food suitable for children out of hours.
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 labeling 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. Specialist palliative care nurses were available and each ward had an end of life link nurse.
We saw evidence that compliance with infection control and environmental cleaning standards were monitored regularly and maintained in the mortuary.
Risks to people, who use services were assessed, monitored and managed on a day-to-day basis. Staff used a community-wide electronic patient

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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.

End of life care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was a comprehensive audit programme in place against national standards for end of life care. The trust included a session on end of life care in the core mandatory training programme for ward nursing staff. The service was planning to introduce the Gold Standard Framework to hospital staff on eleven wards in 2017.

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.

We observed a caring and compassionate approach from palliative care team members and ward nursing staff during their interactions with patients and family members. We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the specialist palliative care team during their assessment of the patient in the hospital. Chaplaincy and drop in services were also available.

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.

Summary of findings

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 leadership was knowledgeable about quality issues and priorities within end of life care, understood what the challenges were and took action to address them. Risk issues such as achieving rapid discharge were escalated to the relevant committees and the board through clear structures and processes.
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. 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 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.
People were supported to make decisions about resuscitation but, where appropriate, their mental capacity assessment was not always recorded.
There was no regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, achieving preferred place of death, referral management and rapid discharge of end of life patients.

Outpatients and diagnostic imaging

Requires improvement

There were issues regarding referral to treatment (RTT) 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

Summary of findings

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.
No specialties were above the England average for non-admitted 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.
Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour. 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. Staff were aware of how to report safeguarding concerns.
Areas we visited were visibly clean and tidy. Medicines checked were found to be stored securely and 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 ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff. The Did Not Attend (DNA) rate in outpatients was lower than the England average.
Managers were able to describe their focus around addressing issues with the referral to treatment indicators and addressing waiting times. There were referral to treatment recovery plans in place for various specialties. Staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty.

Summary of findings

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.

Pinderfields 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 Pinderfields Hospital

Pinderfields Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in Wakefield and serves a population of approximately 355,000 people in the local Wakefield and Pontefract area and 185,000 people in the North Kirklees area. Pinderfields Hospital employs around 4611 whole time equivalent staff which included 629 medical staff, 2045 nursing staff and 2621 other staff. . The hospital provided a full range of hospital services, including an emergency department, general medicine, including elderly care, general surgery, paediatrics and maternity care. The hospital had 643 general and acute beds, 58 beds in maternity and 17 beds in critical care.

Wakefield is one of the 20% most deprived districts/ unitary authorities in England and about 21% (12,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.5 years lower for men and 7.8 years lower for women in the most deprived areas of Wakefield than in the least deprived areas. 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.

Approximately 355,000 people live in Wakefield. This is forecast to grow in line with the rest of England by around 2.8% over the next five years. Population growth will be highest in those aged 65 years and over, where the increase will be by around 14.4%. 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. 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:

Detailed findings

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

Inspection Manager: Sandra Sutton, Care Quality Commission

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 Pinderfields Hospital

In total, at Pinderfields, the trust had approximately 643 general and acute beds, 58 beds in Maternity and 17 in Critical care. The trust also employed 7,948 staff, of which 5,295 were based at Pinderfields. This included 629 medical staff and 2,045 nursing staff.

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	Inadequate	Requires improvement	Inadequate
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
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	N/A	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	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 has an emergency department (also known as accident and emergency, A&E, or ED) with total annual attendances of 234,288 in 2015/2016.This equated to 19,500 attendances per month, and was a 4% increase on the previous 12 month period.

Attendance data showed that for the Pinderfields emergency department (ED) site, 104,335 patients attended between January 2016 and January 2017. This equated to approximately 285 patients each day. Approximately 25% of patients were aged under 17. Pinderfields has a separate paediatric ED situated close to the main ED.

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%.

The Pinderfields Hospital ED is a trauma unit, which means that it can treat patients with a wide range of illnesses and injuries including those who have been involved in accidents and incidents. Although it is not a major trauma centre, patients can arrive by foot, road or ambulance. Within the department, there are three distinct areas where patients can be treated. The minors department can treat patient with minor injuries such as simple fractures. The majors department treats patients with more serious illnesses or injuries and the resuscitation area that treats patients with serious and life threatening conditions. The department also has a paediatric ED that treats children and young people up to the age of 17.

The ED is staffed by a wide range of experienced consultants, middle grade and junior doctors, GPs, emergency nurse practitioners (ENPs), advanced nurse practitioners (ANPs) registered nurses and health care assistants seven days a week, 24 hours a day.

We carried out this inspection because when we inspected urgent and emergency care in June 2015, we rated the safe, effective, responsive and well-led domains as requires improvement. During the 2015 inspection, we did not look at the caring domain. At our previous inspection, we identified a number of concerns:

- 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 robust integrated clinical governance frame work.
- 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 were 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. This meant that patients were spending longer in the department and overcrowding was occurring within the ED.

Urgent and emergency services

- Ambulance handover times were consistently double 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 attendances overnight, and had no specific child friendly area to wait or be assessed. Risks occurred in the department when extra capacity areas were opened.
- 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.

At this inspection, we returned to check whether services had improved.

During this inspection we visited on two occasions as part of the overall inspection. Once as an announced visit and once as an unannounced visit. We spoke with five patients and 19 members of staff including nurses, qualified and unqualified, and medical staff. We reviewed 13 sets of records in depth and a further five for specific information, other departmental documentation and reviewed information provided by the trust and external stakeholders prior to our inspection.

Summary of findings

We rated this service as requires improvement because:

- The department was failing to meet the majority of national standards relating to Accident and Emergency performance including: four hour waits, re-attendance rates, time from decision to admit to admission, median time to treatment and ambulance handover times (however, recent information showed that this was improving).
- 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.
- 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 and there were concerns about the long term sustainability of consultant cover.
- 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.

However:

- There were governance processes in place to assess the quality of care patients received.
- The department took part in national and clinical audits to provide assurance of the quality of care provided.

Urgent and emergency services

- The department was aware of its problems and risks and had changed practice and processes in an attempt to tackle them, such as by the introduction of new nursing roles to support ambulance handovers and manage the flow of patients through the department.
- 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.
- Staff praised the executive management team of the trust and the department and told us since our last inspection the atmosphere of the trust felt different. Staff were positive about the future and felt that problems were now more open and being addressed.

Are urgent and emergency services safe?

Requires improvement

At this inspection 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. This put pressure on remaining staff and left the department under planned staffing levels.
- Mandatory training levels were not meeting the trust standards. We identified this as a concern at our last inspection.
- Record keeping in relation to NEWS, pain scores and comfort rounds needed to improve and we found gaps in information in the records we looked at.
- The department had not met the Royal College of Emergency Medicine RCEM standards in relation to patient waits in the department, including ambulance handover times.
- Not all nursing staff had undergone advanced paediatric life support (APLS) training or advanced life support (ALS) training.

However:

- Incidents were reported by staff and we saw evidence of lessons learned being shared across sites.
- The department was clean and well maintained. There was access to personal protective equipment and toys were cleaned regularly and complied with infection control guidelines
- Medication was stored safely and securely.
- There were good safeguarding processes in place to ensure that vulnerable adults and children were protected from the risk of abuse.
- The department had considerably improved ambulance handover times.
- The department had a robust and detailed major incident plan and the facilities to play a key role in any major incidents.

Incidents

- There were no never events reported by the department at Pinderfields. 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 189 incidents between November 2016 and February 2017 at Pinderfields Hospital. Of these, seven were classed as moderate (short term) harm, 62 as low harm and 146 as no harm/near miss.
- The most commonly reported categories of incidents were regarding pressure sores, slips, trips and falls, transfusion of blood related problems and discharge or transfer of patient delays.
- When we spoke with staff about reporting incidents staff told us that they knew how to report incidents and were encouraged to do so.
- 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.
- 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.
- 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.
- Patient toilets were clean.
- 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.
- 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

- Consulting and treatment cubicles were an appropriate size and contained the necessary patient equipment. Cubicles had solid walls and either solid doors or curtains to maintain privacy.
- The department had a zero pressure room, and shower cubicle for use in the event of chemical, biological, radiation or nuclear (CBRN) contamination.
- We found that 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.
- 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.
- The waiting area used by patients was adequate with sufficient seating for patients and relatives.

Medicines

- The department used Mobile View, a computerised storage and dispensing system to store medication. This is automatically temperature controlled and flashes an alert should the temperature rise above the safe storage temperature. 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.
- 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.
- 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.
- 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.
- Most ANPs were independent nurse prescribers. This meant they had been assessed as competent to prescribe medication to individual patients outside of the PGDs. ANPs told us this gave them more freedom in their role to ensure that patients received the appropriate medication quickly. However, there had been some problems with the management of the independent prescriber system and one ANP told us that although they were competent, there had been significant delays in the pharmacy team completing the administrative function. This meant that although the ANP was qualified as a prescriber, they had to work within PGDs.

- 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.

Records

- The department used a mixture of paper and electronic record in the department. Written records were scanned on the electronic system on a daily basis.
- We looked at the records of 13 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 take 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 whom the NEWS charts belonged to. There was a risk that information could be recorded on incorrect charts.
- Paper records were stored securely and accessible only to appropriate people. However, we entered an empty treatment room and found a list of all patients in the department visible on a computer monitor. The screen had not been locked when the clinician left the room.
- 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

- 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.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated theoretical knowledge.
- The trust had two paediatric liaison nurses, former health visitors, who checked over the records of all children who had been through the ED departments of the trust on a daily basis. The purpose of this was twofold; to ensure that any relevant other organisations such as GPs, 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.
- Safeguarding training included specific training about safeguarding topics such as child sexual exploitation, people trafficking and female genital mutilation (FGM).
- The department was meeting the trust standard of 95% compliance for safeguarding adults or children training level one. Administrative staff were 100% compliant for level one children and level one adults and nursing staff were 100% compliant for level two.
- Training figures showed as follows: Safeguarding adults 13% for nursing staff and 38% for medical and dental staff. Safeguarding children level one, 75% for medical staff and nursing staff and level three, 56% for medical staff and 80% for nursing staff. At our last inspection we identified that training levels were low and informed the department they must improve and meet the trust standard of 95% for level one and 85% for level two.

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%.

- Staff told us they could access some mandatory training via the intranet. They reported few problems accessing e-learning other than the occasional shortage of free time or computers.
- Staff told us it was not always easy to attend classroom based training due to staffing pressures on the ward.
- Training compliance levels for mandatory and statutory training varied. All staff groups were meeting the trust 95% standard for diversity awareness and mental capacity act awareness level one.
- Medical staff were not meeting the standard for; conflict resolution (80%),consent (57%), health and safety (67%), infection control (63%), manual handling (81%), medicine management (29%), patient safety (53%), resuscitation training (73%) and fire safety (56%).
- None of the staff groups were fully meeting the target of 85% for role specific mandatory training or 95% for all other mandatory training.
- Nursing staff were not meeting the standard for; health and safety (72%), infection control (88%), manual handling (93%), medicines management (77%), mental capacity level 2 (85%) and level 3 (80%), patient safety (58%), resuscitation training (59%), fire safety (58%), information governance (56%).
- Most notably, none of the staff groups were meeting the target for resuscitation training. Medical staff were at 73% and nursing staff were at 59% against a target of 85%. This meant that not all staff were up to date with their resuscitation training.

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.
- 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 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 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 101 patients waited for more than 30 minutes compared to 509 in October 2016.
- 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. Action the trust had taken in the EDs to introduce a new system to manage patients brought in by ambulance was reflected by the improved hand over times. At the time of the inspection this system continued to work effectively and meant that ambulance patients were handed over quickly and ambulance crews released to go back on the road.

Urgent and emergency services

- In June 2016 46% of patients were handed over within 15 minutes. By June 2017, 87% of patients were handed over within 15 minutes. Additionally, in June 2016 the average handover time was 23 minutes. In June 2017 this had been reduced to 10 minutes.
- The new initial assessment team carried out baseline observations and tests on patients. This meant that if patients deteriorated, it was easier to identify and take action.
- The department used the Manchester triage system for assessing the level of urgency to be seen by a doctor.
- 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 the triage training work book and had 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.
- 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.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable.
- Staff recorded known patient allergies in patient records. All of the thirteen records we looked at had patient allergies recorded.
- The department used the National Early Warning Score (NEWS) to assist in monitoring patients and identifying when a patient's condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. However, we looked at a number of NEWS charts for patients in the resuscitation bays and found no NEWS score in the electronic monitoring system and no nursing documentation. 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.
- 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.
- The department had a sepsis pathway, a lead sepsis nurse and lead sepsis doctor. Patients identified as being septic were started on the sepsis pathway. The department had carried out education to raise staff awareness of sepsis after some missed cases over the last 12 months.
- Deteriorating patients were managed within the department and transferred to other department once stable. Staff told us there were often delays transferring patients to the intensive care unit (ICU) and were able to give us an example of a patient identified as needing ICU who waited 13 hours before being accepted to ICU. This was for a number of reasons including bed shortages and the reluctance of ICU to accept patients.

Nursing staffing

- As at February 2017 the trust reported the Pinderfields department had a vacancy rate of 4.8% for nursing staff.
- The department used bank nurses and agency staff to cover gaps in the nursing rota. The priority was to use bank staff as these were usually regular staff working additional shifts. Information sent to us by the trust showed that Pinderfields 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 this.
- 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. Staffing levels had been increased at Pinderfields as a result of the assessment.

- Planned and actual staffing levels were displayed in the department and updated on a daily basis.
- The paediatric ED was staffed by trained children's nurses and play specialists. The paediatric ED nursing staff were part of the paediatric department and staff were able to rotate on to the children's assessment unit. At busy times in ED staff could request support from the children's assessment unit.
- The department had three advanced nurse specialist (ANPs) and two trainee ANPs. ANPs could treat minor illnesses and injuries in patients aged 18 and over.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses. The trust employed 23 emergency nurse practitioners (ENPs) who could treat minor injuries such as fractures and limb injuries. All ENPs were also triage trained and worked across the three sites.
- 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.
- Staff told us that nurses from ED were often asked to cover shortages on other wards or other sites. Both nursing and medical staff 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. The trust used a tool called CEMBooks to record information about staffing as well as many other aspects of the department. At our unannounced inspection staff showed us the frequency of the department being below its planned staffing levels. 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. All staff expressed concern that this practice placed extra strain on the department.
- We also had some concerns about nursing cover in the resuscitation area (resus). At one point, during our inspection, there were seven patients in resus and only three members of staff to monitor them.
- 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 agency staff used.
- We observed a board round between nurses and saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues. We discussed handovers with staff who told us they found them to be vital to understanding what was going on in the department. Pinderfields had a large team of staff on duty and therefore it was important to ensure that all staff were up to date with the relevant information relating to patients. We saw that this process was robust.
- We looked at the planned and actual staffing levels on the department for April 2017. There were eight dayshifts when actual registered nursing staff was less than planned actual nursing staff. On four of these days, actual healthcare assistant (HCA) staffing was also less than planned. There were 20 days when actual HCA levels were less than planned levels and two when they were greater. There were however, 23 shifts when actual nursing staffing was greater than planned nursing staffing levels.
- There were 11 nightshifts when actual registered nurse staffing was less than planned levels. On two occasions actual HCA staffing was also less than planned. There were 11 nights when registered nursing was less than planned and 7 occasions when HCA was less than planned. There were however, 10 nightshifts that had more HCAs than planned and 15 that had more registered nursing staff than planned. There were 14 night shifts that had more actual registered nursing staff than planned and 22 when there were more HCAs than planned.

Urgent and emergency services

- There were four twilight shifts when registered nursing actual staff levels were less than planned levels and 22 when actual levels were better than planned levels.
- It was unclear whether this information reflected the shifts when staff were taken from ED to support wards when the wards were short staffed.

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.
- The department had one sub-specialty consultant trained in paediatric medicine. However, all consultants were trained in either advanced paediatric life support (APLS) or emergency paediatric life support (EPLS).
- Consultants we spoke with told us that working in the department was very stressful and they were concerned about 'burn out'. Three of the consultants no longer worked over time or did 'on call' due to stress. However, the on call rota was still fully covered.
- The trust was funded for 21 WTE consultants. There were 16.8 WTE in post and a vacancy rate of 4.2 WTE. Locum cover for consultant posts equated to 2.6 WTE. There were 4.97 WTE vacancies for specialty doctors, and 4.4 WTE vacancies for associate specialists.
- 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.
- The sickness level amongst medical staff was 0.42%.
- 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 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.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.

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 provide 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

At this inspection, 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.
- Patients could access cold drinks and snacks in the department.

However:

- The rate of nursing staff appraisal did not meet the trust standard.
- The department was performing worse than the national unplanned re-attendance rate.
- The process to ensure that staff had sufficient experience and skills to triage patients was not robust and relatively inexperienced, newly qualified, or new to emergency medicine could carry out triage.

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 CEMBooks.
- We saw evidence that the department had pathways for a number of conditions such as sepsis and head injury for both adults and children.
- 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 Pinderfields 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.

Pain relief

- We looked at the records of 13 patients who had attended the department. 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 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.
- Some of the ANPs were independent nurse prescribers. This meant that they could write prescriptions for individual patients beyond the medication included in PGDs. Being able to do this meant that patients received the most appropriate medication for their condition without waiting to see a doctor.

Nutrition and hydration

- Staff told us that sandwiches and beverages were available to patients. 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.
- 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.
- We spoke with two patients who confirmed they had been offered a drink and informed of the location of the water fountain.

Patient outcomes

- Between February 2016 and January 2017, the trust's unplanned re-attendance rate to A&E within seven days was consistently 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 department at Pinderfields had participated in all the recent RCEM (Royal College of Emergency Medicine) 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. However, all five standards had a compliance rate of 100% and the trust was not meeting any of these standards fully. 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 however all standards had a compliance rate of 100% and the trust was not meeting any of these standards fully. 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, 59% of nursing staff and 61% 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 and advanced 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 Emergency Department 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.
- 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.
- The trust had an admission avoidance team who worked to support staff and patients to access alternative services in the community and avoid hospital admission. Any patients who required admission were transferred to a ward as soon as a bed was available.

Seven-day services

- The ED offered 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 until 3am.
- 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.
- 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 CEMBooks.
- 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.
- The senior management team could also access CEMBooks. 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- 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 we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient

agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them. We witnessed staff requesting consent from patients before carrying out tests and treatments.

- Staff working in the children's ED were aware of Fraser guidelines relating to decisions made by children and young people. We saw an example of a young adult accompanied by their parent being asked for consent to undergo a medical procedure. We discussed the episode with other staff in the department who confirmed that they would have acted the same way. Staff were able to confidently explain about assessing competency in young people and we had no concerns about their knowledge of these matters.
- Mental Capacity Act and consent training was part of safeguarding adults training.

Are urgent and emergency services caring?

Good

When we inspected the department in July 2015 we did not rate caring in the department .

At this inspection we also rated caring as 'good' because:

- Staff ensured that the privacy and dignity of patients and their families was maintained.
- Patients and their relatives were given information about care and treatment and kept informed about tests and planned treatment.
- 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 five patients who were happy with the care they received.
- Patients described to us how staff treated them with dignity and respect.
- 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, Pinderfields Hospital scored 79% 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. The national average was around 87%. There was a trend of improvement over this time.
- 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.
- Staff were very busy however they took the time to deliver care that was compassionate and we saw patients being treated with patience and kindness at all times from all members of staff at all levels.
- 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

- During our inspection we witnessed a number of very good interactions with patients. Staff made sure that information they gave was in language that the patient and their family could understand.
- We saw patients being given information and supported to make decisions about the treatment they would like to receive.

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.

Urgent and emergency services

- 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 carried out this inspection because, when we inspected the department in July 2015, we rated responsive as 'requires improvement'. We asked the provider to make improvements following that inspection.

At this inspection we rated responsive as 'requires improvement' because:

- The department was consistently 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 around 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.

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.
- The department was meeting the RCEM consultant cover recommendations.
- The department had implemented some system changes in order to improve their performance against standards.
- 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.
- Pinderfields General 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 15 hours each day.
- Local GPs worked shifts in the department to support demand management. They could treat patients with minor illnesses and those who may not have needed to attend ED, thus all patients could be seen more quickly by the most appropriate clinician.
- At the time of the inspection, as part of the reconfiguration programme, Pinderfields accepted a wide range of patients including those suffering stroke, trauma, cardiac arrest, surgical emergencies and obstetrics and gynaecology emergencies. There were some patients such as those having a heart attack, or victims of major burns or major trauma who were taken to their nearest major trauma centre.
- Because there was a paediatric ED, the hospital accepted babies, children and young people of any age.
- 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 prompt access to 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. This was usually via telephone. However, we 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. However we noted that there had been a complaint in the previous 12 months about failure to support a patient with hearing impairment by organising an interpreter. We did not have access to the outcome of the complaint at the time of writing.
- 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 access to chaplaincy services for patients and relatives of different faiths or none.
- Patients with purely mental health needs waited either in the relatives' room or a quiet cubicle. There was a suitable mental health room. It had two exits and no ligature risks.
- The trust had access to the psychiatric liaison team by telephone. 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.

Access and flow

- At the time of our inspection we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using GPs to see some patients, managing ambulance arrival patients better and the introduction of 'streaming' to make sure patients went to the correct part of the department, e.g. majors, minors or to see the GP or ANP. Staff reported that this had a positive impact on waiting times and were hopeful that the number of patients waiting more than four hours would be significantly reduced by the time the new monitoring data was published.
- 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 trust consistently breached the standard between February 2016 and January 2017. Performance was also consistently worse than the overall England performance. On this site, the average across the year was 74%, short of the standard. The department had seen over 90% of patients once and 85% of patients three times in this period. The remainder were between 60% and 70%. This reflected the pressure the department was under and also correlated with the long ambulance handover times previously reported. In June 2017 81% of patients were seen within four hours.
- 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.
- The Pinderfields site employed a patient flow coordinator. They were responsible for alerting the bed bureau about any patients who required admmission and making sure that as soon as beds became available, patients were moved. They were also responsible for making sure that patients were ready to move, had all of their observations up to date and were ready to move as soon as the bed was available. This was a fairly new role, starting in January 2017. However all staff we spoke with told us it was a vital role that had a significant impact on the flow of patients through the department.
- 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. For example, we saw a patient who had waited 13 hours before being accepted by the intensive care unit (ICU) and another patient who had waited 10 hours and was still waiting for a bed on a ward. 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.
- 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 against this metric 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 for this site.
- From our observations and discussions with patients and staff, patients were triaged and assessed quickly.
- The department used GPs at certain times of the day to deal with minor illnesses and injuries to ease the pressure within the department. This also helped ensure that patients were seen by the most appropriate person to treat them.

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, the trust received 143 complaints about the Emergency Department. Of these, seven were rated as high risk, 66 as medium and 70 low risk.
- The most common causes for complaint were; delays and waits (44), staff attitude (25), delayed or missed diagnosis (24), discharge (10) and missed fracture (9).
- Of the complaints made, the trust upheld 39, partially upheld 72 and did not uphold 30. The outcome of two was yet to be decided. One high level complaint was upheld, three were partially upheld and two were not upheld.

- Where applicable, the department generated action plans in response to complaints and followed up with patients and staff as appropriate. When individual staff were involved, they were required to write a reflective piece about the incident to support their learning.
- 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.
- Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff when the issue related to clinical care.

Are urgent and emergency services well-led?

Good

At this inspection we rated well-led as 'Good' because:

- There was a vision and strategy for the trust, including the reconfiguration of service provision across the three sites.
- Staff reported that the trust culture had improved greatly. They felt the trust was more open and inclusive of staff and they could openly voice concerns without fear of repercussions from the highest levels.
- There were governance processes in place to ensure that performance was monitored and managed. There was joint working with the other EDs within the trust including governance and sharing lessons learned. Some of these were new and were yet to be embedded into routine practice.
- The department had implemented some innovations to manage demand, enable better cross site communication and improve staff engagement.

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.
- 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.
- Urgent and emergency care services were in the process of being reconfigured across the three ED sites within the trust.
- 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.

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.
- Staff were invited to attend clinical governance, patient safety and clinical audit meetings. They were not always able to attend due to staffing pressures however were encouraged to do so whenever possible.
- 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.
- The staff we spoke with were clear about the 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. The department was working with other departments to try to address risks such as staffing.

- 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.
- A trust wide departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department. 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.

Leadership of service

- The ED departments 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.
- Similarly, medical staff told us their leadership was strong and inclusive and provided good leadership within the department and strong representation for the department within the wider trust.
- All of the staff we spoke with told us that there was a positive feel about the new management team within the trust and the trust was improving, not only in performance but also in the approach to leadership and management.
- Staff told us that senior executives from across the trust visited the department and provided strong visible leadership. Staff described how the executive team came and gave thanks personally and at Easter had sent chocolate eggs for staff. Staff felt that these gestures reflected an overall positive change in the management style within the trust.
- Staff gave us examples of when the senior leadership had visited the department to offer practical support to staff in times of extreme demand, had addressed patients and met with patients and their families to resolve serious concerns and complaints.
- Despite the department being very busy, it appeared to be organised and working efficiently. Shift leaders appeared to be fully aware of the demands in the department at the time and were making sure that staff were appropriately placed to meet these demands.

Culture within the service

- We spoke with a number of staff from different disciplines about the culture of the department. We received a consistent message about the department. Staff 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 told us that the culture across the trust had changed over the past year to be more open and supportive. People were no longer afraid to admit errors or suggest changes to working practices.
- The atmosphere in the department showed that staff focus was on treating patients in an efficient way.
- 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 felt that their hard work was recognised and they felt appreciated by colleagues and line managers.
- We saw examples of the department being a teaching and learning environment as more experienced staff explained patient conditions to junior colleagues and carried out informal teaching sessions to improve staff knowledge.

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 were unable to 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 that had approximately 300 staff members. Staff were able to share information, concerns and discuss events in the departments. Although the page was not monitored, senior staff were able to see the issues within departments and monitor concerns and problems discussed by staff. They were able to make sure there were no problems with morale and take action if anything caused them concern.
- 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 that they were kept informed about opportunities to progress.

Innovation, improvement and sustainability

- The trust had introduced a number of new initiatives to enable them to manage demand and work towards achieving the government set indicators.
- Patient waiting time, number of patients in the department and number of patients waiting to be seen by a doctor were displayed in the department waiting rooms and also on the trust's website.
- The trust's website was linked to Google translate, so that people whose first language was not English, or who could not read English, were able to read the website after a few clicks of a button. Although the translation was inaccurate in places, it would support patients to find basic information.
- The department had introduced a video link across sites to enable staff to communicate effectively and attend meetings without having to take travel times in to consideration.
- The trust had a closed social media profile for staff to share information, celebrate success or share learning.
- The department ran hot clinics such as an emergency surgery clinic, gynaecology assessment clinic and plastics assessment clinic. These enabled patients with these conditions to access treatment quickly with an appropriate member of staff.
- The use of an IT system 'ICE' enabled some emergency ambulatory care patients to leave the department over night and return in the morning.

Medical care (including older people's care)

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provided medical care, including older people's care across three sites. The main activity focussed at Pinderfields General Hospital (Pinderfields) in Wakefield and Dewsbury and Distract Hospital (DDH) in Dewsbury. The division had recently relocated a stroke rehabilitation ward from Pinderfields onto the Pontefract site.

A single management team covered divisional wards and services across all sites.

Pinderfields had 16 medical wards (referred to as 'gates') accommodating 475 beds. These included stoke and neurology services, a regional spinal unit, ambulatory care services (AEC), an acute assessment unit (AAU), older person's services, haematology and oncology wards (including a chemotherapy day unit), cardiology and coronary care (CCU), diabetes and endocrinology, respiratory (including an acute respiratory care unit – ARCU) and gastroenterology. There was also a surge ward open at the time of our inspection. The medical division also hosted an infusions unit, a cardiorespiratory investigations unit, endoscopy services and the discharge lounge.

The division had 72,684 medical admissions between December 2015 and November 2016 of which 41,848 (58%) were at Pinderfields. These were broadly categorised as emergency admissions accounting for 24,988 (60%), 16,017 (38%) were day case, and the remaining 843 (2%) were elective. The top three admitting medical specialties were general medicine, elderly medicine and respiratory..

During our inspection (unannounced on 11 May, comprehensive on 16-19 May and unannounced on 5 June 2017), we spent time at Pinderfields visiting all wards and clinical areas managed by the medical team. We spoke with 74 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed 28 reviews. Our team met with 35 patients and relatives, observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times and care being delivered at various time of the day and night. We also utilised the Short Observational Framework (SOFI) to capture the experiences of people who use services who may not be able to express this for themselves.

Medical care (including older people's care)

Summary of findings

The service was inspected as part of our comprehensive visit in June 2015 with additional unannounced visits in August and September 2015. Overall, medical care at Pinderfields was rated 'requires improvement'. A number of areas for improvement were highlighted and the service was told to take action to:

- Ensure sufficiently skilled staff were deployed at all times;
- Ensure policies and procedures to monitor safe staffing levels were understood and followed;
- Ensure patients identified at risk of falling have an appropriate assessment of their needs and levels of care implemented;
- Ensure improvements are made in the monitoring and assessment of patient's nutrition and hydration needs and these needs are met;
- Ensure staff have completed mandatory training and have had an annual appraisal;
- Ensure knowledge and training in relation to Mental Capacity Act and Deprivation of Liberty Safeguards is strengthened;
- Ensure medicines are safely stored and administered;
- Ensure infection control procedures regarding hand hygiene, the use of personal protective equipment and cleaning of equipment are followed;
- Ensure resuscitation and emergency equipment was checked on a daily basis;
- Ensure systems are in place to assess and monitor the quality of care; and,
- Ensure actions taken to reduce risks are monitored and sustained.

During this inspection, we found the service had made improvements however had failed to meet all the requirements stated:

- There had been active recruitment drives in registered nurse (including overseas campaigns) and medical staffing however, we found nurse staffing remained vulnerable with limited resilience to deal with current demand. Medical staffing was heavily reliant upon locum support and rota gaps were evident.
- There had been efforts made to reinforce staffing escalation procedures however, we found some of these initiatives such as 'Matron of the Day' and the implementation of the divisional bleep holder added little benefit to the process.
- There had been a reduction in patient harms relating to falls following the appointment of a falls lead and a number of local initiatives. Falls remained a significant contributor of patient harms across the division. The completion of falls related documentation, namely risk assessments and the falls care bundle, was found to be lacking.
- The monitoring and assessment of nutritional and hydration needs remained a concern. Care plan documentation, risk assessments, food and fluid charts and intentional rounding records were deficient. We found the ward meal time initiatives implemented to support patients requiring assistance with eating and drinking were not effective.
- There had been an improvement in mandatory training figures and staff appraisals across the division.
- Staff understanding of their roles and responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards was variable. There was an inconsistency in the assessment of capacity to support care decisions.
- There had been improvements in the storage and administration of medicines. There were some prescribing deficits in particular around anti-microbial stewardship and oxygen therapy. Controlled drugs and emergency drugs were checked and stored in accordance with local and national guidelines.
- We found infection control practices relating to hand hygiene, the use of personal protective equipment and the cleaning of equipment were good.
- Resuscitation and emergency equipment checking was good and in line with local and national guidelines.
- There were systems in place to assess and monitor the quality of care and there was evidence of actions taken to review and reduce identified risks.

We rated medical care (including older people's care) as 'inadequate' overall because:

Medical care (including older people's care)

- Divisional wards were consistently understaffed. The division failed to meet safe registered nurse staffing ratios and actual nurse staffing figures were significantly below establishment planned numbers, evidenced by poor fill rates.
- There was a reported and identified correlation between deficient nurse staffing and patients suffering harm. The effect of the current nurse staffing situation impacted in all clinical areas. This was compounded by current demand and extra capacity being staffed from within the existing nurse compliment.
- Medical staffing was vulnerable. There were a number of senior medical vacancies and a heavy reliance upon locum staffing. There were regular rota gaps, a number of which went unfilled or were backfilled by 'other' grades.
- There had been an increased incidence of clostridium difficile infections reported across the division. These figures were significantly above the annual threshold.
- The divisional wards were ill equipped to deal with the addition of extra capacity beds above the ward bed base. The ward environment did not lend itself to additional patient beds in non-designated bed spaces. Patients in extra capacity beds (and neighbouring patients) had personal care space compromised, did not always have access to suitable furniture and to nurse call bells.
- Antimicrobial prescribing standards and antibiotic administration required improvement to ensure patients received safe treatment in a timely manner for the right reasons and for the correct duration.
- Nursing documentation standards were variable. We found deficiencies in risk assessment completion for falls and pressure ulcers. There were also significant omissions on fluid, food and intentional rounding documentation.
- Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable. There was confusion around the internal processes and in the completion of the associated documentation. Patients were subject to restrictions of liberty.
- There was an inconsistent assessment of patient capacity and therefore uncertainty in assurances around patient ability to consent to care and treatment decisions.
- The meal time initiative to support patient nutrition and hydration was not robust. Staff were distracted whilst supporting patients with eating and drinking. Due to patient demand, some meals were allowed to go cold and were wasted. Patients did not always have ease of access to drinks and the use of the 'red jug, red tray' was inconsistent. Nursing documentation to support nutrition and hydration was poor. Fluid charts, food diaries and intentional rounding documentation was absent, incomplete or partially completed.
- Privacy and dignity of patients being cared for in extra capacity beds was compromised. Staff commented how utilisation of extra capacity beds on wards restricted space to deliver care, impinged on neighbouring patients bed areas and was hazardous due to a lack of nurse call bells and inadequate screening. Divisional leaders recognised this affected the quality of the patient experience.
- Due to limitations in patient flow across the division, there was a considerable number of patient moves after 10pm causing distress, inconvenience and confusion to many patients. There was no upper time limit cut-off and patient moves during the night had become a normal feature in divisional flow.
- There were high numbers of 'on the day' cancellations across endoscopy services causing inconvenience to patients and delay in patients receiving necessary investigations.
- Divisional managers recognised the additional beds currently in use across the division compounded by staffing shortages caused dissatisfaction with staff and destabilised ward leadership. Staff morale was variable across the division.
- Governance and assurance processes for the care and management of patients in extra capacity beds did not support the provision of safe care, quality outcomes and positive patient experience on divisional wards.

However:

Medical care (including older people's care)

- The division had appointed Safety Support Workers to support the existing nursing compliment. A number of additional registered nurse appointments had been made and were due to commence in the summer 2017.
- There had been a reduction in some patient harms reported, namely category three and four pressure ulcers and falls with harm. The division had reinforced their objective to reduce patient harms further with the appointment of a Falls Lead.
- Staff responded proportionately to clinical indicators suggesting patient deterioration. They had a good understanding of escalation triggers and processes underpinned by clinical judgment and recognition of the National Early Warning Score tool.
- There was a real recognition of the value and importance in multi-disciplinary team working across the division. All disciplines acknowledged pressures colleagues faced and all worked together in a coordinated and cohesive manner to support patient outcomes.
- Staff delivered evidence based care and treatment underpinned by national guidelines, quality standards and best practice standards. The division had developed a number of local care pathways to standardise care and improve patient outcomes.
- Staff were passionate and driven to deliver quality patient care that they considered a priority. We observed kind, compassionate and caring interactions with patients and they commented positively about the care they received.
- There were a number of considered and thoughtful examples of staff engaging with patients and their family members to improve the quality of care received.
- The division planned services to meet the needs of the local population and were actively involved in the on-going acute healthcare reconfiguration across the trust.
- The division involved commissioners and network colleagues when reviewing service delivery.
- There were positive and dynamic initiatives to support vulnerable patients living with dementia and for those with additional needs because of learning difficulties.

- There were clearly defined leadership structures across the division with a vision and strategy aligned to the trust agenda.
- The division had clear governance channels into the wider organisational executive management structure. Divisional meetings considered safety, risk and quality measures. The division had a live risk register, which was reflective of real issues faced across divisional services impacting on patient care, staff wellbeing and service quality.
- There was evidence of positive progression being made within the divisional ethos underpinned by a number of public and staff engagement projects.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We rated safe as inadequate because:

- The division continued to report a high number of patient harms, in particular around falls and pressure ulcers. There was a serious backlog of incident investigations, reported to be in the region of 250 outstanding at the time of our inspection. Divisional leaders acknowledged and recognised this by including the same on the divisional risk register.
- Learning opportunities from incidents was variable and not embedded across the division.
- There had been an increased incidence of clostridium difficile infections reported across the division. These figures were significantly above the annual threshold.
- The divisional wards were ill equipped to deal with the addition of extra capacity beds above the ward bed base. The ward environment did not lend itself to additional patient beds in non-designated bed spaces. Patients in extra capacity beds (and neighbouring patients) had personal care space compromised, the ward area became increasingly cluttered, there was limited access to suitable furniture and to some patients did not have the use of a nurse call bell.
- Antimicrobial prescribing standards and antibiotic administration required improvement to ensure patients received safe treatment in a timely manner for the right reasons and for the correct duration.
- Nursing documentation standards were variable. We found deficiencies in risk assessment completion for falls and pressure ulcers. There was also significant omissions on fluid, food and intentional rounding documentation.
- Divisional wards were consistently understaffed. The division failed to meet trust defined safe registered nurse staffing ratios and actual nurse staffing figures were significantly below establishment planned numbers evidence by poor fill rates.
- There was a reported and identified correlation between deficient nurse staffing and patients suffering harm. The ripple effect of the current nurse-staffing situation affected all clinical areas. This was compounded by current demand and extra capacity being staffed from within the existing nurse compliment.
- Some staffing escalation procedures added little to the staffing situation. The divisional 'bleep holder' initiative was criticised and staff were cynical about the 'badge system' as a means to identify staff suitable to support outside their ward expertise. Senior clinicians considered highly skilled and specialist nurses were being misused as part of the escalation process.
- There were a number of senior medical vacancies and a heavy reliance upon locum staffing. There were regular rota gaps, a number of which went unfilled or were backfilled by 'other' grades.

However

- The division had appointed safety support workers to support the existing nursing compliment. A number of additional registered nurse appointments had been made and were due to commence in the summer 2016.
- There had been a reduction in some patient harms reported, namely category three and four pressure ulcers and falls with harm. The division had reinforced their objective to reduce patient harms further with the appointment of a Falls Lead.
- The environment for rehabilitation and therapies in the spinal unit were modern, current and progressive.
- Mandatory training figures had improved.
- Divisional wards at Pinderfields had adopted the use of 'VitalPac' (an electronic hand held device to record patient observations). We found clinical observations recorded accurately and at a frequency relevant to the clinical need of the patient. Staff responded proportionately to clinical indicators suggesting patient deterioration. They had a good understanding of escalation triggers and processes underpinned by clinical judgment and recognition of the National Early Warning Score tool.

Incidents

- The division reported incidents through the trust electronic reporting system.
- The division graded incidents according to risk rating and severity of harm in line with their incident management policy (including the management of serious incidents).
- Such reported incidents were then categorised according to severity ranging from no harm, low,

moderate, severe/death. Ward managers, matrons and the divisional leadership team reviewed submitted incidents and grading of harm. Staff escalated serious incidents accordingly.

- Between March 2016 to February 2017, the division reported 6,896 incidents; the highest number of incidents from any service. Of incidents recorded across the division, 4,540 (66%) were reported from Pinderfields. Overall, 68% were no harm, 29% were recorded as low harm, 2% were rated moderate and less than 1% were classed as severe (n=14) or resulted in death (n=9).
- At our meeting with divisional leaders, they acknowledged there was an incident backlog which had peaked at over 700 in December 2016. We were informed the division had worked hard to address the backlog and current figures were in the region of 300.
- At the 'Quality Catch-Up' meeting attended on 16 May 2017, the Head of Nursing and divisional governance lead confirmed outstanding incident reports had reduced to a backlog of 250 (a reduction of 40 from previous week). Incident themes and trends tended to focus on patient harms relating to falls and pressure ulcers. The team had also noted an increased number of 'staff related incidents' and this was being monitored. The divisional team had incentivised staff working on the incident backlog by way of a 'Prosecco Challenge' (a bottle of prosecco awarded to a ward manager, matron or divisional lead who had cleared backlogged incidents allocated to them in the given period).
- Ward managers, matrons and divisional leads all monitored incident trends and themes. The most common incident type was the 'infrastructure' category (30%). This included incidents relating to staffing, facilities and the environment. No incidents in this category were reported in the severe/death classification.
- The second most commonly reported category was 'patient accident' accounting for 1,198 (26%) of all incidents reported across the division. This category included three deaths and four severe harms.
- 97% of incidents were reported using the National Reporting and Learning System (NRLS) within 30 days.
- In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) across the division which met the reporting criteria set by NHS England between March 2016 and February 2017. 32 (73%) of these incidents originated from Pinderfields. Of these, the most common type of incident reported was Slips/trips/falls meeting SI criteria (64%).
- The division reported 13 SIs in April – May 2017. Where incidents were categorised as SIs, staff allocated an investigation team to follow up the report.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers and manpower/resource deficiencies.
- Between March 2016 and February 2017, the division reported two incidents which were classified as Never Events for medical care. 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 (Strategic Executive Information System, STEIS). These related to a wrong route medication administration and a scoping error which occurred at the Pontefract site.
- We reviewed the detail behind the nine reported deaths. These reported incidents related to patient accidents, clinical assessment and implementation of care and ongoing monitoring reviews.
- We also reviewed three incident investigation reports/ root cause analysis (RCA) documents attached to SIs. We found the investigation reports provided a concise incident description, a background leading to the investigation, details of the investigation team and their terms of reference, a chronology of events, a brief of the discussions held by the investigating team, an analysis of the findings, a consideration of care and delivery implications including contributory factors, a root cause analysis, lessons learnt and recommendations. The reports concluded with a list of action plan points detailing a responsible person(s) and target dates for implementation. There was a section entitled 'arrangements for shared learning' and appended documents relevant to the investigation.
- Commissioners felt the quality and consistency of RCA reports relating to falls and pressure ulcers required a more in depth analysis of the root cause and contributory factors. Overall, of those reviewed, we found there to be a consistent framework used however the depth of the scrutiny and analysis did vary.

- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust 'Duty of Candour Being Open' policy. Staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.
- The division shared learning from incidents and when things went wrong. Management discussed outcomes at divisional meetings, matrons and ward managers shared learning and cascaded key information to their staff at ward meetings and at safety huddles, through newsletters and communication bulletins and some incidents were themed on the local intranet.
- Ward 45 mapped incident trends to pick up local themes and these were shared with staff on the unit.
- Overall, staff agreed feedback from incidents was inconsistent and often lacked detail to fully benefit from any potential learning opportunities. Staff who submitted incidents stated they did not always get feedback.
- Consultants attending the focus group commented how they felt feedback from incidents was variable across the division. Divisional leaders acknowledged learning from incidents was not fully embedded across the division.
- Managers stated where staff were involved in incidents and required professional support, this was provided by the ward manager and the matron. Where staff required additional support of a non-professional nature, they could access occupational health and the counselling service. and staff could also access counsellors if required.
- The division held monthly clinical governance meetings where mortality data and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) mortality and morbidity (M&M) reviews were discussed. The chair and attendees considered case summaries presented, reviewed outcomes and summarised key findings. It was unclear from the meeting minutes how lessons learnt from this forum were disseminated to the appropriate persons and to wider audiences for shared learning. Ward managers informed us that outcomes from the M&M group (where relevant to their area) were discussed at ward meetings.
- Endoscopy specific incidents were considered by the Endoscopy Users Group.

Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the trust reported 105 new pressure ulcers (PUs), 40 falls with harm and 32 new catheter urinary tract infections between February 2016 and February 2017 for medical services.
- Overall, the prevalence rate of pressure ulcers has fallen from February 2016 to February 2017; however some months reported a slight increase from the previous month. February 2017 saw the lowest reported rate for the 13 month period. The rate of falls and CUTI's has fluctuated over the 13 month period; however from November 2016 the rate has slowly decreased.
- The overall harm free care target reported in quarter 4 (January – March 2017) was 82.55% (worse than the 95% tolerance).
- Divisional leaders focussed on patient harm reduction initiatives. This tended to be prioritised around falls and PUs.
- At our meeting with divisional leaders, they informed us there had been a 50% reduction in PUs from 2015/16 data. During our discussions with the Tissue Viability Nurse (TVN) and the Quality Improvement Matron, we were advised there had been an increase in category two reported PUs of 6.2% and a 68% reduction in category three and four PUs compared to 2015/16 figures.
- The Divisional objective was to maintain good progress with reduction of serious PUs and extend the focus onto category twos by reducing referral time, improve bedside teaching around wound grading, develop an overarching action plan to track and manage this cohort by reigniting the 'React to Red' campaign and target clinical 'hot spots'.
- Between February and April 2017, the division reported 355 PUs of which 154 (43%) were hospital acquired. The division documented 148 as category two with AAU,

ward 43 and the stroke unit reporting the highest incidence. In the papers prepared for the Board Meeting of 11 May 2017, the Director of Nursing and Quality confirmed a correlation between poor staffing fill rates and an increase in category two PUs (reference to ward 31).

- Between April 2016 and March 2017, NRLS data showed 1,579 incidents linked to falls across the division, 22 of which had been reported as SIs. This broadly correlated with data provided by the Falls Lead where 1,548 were reported across the division; a reduction of 7% from 1,668 in 2015/16. The division also reported a reduction in falls per 1,000 occupied bed days (OBDs) of 13.3% from 6.8 from 7.85. Using NRLS figures, 1,102 (70%) were categorised as no harm/near miss, 420 (26%) were low or minimal harm, 54 (3%) moderate harm and three (less than 1%) classified as severe or death. AAU and ward 43 reported the highest incidence. In Quality Committee papers (May 2017), the reported overall falls reduction of 8.4% compared to 2015/16 was noted. The local target was to sustain the trend in falls reduction; 15% in severe/death falls per 1000 OBDs and 10% reduction in moderate categorised falls incidents.
- To support this agenda, the trust had appointed a Falls Lead (fixed term basis). The Falls Lead had implemented the falls bundle across all divisional wards, had secured purchase of additional equipment (such as beds and sensors), had progressed training and education around falls awareness and had engaged with community colleagues to improve and support care for 'frequent fallers'. Additionally, The division had also appointed a number of safety support workers in addition to the existing staffing compliment to help target patient harms of this nature. The division had representation at the falls prevention meetings and the falls improvement group.
- The Falls Lead completed a staff questionnaire in November 2016 to get a benchmark of current staff understanding and awareness of falls issues. Staff knowledge was variable. 83% knew of the falls bundle, 99% confirmed falls risk was discussed at handover, 74% of staff knew how to escalate, 87% had an awareness of the falling star initiative and 54% didn't know when the last fall was in their clinical area.
- Commissioners spoke positively of their patient safety walkabouts, the work of the falls improvement work-stream and the PU improvement group.
- The division were involved in the venous thromboembolism (VTE) risk assessment documentation compliance audit 2016. Auditors reviewed a minimum of ten sets of patient records per speciality and recorded compliance against NICE guidelines and trust benchmark of 90%. The findings reported good completion of patient demographics, poor completion of record entries (dated and timed at 30% and 27% respectively), variable mobility assessment reported at 82%, variable reporting of thrombosis risk factors at 85% and poor bleeding risk assessment at 15%. Pre-admission assessment for elective medical patients was good however for 'all patients' VTE assessment on admission was poor with no speciality meeting the 90% benchmark. There were no areas across the division who completed a reassessment within 24 hours and none of the divisional wards provided the patients with documentation on VTE prevention as part of the admission process. Auditors highlighted a number of recommendations and of particular note, to work within the division to improve VTE risk assessments and documentation generally. The division reviewed the outputs from the audit in December 2016 and further reinforced recommendations to be rolled out to the sub-specialisms.
- Between January and March 2017, VTE compliance results showed a significant improvement in VTE risk assessment of 92% of patients being risk assessed using the National Tool with monthly compliance figures across medicine reaching an average of 90.8% for 2016/17. In the divisional integrated performance report in March 2017, VTE compliance was reported to be above 95%. Of the 28 charts reviewed, there were two (7%) where we could not locate any VTE assessment but where VTE prophylaxis was prescribed. This coincided with local findings.
- We found safety thermometer information displayed clearly and consistently in an accessible and readable format on large whiteboards situated at the entrance of all wards.

Cleanliness, infection control and hygiene

- Overall, divisional wards we visited were visibly clean and tidy.
- All clinical and non-clinical areas had cleaning rotas and all equipment checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy.

- We observed clinical waste, cytotoxic waste and sharps been disposed of appropriately.
- The divisional wards were subject to front line (FLO) audits measuring compliance against key cleanliness criteria. Across the division, general ward areas, patient areas and utility area cleanliness was consistently reported over 95%. The audit also showed divisional wards were complaint for equipment cleanliness, linen and sharps disposal.
- In the Patient Led Assessment of the Care Environment (PLACE) 2016, the site was scored as 97.4% for cleanliness (slightly lower than national average of 98.1%).
- The division followed the trust infection control procedures.
- The division had representation in the Infection Prevention and Control (IPC) Group through their designated IPC nurses.
- The trust healthcare associated infection (HCAI) prevention and control improvement strategy was underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety. This was outlined in the IPC Annual Report 2016.
- In the HCAI dashboard for 2016/17 (to March 17), the division reported no methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections and non-elective MRSA screening was reported at 93%. The division reported 14 methicillin sensitive staphylococcus aureus (MSSA) infections and 47 attributed escherichia coli (e.coli) infections. Blood culture contaminations rates were slightly above threshold of 3% in 10 of the 12 reporting months.
- At the divisional IPC meeting on 16 May 2017, we were informed they trust reported 44 clostridium difficile (c.diff) cases against a threshold of 27 (for 2016/17). We were told the division accounted for 40 of these cases. The IPC team identified three causative factors for this – sampling problems, difficulties in isolating patients and an inconsistency in stool charting. There had been a recent c.diff cluster on ward 43. In view of the incidence of reported cases, the Director of Nursing and Quality planned a c.diff summit in July 2017.
- The division were involved in the trust wide IPC monthly audits to monitor compliance against key IPC quality measures such as hand hygiene, cannula care, commode and mattress cleanliness, spray and glow, catheter care and standard precautions. Auditors rated compliance against a 'green' benchmark of 90%. Across divisional wards at Pinderfields, compliance rates for hand hygiene, isolation procedures, clinical IPC procedures (including bare below the elbow) were consistently good. Auditors found variable results in on-going urinary catheter care, peripheral cannula and central venous catheter (CVC) care. The aseptic non-touch technique (ANTT) compliant figures for medical staff were below the trust benchmark (85% compliance against 95%).
- The division were involved in a number of on-going audits driven by the IPC team.
- In December 2016, the division took part in the Peripheral Intravenous Cannula (PIV) audit. Overall PIVC management was good however auditors identified some poor documentation issues around the recording of visual infusion phlebitis (VIP) scores were not recorded at least once per shift.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. Staff used PPE appropriately.
- Staff informed us of the procedure when caring for patients who required isolation for IPC measures. We observed the isolation procedure in force on two divisional wards at Pinderfields. Staff used appropriate signage and reinforced best IPC practice to visitors to the ward.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the Bare below the Elbow protocol.
- The endoscopy suite had disinfection facilities on site. We had sight of the annual review of decontamination facilities at Pinderfields dated February 2017 which provided a 37 point checklist in accordance with British Standards and International Standards Organisation. The audit found equipment to be well maintained and in good working order. Auditors recommended upgrading cabinets with integral compressors and the installation of air condition units. Auditors identified the same findings at the Pontefract site.

- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required. 85% of staff in the medical division had completed this training against a target of 95%.

Environment and equipment

- Pinderfields Hospital was significantly rebuilt and refurbished following a private funding initiative (PFI) in 2010.
- The divisional wards were situated in the main new structure. There had been considerable investment to improve the internal and external environment.
- The division were involved in the PFI Area Performance monitor checks. These checks reported overall environmental performance as 97.5%.
- The division followed the 'Standard Operating Procedure for Risk Based Servicing and management of Medical Equipment' ratified in March 2017. The same detailed the role of the medical physics department in servicing medical equipment. The policy was in line with MHRA Device Bulletin (2006)(05).
- PLACE (2016) auditors reported the condition, appearance and maintenance score to be 94.8% (better than national average of 93.4%).
- All patients within the established bed base had designated bed area, which included a personal locker, a bedside chair, table, call bell and access to gender specific toileting and bathing facilities. Patients in extra capacity beds (beds placed into areas above the existing established bed base), did not have sufficient space. This also compromised neighbouring patients. We found bed tables lacked the adjustable function for a number of patients in extra capacity beds, call bells were not available (with some patients using hand held bells) and the screens provided, where available, did not provide sufficient cover for the extra capacity bed space.
- Patients on the spinal unit accessed a modern gym and therapy room. There was also assisted technology equipment, robot assisted walking device, hydrotherapy pool and bedside entertainment systems which could be controlled by way of visual recognition. These facilities were designed to promote rehabilitation.
- Staff accessed higher grade pressure relieving equipment for patients who had a particular need or risk. These included mattresses and cushions stored on site.
- We checked the resuscitation trolleys on all the wards we visited and these contained correct stock. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed fuller weekly content checks of all stock including emergency drug expiry dates. We saw each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly.
- All equipment we checked had safety-testing stickers in date, which assured staff the equipment used was safe, and fit for purpose. Staff confirmed where equipment had not been routinely checked, they ceased to use it until they received approval from the medical physics department.
- The chemotherapy day unit had been designed to meet the National Cancer Peer Review Standards which covered treatment areas and equipment.
- There was static and portable equipment available to monitor patients where clinical need required such as those in CCU, ARCU and on the stroke unit for patients undergoing thrombolysis. The CCU had monitored beds however the area was not bespoke for CCU patients and formed part of the wider cardiology ward.

Medicines

- Medicines on the divisional wards at Pinderfields, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Staff managed controlled drugs (CDs) appropriately and maintained accurate records in accordance with trust policy, including regular balance checks.
- Nursing staff were aware of local policy, professional standards for medicine management and for the storage and administration of controlled drugs.
- Staff stored emergency medicines on the resuscitation trolleys in tamper evident boxes in accordance with local policy and national standards. The integrity of the container and the contents were checked daily.
- The division (eight wards) took part in the antimicrobial resistance (AMR CQUIN) audit 2016/17. Auditors found good compliance of prescriptions with 72 review documented following antibiotic prescribing with performance exceeding the 90% compliance target.
- A divisional ward was subject to a focussed antimicrobial audit in October 2016. This followed an increased incidence of c.diff infection on ward 43. The audit found that 80% of patients were prescribed appropriate antibiotics and 100% of patients had a review/stop date and indication recorded on the prescription (trust average of 57% and 82%

respectively). One of the prescription charts our pharmacist reviewed on this ward recorded that antibiotics had been prescribed for sepsis however the first dose had not been administered (estimated time from prescribing – eight8 hours). This was also observed by our pharmacist on ward 45 where doses of antibiotics had been missed but an incident report had not been made. Auditors drafted recommendations to prescribers and the antimicrobial stewardship committee to follow up findings. At the time of our inspection, antimicrobial ward rounds were not being completed routinely on the medical wards due to a lack of Consultant Microbiologist time.

- Of the 28 medication charts reviewed, we found them to be legible, completed in a timely manner and allergies completed in all cases. 20 of the charts had antibiotics prescribed and of these we found 'indications for' completed in 18 (90%). We also found 'stop dates' omitted in two charts however the prescription chart provided for an automatic review at 72 hours.
- Our pharmacy team completed a review of a further 12 medication charts. All charts had allergies recorded, evidence of timely reconciliation and pharmacist review. There were some omitted medications appropriately coded however one chart showed missed antibiotics for three days; this matter was duly reported as an incident for investigation. Divisional wards were involved in self-medication and discharge medication pilots.
- Divisional wards completed CD checks on a daily basis. We found storage, handling and administration to be in line with local and national guidance. Local CD audits were co-ordinated by pharmacy and where concerns or discrepancies were noted, these were highlighted to the accountable officer. Additionally, staff also stored and handled 'patient own' CDs in accordance with local guidelines. Where such medications were stored on the ward, staff maintained regular checks in 'patient own' CD books.
- Medicines requiring refrigeration were stored securely. Staff completed daily fridge temperatures checks to ensure these medicines were safe to administer. We found some omissions in historic daily checks on divisional wards. Staff informed us when a temperature reading was outside the upper or lower limit, they would immediately contact the pharmacy department for guidance. Some wards had remote electronic fridge temperature monitoring which was co-ordinated by pharmacy.
- Staff we spoke with knew how to report incidents involving medicines. There was an open culture to incident reporting and staff received support from ward managers to learn from incidents. This was evidenced following a recent never event where all staff had received support and training following the incident.
- Pharmacists visited the medical wards daily to review prescription charts and provide clinical advice. Staff valued this service and expressed that a seven day ward based pharmacist service would be beneficial to support locum doctors and discharges at the weekend. The weekend pharmacy service provided pharmacist visits to PGH MAU between 9.30am and 4.30pm on Saturday, Sunday and Bank Holidays. Additionally, divisional wards benefitted from a dispensary based service during the same hours.
- We visited ward 45 which was one of two wards where ward based dispensing had been implemented to try facilitate the supply of take home medicines on discharge. The outcome of these pilots had not yet been formally reviewed but we were advised there were plans to continue this service. Information about patients' medicines on discharge was sent electronically to the patients GP. If assessments showed a patient needed a compliance aid to support the safe administration of medicines, these were provided on discharge.
- Pharmacists attend the divisional governance group to present the divisional medicines safety report and medicines related audit findings. Pharmacists also facilitated discussion of any medicines safety incidents, and to sharing of new medicines guidance and updates. Key learning points were summarised at each meeting to support learning from incidents. Feedback from 'Medicines Safety Walk Arounds' completed within the division was also shared and action logs were monitored to help ensure and recommended improvements were made.
- At our previous inspection, we found that oxygen was not always prescribed. Pharmacy had sent out alerts and reminders across the trust reminding staff of the need to prescribe and record the use of oxygen. A recent audit (2017) found that 58.8% of patients using oxygen had a valid prescription with target saturation range. Of the prescription charts we reviewed, there were six where oxygen had been prescribed. Five (83%) had been prescribed in accordance with local policy.
- The division provided us with sight of 'Safe intravenous conscious sedation practice during gastrointestinal and

respiratory endoscopic procedures in adult patients' policy. The same was ratified in July 2014 and was due for revision in July 2016. This was overdue and was to be captured within the JAG task force review.
- Patients receiving care on the chemotherapy day unit have their medications prescribed electronically which facilitates ease and timeliness of administration.

Records

- The division recorded relevant clinical patient information in paper records and a number of core documents were completed on the electronic patient record (EPR).
- The presentation and storage of paper nursing and medical records varied across divisional wards. There did not appear to be a consistent approach to the format of patient records which made it difficult to locate documents in a timely manner.
- Patient records tended to be stored in lockable trolleys situated in or near to staff bases however on occasion we found notes stored away from staffed areas and not secured.
- The division had developed a number of care bundles and specialist care pathway documentation following best practice guidelines, such as sepsis, dementia care and condition specific pathways.
- We reviewed 28 sets of nursing and medical records. Overall, the records were up-to-date with evidence of on-going review, diagnosis and management plans and patient involvement. Staff documented multi-disciplinary team (MDT) discussion.
- Nursing care plans were developed from a core template and there was evidence of these being individualised for each respective patient. We found care plan evaluation completed at the end of each shift.
- We found some minor omissions in initial medical clerking proforma templates and in the nursing admission documents. Risk assessment completion was variable. Of particular note, seven sets of nursing notes (25%) where the falls risk assessment was absent, incomplete or inaccurate. We found three charts (11%) where the pressure area assessment was absent, incomplete or inaccurate.
- The falls care bundle and SSKIN (five step model for pressure ulcer prevention) bundles had recently been introduced to staff and were not fully embedded. The TVN acknowledged how some staff found the SSKIN bundle to be complicated. The TVN service planned to introduce PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) to support and improve documentation and record keeping in this area.
- A number of patient records were kept bedside and these included fluid and food charts and intentional rounding documentation. Of bedside charts reviewed, we found 12 of the 28 records (43%) to be deficient. This included absent charts, incomplete charts or only partially completed records.
- There were some patient documentation captured on 'VitalPac' (an electronic hand held device for the recording of clinical observations and assessments). This was not in place across all divisional wards however from our review, we found entries on the VitalPac system to be accurate and in accordance with clinical need.
- Divisional Matrons completed a bi-monthly 'health check' looking at 13 documentation standards relevant to patient detail and ward detail covering areas such as patient observations, risk assessments and resuscitation documentation checks. Using a 90% benchmark for compliance, the results presented in May 2017, were variable across the domains during each audit cycle. There were some repeated non-compliance measures highlighted and these appeared around nutritional assessments (from 83%), completion of fluid charts (from 80%), pain management (from 74%), patient dignity (from 51%), patient observations (from 53%) falls risk assessments (from 66%) and discharge planning (from 62%). Auditors proposed presenting findings at divisional governance meetings and recommended each division analyse results so improvement actions could be put in place.
- The division took part in the trust wide record keeping audit completed between July and December 2016. The results were presented in May 2017. A total of 216 records were reviewed from the division against Royal College standards. Auditors followed a 90% benchmarking standard. Across the division, compliance against 'author name printed' (82%), 'author name signed' (90%), 'designation' (66%) and 'GMC number' (15%) were poor. These figures however had improved from 2015/16 data. Auditors recommended divisional action plans to address deficits identified.
- The division took part in the trust wide discharge audit report during September 2016. Of the 56 records

reviewed, 68% of patients had an electronic discharge letter and summary completed, 28% had a 'flimsy' electronic discharge summary in the case notes and 4% had a discharge letter with a flimsy summary on the electronic file. 80% of records had on-going care arrangements detailed. 60% of discharge letters were sent within 24 hours with 40% outside this window (up to 40 days post-discharge). Ten discharge information compliance questions were considered and these addressed content such as 'diagnosis', 'details of examination findings' and 'actions for GP'. Overall, the content of the discharge letters were very good however results of important investigations and treatment received was poor. Auditors reported recommendations to the Discharge Policy team and presented at the clinical records group for actions to follow.

- During our visit to AAU, we were informed of a backlog of approximately 100 patient discharge records. We were assured by the senior clinicians and administration team this was being addressed as a priority.
- The division took part in the National Cancer Patient Experience Survey (NCPES) 2015 receiving 558 responses. Auditors reported 39% of patients were given their care plan to refer to. This was better than the national average of 33% however only 78% stated there was clear written information in their care plan about what to do post discharge (compared to 84% nationally).

Safeguarding

- The trust had an executive and non-executive lead and designated team for safeguarding across the organisation. The team were fronted by a Head of Safeguarding and a Named Professional Safeguarding Adults. .
- Senior divisional staff were involved in safeguarding board meetings and in the development of the trust wide strategy.
- Staff were aware of safeguarding policy and accessed safeguarding information such as the strategy, reporting systems, key contacts, training information, signposting guidance and policies and procedures on the intranet.
- The trust set a mandatory target of 95% for completion of mandatory safeguarding level 1 training and 85% for safeguarding level 2 training. For 2016/17, compliance across the division was reported as 90% and 69% for medical staff and 76% and 79% for nursing staff (level 1 and level 2 adults respectively). The division did not meet the trust target for safeguarding training.
- We observed safeguard policies and procedures on display in designated staff areas of some divisional wards. This information included process guidance, where to seek specialist advice and provided key contact details for escalation and further advice.
- Staff knowledge about safeguarding procedures and trust processes was variable.

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%.
- Between April 2016 and March 2017, compliance for mandatory training courses varied across staff groups. Nursing staff achieved target in Mental Capacity Act and diversity awareness training however did not meet target in the other core elements which ranged from 91% for manual handling to 62% for fire safety. Mandatory training for medical staff showed a similar picture, meeting target for diversity awareness and health and safety. Compliance against other core elements varied from 93% in Mental Capacity Act training to 68% for fire safety.
- All wards monitored their own mandatory training figures.
- Ward managers showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward based capture of mandatory training was higher than reported.
- Ward managers kept an internal ward level list of key mandatory training dates.
- Many ward staff completed e-learning mandatory training modules at home to minimise time off the ward.
- Ward managers confirmed where identified shortfalls in mandatory training, staff were booked to attend the relevant session. Staff on divisional wards at Pontefract confirmed where training was held at Pinderfields it was sometimes difficult to access.

Assessing and responding to patient risk

- Staff used various tools to assess, monitor and respond to patient risk.
- All patients admitted to divisional wards at Pinderfields had core risk assessment documents completed as part of an initial assessment. This included an assessment of falls, pressure ulcer, nutrition, sepsis and VTE. Staff completed reassessment of risk periodically and/or as clinical need required.
- The division highlighted patient safety as a key concern within the trust and had increased resource to address particular areas of priority such as falls and pressure ulcer reduction. A falls lead had been appointed and was leading on falls reduction across the trust and the TVN team were strengthening education across the division with link nurse champions. All wards had purchased new equipment and there was greater engagement with the wider MDT, patient and carers to reduce risk associated potential patient harms.
- The TVN reviewed all category three and four PUs reported within five days however did not review category two ulcers unless specifically requested to do so. The TVN had also developed extended referral networks with colleagues in vascular, plastics and podiatry to support care where appropriate.
- The division provided flyers to patients detailing '6 steps to keep yourself safe in hospital'. We say these displayed on wards.
- All patients had clinical observations (blood pressure, pulse, temperature, respirations) recorded regularly as part of the National Early Warning Score assessment (NEWS – where six observational parameters are scored, respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness, to identify a variance from the norm) to support escalation of care decisions. These were uploaded onto VitalPac. We noted frequencies varied in accordance with clinical need and trigger scores.
- Staff understood the NEWS parameters, trigger levels and the local escalation process. Staff informed us they used NEWS in conjunction with clinical judgment, patient presentation and any adjusted ceiling of care.
- We reviewed the VitalPac system and NEWS readings. Of the 28 records reviewed, we found all (100%) clinical observations to be recorded in line with local guidelines, clinical need and NEWS recommended frequencies. We observed appropriate escalation steps followed when observations scores triggered and we identified corresponding entries in the nursing and medical records. We were shown how staff could override NEWS trigger thresholds where a ceiling of care was applied or a patient baseline had been altered (such as for a patient with chronic respiratory disease). All overrides were by registered nurses only.
- On AAU, all decisions to override/escalate were also considered by the shift coordinator as part of the SBAR (Situation, Background, Assessment, Recommendation) procedure to facilitate prompt clinical decision making.
- The division accessed the Critical Care Outreach Team (CCOT) for support when NEWS triggered and additional critical care support was required (available seven days a week until 6.30pm). The CCOT confirmed they did not get an automatic alert via VitalPac when a patient triggered and still relied upon the ward based nurse to contact them. They additionally advised there was no mechanism for them to review NEWS remotely and again, relied on ward based nurses to keep them appraised of changes in the patient condition after any interventions. All CCOT nurses were trained in intermediate life support (ILS).
- Staff in ARCU identified a shortfall in VitalPac NEWS recording for stable non-mechanically ventilated patients. Staff confirmed they considered observation readings (and changes in patient clinical presentation) along with other clinical variables outwith NEWS to determine escalation steps.
- The division took part in an audit of NEWS compliance including the use of VitalPac. Between September and November 2016, auditors reported 59% of observations recorded as prescribed by VitalPac (down from 67% in previous audit cycle). Auditors found the key reason for non-compliance was staff overriding the system; 6% of these were approved by a HCA, not in line with agreed protocol. Where overrides were not applied, 31% of patients did not have observations recorded on time, 95% of these delays were over 1 hour. Of 104 patients who triggered escalation, 86.5% were found to have done so appropriately. 12.5% of patients who triggered and required escalation, did not get referred and did not have a plan in place for such eventualities. Where patients did not have matters escalated, 67% had a written plan in place with altered trigger benchmarks. Auditors presented the findings in March 2017 and compiled an actions table to reflect findings. There were a number were on-going at the time of the inspection. The deteriorating patient group followed up actions pending.

Medical care (including older people's care)

- The NEWS audit was repeated in February 2017. At Pinderfields, 40% of patients had observations recorded as prescribed and 57% did not have observations recorded on time (the delay ranged from less than an hour to over nine hours). 56% of patients did not have the override used. Where an override was used 61% were clinically appropriate or where an escalation plan existed however there remained 5% where the HCA approved this course of action against policy. Overall, the findings in the repeat audit had deteriorated. The action plan was updated and escalated to the respective divisional matrons. The outputs had been added to the risk register.
- The division had also reviewed the use of VitalPac and NEWS recording for mortality risk stratification. Auditors found their findings correlated with national outcomes where patients scored a NEWS greater than seven.
- Staff provided patients receiving chemotherapy with an alert card detailing symptoms to look out for which may be indicative of neutropenic sepsis. The card provided details for a 24 hour helpline number where they could seek advice. On receipt of a call from a patient, nursing staff completed the Oncology Nursing Society risk assessment triage log which provided direction on the required level of care such as urgent admission, clinic attendance or home care advice.
- The cardiac catheter lab provided a 24 hours, seven days a week consultant cover to respond to any emergencies and to respond to any patient deterioration. The lab offered various cardiac interventions such as pacings and percutaneous coronary intervention and proceeds (PCI – non-surgical procedure to improve blood flow to the heart). Where patients were diagnosed as suffering a STEMI (ST elevation myocardial infarction - a serious heart attack), the division had escalation arrangements in place with the specialist centre in Leeds.
- The division had a specialist stroke nurse on site 24 hours, seven days a week who carried the 'stroke bleep'. The bleep was activated when the ambulance service considered they had a patient who would benefit from an urgent stroke assessment. This allowed the nurse to respond immediately before the patient arrival to coordinate scanning and the thrombolysis facility. Additionally, the nurse could respond in the event of an in-patient deteriorating and needing specialist assessment.
- To address the risk associated in the management of medical outliers, the division allocated a designated consultant to oversee their care. At the junior doctor focus group, they commented on medical outlier management. They considered in the absence of a definitive list of the whereabouts of patients (newly admitted or moved), they had to hunt patients down. They considered this wasted time and caused delays in responding to patient needs. The CCOT added how there was some confusion at times as to who was leading on the patient care when the patient was repatriated to their base medical ward.
- Where a patient was admitted due to concerns around sepsis, the division followed the sepsis care bundle to screen and identify those vital high risk factors within an hour. The sepsis care pathway flowchart provided guidance in treating severe sepsis, management plan documentation, critical care considerations and observation monitoring. We found this documentation used inconsistently across divisional wards.
- The division were involved in the 'sepsis action plan' updated in September 2016 to respond to risks associated with sepsis care and management. This flowed from the Sepsis CQUIN to improve care for patients being admitted into divisional wards where sepsis was a concern. This covered topics such as communication, training, guidelines, antibiotic stewardship, screening, pathways and bundle documentation.
- AAU also had access to a sepsis trolley which housed key equipment in the event of a patient presenting with sepsis. Staff confirmed this was rarely used. We did observe 'Sepsis 6' posters on display across the medical wards.
- In AAU, the consultants completed twice daily ward rounds with a strong focus on patient priority and clinical risk. This allowed for those more clinically vulnerable patients to be reviewed urgently and those who would benefit from support from other specialisms identified early in the care pathway (such as the PERT 'Pinderfields and Pontefract Emergency Respiratory Team' or REACT 'Rapid Elderly Assessment Care Team')
- The division housed the ARCU which provided specialist respiratory care for patients. This was accessible 24 hours, seven days a week. The lead consultant had devised referral and admission criteria to ensure the right patients, received the right care, at the earliest opportunity.

Medical care (including older people's care)

- In AEC, the division had devised eligibility and exclusion criteria for patient streaming. This was to ensure the right patients, based on clinical risk and care need, received treatment within the unit or were diverted elsewhere. Additionally, staff completed an 'AMB' score to identify patients who may require care escalated beyond the AEC. This criteria included the likelihood of intravenous treatment, confusion, NEWS scores and recent hospitalisation/discharge.
- The dementia team confirmed prior to any discharge all patients on the dementia or delirium pathways will have a further abbreviated mental test score (AMTS) carried out to capture if any deterioration prior to returning to the community.
- The division provided a 24 hours, seven days a week gastrointestinal (GI) bleed rota in the event of patients requiring urgent endoscopic procedures.
- Divisional leaders informed us where extra capacity beds were used due to service demand, all patients allocated to these beds underwent a local clinical risk assessment to ensure they could be safely cared for in the extra capacity space. The aim was to ensure the most able-bodied patients would be temporarily placed in these beds. We found this process was not always adhered to. Staff commented how they often had unwell patients in these bed spaces who required access to oxygen (and where there wasn't a designated oxygen point). Patients in these beds did not always have access to a nurse call bell and staff commented how the lack of space had caused problems during an emergency situation. One staff member commented how It's not want we want to do. It's a hazard for us, for them and for their family.
- In the event of a patient deteriorating and requiring senior medical input, staff confirmed they could always get a consultant promptly in and out-of-hours. If a patient required level 2 or level 3 critical care (for example on an intensive care unit with full ventilator support), Pinderfields had an intensive care unit (ICU) and access to ARCU.
- Staff at Pontefract detailed the escalation process in the event of a patient deteriorating and requiring transfer to Pinderfields. The patient would initially be attended to by the on-call anaesthetist and senior medical staff before being escorted by urgent ambulance to the relevant department at Pinderfields.

Nursing staffing

- Division managers confirmed the service used the Safer Nursing Care Tool (SNCT) to measure patient dependency and determine the numbers of staff required to care for those patients. The division also monitored acuity and staffing levels using the safe care system on a twice daily basis in order to respond to fluctuations in patient need and changes to anticipated staffing levels.
- We were informed divisional leaders, the 'Matron of the Day' and the staffing bleep holder analysed the daily staffing acuity to inform any potential staff movements. The division also undertook six monthly staffing reviews with information triangulated from safe care, care hours data, red flags and professional judgment. We were informed all wards were established at a registered nurse (RN) to patient ratio of 1:8 unless otherwise agreed by the Director of Nursing. We were also informed CCU was established at a ratio of 1:6. The division specified they did not have a medical high dependency unit (HDU) however provided no establishment ratios for the acute respiratory care unit (ARCU).
- At our meeting with divisional leaders, they reported 25 whole time equivalents (WTE) nursing vacancies across the division. These figures were in contrast to data provided which showed overall nurse staffing establishment figures in March 2017 to be 628.89 WTE of which there were 560.47 in post working across divisional wards. This equated to a shortfall of 68.42 WTE. The individual ward figures suggested all areas had vacancies with the exception of gate 20 (24.33 against establishment of 23.68) and gate 46A (19.79 against establishment of 19.72). Gate 12 and gate 42 reported the greatest deficit of 15.41 and 12.2 WTE shortfall accordingly. In board papers prepared for the May 2017 meeting, the Director of Nursing and Quality reported RN vacancy rates across the division to be 32.08 WTE (7.9%), advanced practitioner vacancy rates of 12.96 (61.8%) and safety support worker vacancies of 19.71 WTE (29.1%). Healthcare Assistant (HCA) appointments were above establishment by 8.89 WTE.
- The divisional lead nurse confirmed 13 RN posts were filled recently and staff were due to be inducted during Summer 2017. Staff also commented positively about the divisional workforce initiative to employ safety

support workers to compliment ward based staffing. These staff were excluded from the staffing figures and proved to be a useful asset to assist in supporting patient care and safety.

- In February 2017, overall divisional registered nurse vacancy rates at Pinderfields were reported at 12% (compared to 8% trust wide), turnover rates at 12% and sickness rates at 9% (compared to trust average of 6%).
- The trust provided us with data on the use of bank and agency nursing staff between March 2016 and February 2017. The use of bank and agency nurses across the division at Pinderfields was reported to be 15%.
- The management team confirmed nurse staffing remained an issue within the medical division and this appeared on the service risk register.
- All wards visited confirmed they had registered nurse vacancies, relied on bank and agency staff to varying degrees and rarely met nursing establishment figures. The division had challenges meeting the 1:8 RN staffing ratio.
- Ward managers confirmed they lost their protected managerial time to support clinical shifts and where wards provided for a coordinator role, this was often disbanded to bolster the nurse compliment.
- We were provided with sight of daily and monthly fill rates across divisional wards at Pinderfields and we reviewed historic ward staffing rotas between February to April 2017. The division graded fill rates using a 'RAG' (red/amber/green) rated scale with wards filling at over 80% being classified as 'green'. In March 2017, only one divisional ward at Pinderfields achieved a daytime 'green' rating which was ward 42 at 83%. All other divisional wards reported fill rates below 80% during the day. Overall, night shift fill rates were better with all wards achieving over 80% fill. These figures correlated to our review of historical nursing rotas.
- The nurse staffing themes across the division base wards can be exampled with reference to ward 41. Vacancy rates were reported at 17%. There was only three RN day shifts in February, one in March and five in April which met established figures. RN night fill rates were better however were heavily supported by bank and agency staff accounting for an average of 24 shifts each month. The reported fill rates in March were 70% during the day and 102% during the night. Where RN shifts could not be filled, additional HCA staff were used. At the time of our visit, the RN to patient ratio was 1:10.25.
- The division also faced challenges meeting nurse staffing establishment in acute areas such as AAU, stroke and ARCU. For example, on AAU, a 58 bedded unit (with four extra capacity beds at the time of our inspection), there were no RN day shifts at full complement during February and March. There were only three RN day shifts at full establishment during April. The unit used bank and agency nurses to cover an average of 18 day shifts per month and in March reported RN day fill rates of 69% and 84% at night. On the day of our visit, the ward was three RNs short against planned nursing figures.
- On the stroke unit (ward A2), the ward manager split the ward into three sub-areas namely the hyper-acute stroke area (HASU), the ward and the neurology bed base. The ward manager aimed to staff HASU at a ratio of 1:2 (in accordance with National Clinical Guidelines for Stroke, Royal College of Physicians, 2016) however this was not achieved. At the time of our inspection they were one RN short providing a ratio of 1:4. Where the unit utilised the thrombolysis room, they received support from the stroke specialist nurse to ensure the patient received 1:1 care during the acute period. The neurology bed base was one nurse short at the time of our inspection providing a ratio of 1:17. Reported fill rates in March were 68% during the day and 102% at night.
- On ARCU, the unit was providing care for patients classified as level 1, 2 and level 3 (as defined by the Intensive Care Society – Levels of Critical care, 2009) at the time of our inspection namely 'a patient receiving basic respiratory support where more than 50% oxygen is delivered by face mask' and 'a patient receiving advanced respiratory support by invasive mechanical ventilator support applied via a tracheostomy'. The unit did not meet the required staffing ratios provided by the Core Standards for Intensive Care Units 2013 or the British Thoracic Society guidelines – The Use of Non-Invasive Ventilation, 2008. The unit did not meet RN establishment nurse figures during the day throughout February and March, and on only three occasions in April. RN fill rates were reported at 71% during the day and 83% overnight in March 2017.
- The Regional Spinal Unit (ward A4) reported consistently poor RN fill rates in March at 69% and 93%, and in April at 73% and 86% (day and night respectively). Senior clinicians, nursing staff, therapists and patient support groups stressed the significance of understaffing on

their unit and how this impacted on patient care. The ripple effect of the staffing shortfall and staff being asked to move from the unit to support other divisional wards, impacted on patients being ill-prepared for their designated therapy slots. This caused therapy delay, interrupted therapy sessions and derailed the therapy timetable during the critical recovery phase.

- The division had recently converted two extra capacity wards into the existing bed base. These wards were in the process of being staffed to compliment and reported fill rates during the day (March 2017) of 66% on ward 20 and 53% on ward 32. The ratios at these wards at the time of our visit were 1.11.75 and 1:11.5 respectively.
- Our staffing review highlighted consistently poor RN day fill rates despite the use of bank and agency staff. In board papers (May 2017), the trust reported 9511 shifts were put out to NHSP of which 4841 were filled (51%) in March 2017. At the student nurse focus group they commented how they often counted in the numbers and used as HCAs when staffing levels were deficient.
- The division monitored red flags (defined as 'patient missing care or patient harms') aligned to nurse staffing. In March 2017 data prepared for board meeting (May 2017) showed all divisional wards raised red flags. These included unplanned omissions of medicines, falls, NEWS not recorded, missed regular checks of patients, inability to provide 1:1 Care, shortfall in RN time and a delay in providing patient pain relief when requested. The trust also measured patient quality indicators aligned to nurse staffing which covered areas such as falls with harm, IPC, PUs, serious incidents and never events, incidents where staffing levels were contributory, complaints and FFT. In quarter four (January to March 2017), all wards (except ACU) reported falls with harm and category two PUs. Ward 12 and ward 43 reported the greatest numbers under both heads.
- In board papers (May 2017), the trust confirmed over 100 extra capacity beds were being staffed from within existing nurse compliment. This was compounding the pressure on an already depleted nurse staffing workforce.
- The division had escalation processes in place to deal with nurse staffing concerns. Staff knew about escalation processes and how to seek assistance when required. Ward managers detailed the process which involved – local attempts to fill rota gaps with existing nursing staff, alerting the 'bleep holder' and the Matron to see if staff could be relocated from elsewhere in the division and making requests for bank or agency staff.
- Staff commented how the role of the 'divisional bleep holder' did not always support the escalation process. The divisional bleep holder was a senior ward based nurse who was excluded from their ward based rota for the duration they held the 'bleep'. The responsibility of the 'bleep holder' was to get oversight of divisional wards and assist in the coordination of staffing across the division. Some 'bleep holders' felt pulled into ward based duties whilst holding the bleep and that they were not fully equipped to deal with staffing escalation issues in areas outside their own ward based expertise. They considered this role would be best suited and managed by the 'Matron of the Day' who could provide greater oversight.
- At the consultant focus group, senior medical staff commented how nurse staffing ratios remained problematic. They added they considered highly skilled and specialist nurses were being misused by being asked to cover in non-specialist areas where safe staffing ratios were not being met.
- Some staff were cynical about the benefits of the 'badge system' (worn by staff denoting level of experience) to underpin decisions around which staff member could be moved to which location to support in times of staffing deficit.
- Nurse staffing was a regular theme in incident reporting. This was particularly noted on ward 41 and ward 42 where inadequate staffing levels were raised. The issue of staff being moved to cover other clinical areas (depleting their own ward compliment) was particularly noted on ward 45. Additionally, in incidents where nurse staffing was highlighted, the reporter 'painted a picture' of an aligned decline in care due to a lack of staff.
- Various patient feedback initiatives (Family and Friends, Always Events, Dementia satisfaction surveys) and audit comments (National Cancer Patient Experience Survey 2015) referred to a lack of nursing staff on the divisional wards.
- 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.

Medical staffing

Medical care (including older people's care)

- Medical staffing across the division had improved since the inspection in 2015 with all specialist heads being substantive appointees.
- At our meeting with the divisional leadership team, they reported 21 consultant vacancies across the trust. All posts were filled by locum staff with the majority on long term contracts. There were identified 'hot-spots' in acute medicine and gastroenterology. All clinical heads were substantive consultant appointments.
- Divisional leaders also highlighted challenges in covering middle grades positions which was also supported by locum staff.
- To support recruitment matters, the division had appointed a recruitment lead for the division.
- We were provided with information from the trust regarding medical specialty staffing and medical on-call cover at Pinderfields. These consisted of foundation year junior doctors (FY), senior house officers (SHO), core trainees (CT) and registrar grades.
- Junior doctors commented about the on-call pressures and the workload overnight. They stated they felt supported by all senior grades however added a number of the on-call medical staff were locums and lacked ownership. They considered this impacted on the substantive members of staff.
- We reviewed medical staffing rotas from March to May 2017. The same showed a reliance on internal and external locum cover at all medical grades.
- Based on the average number of slots in the rota for consultant grades for the period, we found an average of 48% were covered by substantive appointees with the remaining 52% covered by internal and external locums (5% and 47% respectively). No consultant rota slots went unfilled.
- For registrar grades, we found 77% of the rota was covered by substantive appointees. Internal and external locums covered the remainder however approximately 0.8% of rota slots went unfilled monthly.
- For CT/FY2 grades, 67% of the rota slots were managed internally. There was approximately 2.7% of slots left unfilled. The remainder was worked by internal and external locums accounting for approximately 30% of the rota monthly.
- FY1 grade rotas were more robust with an average of 94% covered by trust doctors. There remained a small number unfilled, equating to approximately 2.8% monthly. The remaining shortfall of 3% was met by internal and external locums.
- Overall, we found there to be a decreasing reliance upon external locums with an increasing number of rota slots being covered by substantive appointees (70.1% in March to 74.7% in May 2017).
- In the medical focus groups (consultants and junior grades), the issue of the medical rota covered was raised. Consultants commented how they had filled registrar gaps and juniors commented on the rota understaffing and how this impacted on patient safety.
- Some clinical areas within the division implemented the 'consultant of the week' initiative to provide consistent cover. This was apparent in cardiology and the spinal unit.
- AAU consultants confirmed they often completed ward rounds without junior medical staff being present to follow up immediate actions. On the day of our visit, there were no registrars working on AAU (expected two to support the team) and they had been unable to secure locum cover.
- Medical staff acknowledged the impact vacancies and locum availability had on rota planning however also commented on the need for a review of the rota management system to provide better efficiencies.
- 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. This in turn had brought about increasing appraisal rates for this cohort, reported at 93% for 2016/17.
- In February 2017, the trust reported medical staffing vacancy rates to be 17% across the division. Turnover rates at Pinderfields were reported as 38% and sickness rates at 1%. Medical staff confirmed the use of locum support on an ad-hoc, short term and long-term basis.
- In papers drafted by the Associate Medical Director for the board meeting (May 2017), the trust reported 97.57 WTE medical vacancies (equating to 11% vacancy rate overall). The division reported the greatest use of locum staff. The report confirmed the recent appointment of two consultants. The division reported current vacancy rates to be 15.95 WTE consultants, 12.97 WTE Specialist Associates, 23.42 Specialist Registrars, 4 WTE staff grades and FY1/FY2 at establishment. The report commented how the cost of locum medical staff impacted on the annual expenditure forecast which has been exceeded in excess of £3m.
- We were provided with sight of staffing for allied health professionals across the division. In March 2017, the

division confirmed a full staff compliment in dietetics, a shortfall in physiotherapy and occupational therapy of 5 WTE and a shortfall in speech and language therapy (SALT) of 1.16 WTE.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke knew how to access the major incident policies for guidance.
- Staff in high-risk areas received specific major incident and CBRN training (chemical, biological, radiological and nuclear).
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.
- The division followed the trust Operational Pressures Escalation Levels Framework (OPEL) published by NHS England. This assisted divisional leaders in dealing with operation pressures and escalation priorities.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable. There was confusion around the internal processes and in the completion of the associated documentation. Patients were subject to restrictions of liberty.
- There was an inconsistent assessment of patient capacity and therefore uncertainty in assurances around patient ability to consent to care and treatment decisions.
- The meal time initiative to support patient nutrition and hydration was not robust. Staff were distracted whilst supporting patients with eating and drinking. Due to patient demand, some meals were allowed to go cold and were wasted. Patients did not always have ease of access to drinks and the use of the 'red jug, red tray' was inconsistent. Nursing documentation to support nutrition and hydration was poor. Fluid charts, food diaries and intentional rounding documentation was absent, incomplete or partially completed.
  - The 2015/16 MiNAP report, published in June 2017, showed an improvement in outcomes at PGH. The trust HSMR (Hospital Standardised Mortality Ratio) data from June 2014 to May 2017 for 'acute myocardial infarction' was reported as 58.9 (better than the national average).
- The use of the pain assessment tool was variable. Staff did not provide patients with timely pain relief upon request.
  - Following the JAG (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards) linked visit to Pinderfields Hospital in January 2015, the endoscopy unit's status was changed to 'assessed: improvements required'.

However,

- There was a real recognition of the value and importance in multi-disciplinary team working across the division. All disciplines acknowledged pressures colleagues faced and all worked together in a coordinated and cohesive manner to support patient outcomes.
- Staff delivered evidence based care and treatment underpinned by national guidelines, quality standards and best practice standards. The division had developed a number of local care pathways to standardise care and improve patient outcomes. There was a number of divisional and specialist competencies developed underpinned by a supervision framework to support staff practice and care delivery.
- Overall, patients commented that the quality of food, menu choices and food presentation was good. Staff used some positive interactions to support patients with nutrition and hydration needs such as encouragement, gentle persuasion, empowerment and appropriate distraction techniques.
- The division had reviewed current working streams against seven day standards, the outcomes of which were not unfavourable. There were particular strengths noted in consultant reviews and support from radiology colleagues.

Evidence-based care and treatment

- Staff referred to a number National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, Royal College and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner and had review dates. These covered clinical policies, departmental specific guidelines and medical pathways.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment.
- The division had developed a number of evidence based condition specific care pathways to standardise and improve patient care and service flow, for example ambulatory care, stroke and respiratory care.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. Staff fed these into the respective business units and incorporated into local quality improvement projects.
- The division had developed guidance for the management of sepsis (March 2017) in line with NICE recommendations (Sepsis: recognition, diagnosis and early management, NG51) updated in July 2016. This included treatment pathways, management plans and risk stratification tools. The division met 118 of the 119 recommendations for sepsis management. The division were involved in the development of the trust sepsis action plan to meet the sepsis CQUIN targets.
- Following the JAG (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards) linked visit to Pinderfields Hospital in January 2015, the endoscopy unit's status was changed to 'assessed: improvements required'.
- The division had a designated clinical audit lead and specialist units were active in the trust clinical audit group.

Pain relief

- We found all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis.
- Staff considered the use of analgesia alongside the patient's clinical condition and particular need.
- Staff informed us they monitored pain and assessed effectiveness of pain relief using a number of techniques such as direct questioning, by observation, anticipatory ahead of procedures, with reference to observations and using the trust pain assessment tool. This tool referred to a 0-3 pain scale and provided a section for patients who were unable to vocalise their pain covering facial expression, behaviour change and physiological changes.
- Patients informed us staff asked them if they had any discomfort or if they required any pain relief. Patients added when they request analgesia in sometimes took staff a period of time to provide this. Patients considered this was due to staffing levels and ward demands.
- The division completed a patient comfort audit for patients undergoing endoscopy procedures during 2016. This audit included 203 patients from all sites. 58% of patients reported no discomfort, 29% reported mild discomfort and 13% reported moderate or severe discomfort. 18% of patients felt as though they had more pain or discomfort than expected and overall, 14% of patients felt as though they needed more sedation for their procedure.
- The division used two compliance initiatives to monitor pain management standards in line with Faculty of Pain Management standards.
- Divisional matrons completed a bi-monthly quality audit, referred to as a ward 'health check' which included pain management standards. The audit considered pain management documentation to support patient care and was benchmarked against a 90% compliance standard. In 2016/17, auditors found pain status assessment was completed in 97% of cases, care plans were completed in 87% (range – 74% to 98%) and pain reassessment was documented in 92% across divisional wards.
- The division also completed ward accreditation process looking at three value standards – caring, staff knowledge and patient involvement. The division used a 80% standard. All wards with the exception of ward 43 and ward 44 did not meet the standards in their last accreditation audits scoring 46% and 70% respectively. The audit outcomes were discussed with the respective ward managers and where appropriate escalated into the governance framework.

- The division also used the VitalPac pain assessment option to capture real-time patient perception on their assessment of pain.
- We found a variable use of the pain assessment tool on divisional wards at Pinderfields. In particular, the review of the effectiveness of administered pain relief was not formally documented on the pain assessment tool. In any event, patients stated that staff asked if painkillers had been effective and patients considered their pain requirement needs were well managed.

Nutrition and hydration

- The division stated they recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care.
- Divisional wards held nutritional information, catering menus and detail on healthy diets. There was also information for patients who required special diets or dietary variations. We did not see any meus provided in visual format, large font or alternative languages.
- On wards we visited, all patients had access to a jug of water and a glass or beaker. This was not always in the reach of patients.
- The division had implemented a meal time initiative. Staff were designated specific roles during meal times to ensure the focus at that time was to support patients with nutritional needs. All non-urgent tasks were put on hold and staff were allocated to serve, feed, answer nurse call bells or support the ward generally. We noted a number of family members involved during meal times.
- We observed meal times on a number of divisional wards during our inspection. The meal time process varied across the division and was largely influenced by the number of dependent patients who required assistance. All grades of nursing staff were involved.
- Staff invited patients to wash their hands before eating and ensured their personal table was clear to accommodate a tray. Where accommodation allowed, staff invited patients to sit in a chair or at a communal table. Staff presented food in a pleasant way with necessary utensils and condiments. Staff also provided drinks during the meal service.
- Patients in extra capacity beds did not always have access to a height adjustable table which made it difficult for them to gain a comfortable position to eat their meals.
- We observed a number of initiatives used to encourage patients to eat where they were unable to feed themselves or required support. This involved positive reinforcement, gentle persuasion and distraction techniques. We also observed some unhelpful approaches where staff offered little interaction and spoke negatively about the food presentation such as yellow stuff.
- On wards where there were a number of patients requiring assistance, the meal time initiative was less effective. Staff allocated to feed were distracted by requests from other patients, meals were interrupted due to patients requiring attention and this in turn caused the process to become disorganised. We noted meals were placed out of reach of some patients, some meals were allowed to go cold and staff lost focus on their specific duties during the service.
- Staff commented how meal times can be problematic in areas where there were particular staffing shortfalls. Staff confirmed meals occasionally go cold and as they can't warm these up, patients are sometimes offered a cold alternative.
- Healthwatch completed a visit to ward 43 in 2016. During their visit they observed a breakfast service. They noticed meals were sometimes out of reach of patients. They reported one incident to staff where a breakfast had been left for a patient who required assistance and was untouched for two hours. This was immediately remedied and a replacement breakfast was provided.
- Patients on the surge ward (ward 27) currently being used by the division complained about a lack of hot food availability on this unit. The ward manager liaised with the catering department and sourced 'microfix meals' which are made available to patients 24 hours a day and are suitable for patients admitted to the unit outside designated meal times.
- Overall, patients commented favourably on food quality, choice and portion sizes. There was an occasional dissenting comment received which tended to criticise the temperature of the food not being hot enough. This was mirrored in the PLACE assessments (2016) which reported a ward food score of 89.1% (better than national average of 88.2%).
- On the spinal unit, staff arranged meals out and food to be delivered to the unit for patients who wanted a choice external to the hospital menu.

Medical care (including older people's care)

- Healthwatch Kirkless completed a recommendation survey from service users at Pinderfields. A number of the respondents attended divisional wards. Out of 127 responses, those related to food quality were variable.
- It was reported in board papers (May 2017), comments received from the Friends and family Test (FFT) were critical of food and drink' provision. The division were looking at ways to improve this.
- The division monitored nutritional documentation compliance by auditing nutritional screening, risk assessments and care plans.
- The division was actively involved in the Nutrition and Hydration Improvement group. We were provided with sight of the project plan dated January 2017 which detailed six key areas under consideration. These included the development of the group to engage frontline staff, to improve patient harm and improvement in care quality, to ensure all patients received a hot meal (including patients in the discharge lounge), to improve the monitoring and assessment of nutritional needs and to review standards of food and drink. Of the 31 identified sub-tasks, we found 11 to be completed, 18 to be in progress, two not yet started and one overdue. A number of the tasks appear to have been commenced on or before April 2016 and progression appeared slow.
- In quarter four (January to March 2017), the improvement group focussed on two areas – fluid balance documentation and ward meal time initiatives. The Lead Matron for Quality Improvement identified inconsistent approaches to application of meal time initiative and the use of the red jug and tray system, lacking food and fluid diary usage, non-urgent activities continued during meal times, not all wards provided patients with menu cards to make food choices.
- The dementia nurse lead had devised a plan to improve nutrition and the dining experience for patients living with dementia. The aims were to stimulate appetite and interest in food and drink as part of the delivery of holistic care. This took into account potential physical problems associated with the process of eating, dexterity required and the ward environment. Staff were encouraged to provide choice, finger food options and promote independence. It was emphasised the meal time environment should be calm and relaxed.
- Our findings mirrored those of the improvement group. We found the meal time initiative worked well in wards where there were fewer dependent patients. Where the ward compliment was such that a number of patients required assistance with feeding or had other care needs, the initiative tended to be less effective leading to disorganisation and chaos. This had a negative impact in some areas where vulnerable patients were being cared for.
- We found no consistency in the 'red tray, red jug' initiative and in a number of divisional wards, did not appear to be in force.
- We found the completion of the Malnutrition Universal Screening Tool (MUST) variable in the paper format. Where divisional wards completed nutritional assessments using 'VitalPac', we found these to be completed more accurately and thoroughly.
- Associated nursing documentation detailing fluid and food intake was poor. The use of intentional rounding notes did not support an accurate record of nutritional and hydration intake. In 28 records reviewed, we found 12 (43%) where the fluid chart, food diary and/or intentional rounding record was absent, incomplete or partially complete.
- Food provision across the division (and trust-wide) was monitored against external standards namely the Nutrition Alliance, The British Diabetic Association, Malnutrition Universal Screening Tool (validated by British Association of Parenteral and Enteral Nutrition), Public Health England and Department of Environment, Food and Rural Affairs. Compliance against these standards was self-assessed and RAG (red/amber/green) rated according to compliance. There was only one of the five standards deemed to meet the required standards.
- Staff confirmed they could access support and guidance from SALT and dietetics when required during Monday to Friday.
- From our observations, we could not be assured that the nutrition and hydration needs of all patients were being met.

Patient outcomes

- Staff across the division were involved in large national audits and a number of local reviews to measure patient outcomes.
- Pinderfields General Hospital takes part in the quarterly Sentinel Stroke National Audit (SSNAP) programme. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit, December 2016 to March 2017. Compared to the previous quarter, there had been

noted improvements in three domains relating to occupational therapy, speech and language therapy and the patient centred key indicator. The thrombolysis domain score had reduced from a B to a C. Three domains were A graded; these related to occupational therapy and discharge processes. The multi-disciplinary team working domain rated the lowest with grade E.

- Pinderfields results in the 2015 Heart Failure Audit were worse than the England and Wales average for three of the four of the standards relating to in-hospital care and worse in four of the seven standards relating to discharge.
- Pinderfields took part in the Myocardial Ischaemia National Audit Project (MINAP). Between April 2014 and March 2015, 29.8% of nSTEMI patients were admitted to a cardiac unit or ward at Pinderfields and 90.2% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%. The proportion of nSTEMI patients who were referred for or had angiography at Pinderfields was 66.7% compared to an England average of 79%.
- The 2015/16 MINAP report, published in June 2017, showed an improvement in outcomes at PGH. The trust HSMR (Hospital Standardised Mortality Ratio) data from June 2014 to May 2017 for 'acute myocardial infarction' was reported as 58.9 (better than the national average).
- In the National Diabetes Inpatient Audit (NaDIA) 2016, the division at Pinderfields reported variable findings and some improvements against 2015 outcomes. Patients receiving renal replacement therapy was reported at 1.5% (compared to 3.5% nationally). Foot risk assessment within 24 hours increased from 9.4% to 10.4% however remained worse than national average of 30.1%. There had been a reduction in insulin pump usage down from 11.7% to 10% (national average at 8.2%) however 7.7% of the infusions were deemed not appropriate (compared to 7.4% nationally). The audit reported 37.5% of patients received a multidisciplinary foot team assessment within 24 hours (compared to 56% nationally). Medication errors were higher than national average 39.1% to 37.8% nationally however had improved from 2015. Prescription errors were also higher than national average, 28.3% compared to 21.1% respectively; this was similar to insulin errors which was also higher than national average. The division also reported higher mode3rate and sever hypoglycaemic episodes compared to national average. 60% of patients reported meal times to be suitable and 55.9% reported choice to be suitable. 50.5% of patients reported they could take control of their diabetes care (compared to 60% nationally). Patients also commented on staff knowledge of diabetes and these findings were below national average. Overall, 67.6% of patients were satisfied with their care at Pinderfields which was lower than the national average of 83.7%.
- The division took part in the National Diabetic Foot Audit (NDFA) compiled between July 2014 and April 2016. The headlines reported 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 3 or above (compared to 45.6 nationally). 34% of patients self-presented to the service (compared to 29.9% nationally) and 14.9% were seen within two days of initial presentation compared to 13.4% nationally. 6.4% of the ulcer episodes were not seen for two months or more, compared to 8.6% nationally. The division reported 12 week outcomes under and these three variables (outcome recorded, alive and ulcer free and persistent ulceration) were better than national average figures. The division also reported 24 week outcomes with two of the three variables better than national average.
- 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 reported some provisional findings reviewed during the current collation (ends June 2017) for the National COPD Audit Programme 2017. In the 2014 audit, the division performed better than national average figures for consultant review, oxygen prescribing, NIV provision, spirometry, early supported discharge, smoking cessation advice and BMI recording.
- At Pinderfields between February and May 2017, 159 patients were reviewed for the 2017 COPD audit. The data had yet to be benchmarked nationally however

shows improvements in inpatient mortality, reducing from 7.7% in 2003 to 3.7% in 2017. Average length of stay has remained static however there has been a reduction in the number of patients under the care of the acute physician (down from 63%to 43%). Consultant review and time to see consultant has improved from 2014 with the COPD bundle being used in 91% of cases. Smoking history was not recorded in 10% of records and smoking cessation advice not recorded in 28% of cases. Oxygen prescribing compliance has improved however 26% of patients did not have this recorded and 8% did not have target saturations recorded. The metric recording patients requiring NIV has reduced from 19% to 18% and early discharge figures have also deteriorated from 54% to 45%.

- 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 66% nationally), lower acute respiratory care unit stay (4.7 days compared to 9 nationally) and senior decision making (consultant/registrar) in 92% of cases. The audit identified areas for improvement around resuscitation decisions, poor documentation regarding NIV start times, inconsistency in set-up; inconsistent arterial blood gas monitoring in first 24 hours and only 57.9% of patients being weaned.
- The division reported findings following the British Thoracic Society Emergency Oxygen Audit reported in March 2016. The summary showed 51.6% of patients had oxygen prescribed with target range against national average of 57.5%. The audit found only 17.4% of drug rounds had oxygen prescription signed (worse than national average of 28.4%). 68% of patients had planned monitoring of oxygen saturations recorded worse than national average of 103.5%. The audit found 53.8% of patients were maintained within target range (compared to 65.3% nationally). No patients exceeded their target range by more or less than 2%.
- 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 was 90.5%. The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25.9%. The 2015 figure was 26.4%. The proportion of fit patients with advanced NSCLC receiving chemotherapy was 71.2%, this is not significantly different from the national level. The 2015 figure was 66.3%. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 78.8%, this is not significantly different from the national level. The 2015 figure was 71.4%. The one year relative survival rate for the trust is 37.1%.
- Pinderfields participated in the Royal College of Physicians National Audit of Inpatient Falls 2015 (NAIF). The division had a multi-disciplinary working group for falls prevention where data on falls were discussed. The crude proportion of patients who had a vision assessment (where applicable) was 80%; this did not meet the national aspirational standard of 100%. The crude proportion of patients who had a lying and standing blood pressure assessment (where applicable) was 8.3%; this did not meet the national aspirational standard of 100%. The crude proportion of patients assessed for the presence or absence of delirium (where applicable) was 73.3%; this did not meet the national aspirational standard of 100%. The crude proportion of patients with appropriate mobility aid in reach (where applicable) was 30%; this did not meet the national aspirational standard of 100%.
- The division took part in the Annual Society for Acute Medicine Benchmarking Audit in June 2016. The division had improved in one metric (direct admission review by consultant within 14 hours) but declined in two (NEWS recorded within 30 minutes, and medical review within 4 hours).
- The division took part in the National Cardiac Arrest Audit (NCAA). The NCAA is a mutual initiative between the Resuscitation Council (RC) and the Intensive Care national Audit and Research Centre (ICNARC). The audit collects national clinical data from in-hospital cardiac arrests, the inclusion data is 'all individuals (excluding neonates- children aged less than 28 days) receiving chest compression(s) and/or defibrillation and attended by the hospital based resuscitation team (or equivalent) in response to a 222 call' (NCCA, 2017). The division collated data monthly and this was presented by auditors each quarter. Between April and December 2016, there were 85 reported cardiac arrests at Pinderfields of which 40% were stopped due to patient recovery. 14.1% of patients survived to hospital discharge.
- The division also took part in additional specialist audits in dermatology (BSTOP trial) and in cardiology (BCIS NICOR).

- Locally, specialist nurses across the division had standards for patient review. For example, the diabetes nurse specialist reviewed all patients referred within 24 hours. The dementia team also set a standard to review all patients referred or identified by the service, within 24 hours. The TVN reviewed all category three and four PUs within five days.
- The trust had six active mortality outliers in which the division were involved. These were linked to acute cerebrovascular disease, septicaemia, acute and unspecified renal failure, coronary atherosclerosis and fluid and electrolyte disorders.
- The trust completed a mortality review following the identification of high mortality associated with acute cerebrovascular disease covering the period October 2014 – June 2015. Findings were presented to the Commissioners in January 2017. There was a focus on deaths in the under 60 years group (based on an increased number of deaths in this cohort). The conclusions highlighted the benefits of the structured judgment review which showed delayed movement in A&E, a patient being moved from AAU before consultant review, consideration of other diagnoses, consideration of DNACPR. The division used the data to liaise with GPs locally about the hypertensive status of young stroke fatalities. In a nine month comparator (July 15 – January 2016), the relative risk of mortality reduced from 136 to 114. A further paper was presented in February 2017 to provide assurance on patient flow and the delays in patients reaching the stroke unit from A&E. This detailed an improving overall SSNAP rating over the preceding 12 months and improvements in key domains of scanning, performance in the stroke unit and thrombolysis with the unit performing better than national average against those metrics.
- In July 2016, the CQC wrote to the Chief Executive for an interpretation of the sepsis mortality indicator covering April 2015 – December 2015. The data showed increasing mortality figures for septicaemia deaths. The division supported a review of the cohort referred to and the conclusions showed poor compliance of screening tool, delay to first antibiotic administration and some issues around order of diagnostic coding. This was further considered in National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) findings based on Dr Foster mortality figures (December 2015 – November 2016) against peers for septicaemia. The report highlighted 28.8% more deaths than expected. The presentation highlighted the importance of prompt screening using the screening tool, sepsis pathway and VitalPac observation recording and escalation in line with NEWS.
- In November 2016 and February 2017, the division received a mortality alert associated with primary diagnosis of acute/unspecified renal failure. This showed (data from August 2015 to July 2016) a relative risk of death for this cohort of 151.9. The division senior medical team in conjunction with the Trust Mortality Review Steering Group completed an in-depth review in April 2017. The review identified five themes – incomplete fluid balance charting (reduced staffing numbers and extra-capacity variables referred to), delays in care, DNACPR completion, nursing documentation and nursing observations (NEWS escalation triggers referred to). The review confirmed high mortality findings influenced by a number of the cohort also presenting with sepsis. A number of areas for improvement have been identified and a comprehensive and detailed action plan comprising nine items has been drafted. All actions were on-going at the time of our inspection.

Competent staff

- All staff employed by the trust and working in the division were required to meet their continual professional development obligations.
- The division provided access to a number of on-line and specialist courses in house for staff to attend. The division also had strong links with network colleagues, higher education establishments, medical schools and universities.
- All newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision which varied according to the area worked and subject to competency sign-off. The division followed the preceptorship policy which provided a band 5 core competency framework with a built-in senior supervisory assessment.
- Junior doctors maintained close links with the Deanery as part of their clinical placements and post rotations. They reported consultant support and exposure to clinical learning opportunities to be good. They added however that formal training and clinical supervision varied due to staffing pressures. In the GMC 2016 National Training Survey, the trust was flagged as negative outlier (significantly below the national score

in the benchmark group) for overall satisfaction (Pontefract), clinical supervision, induction, feedback (Dewsbury and Pinderfields), supportive environment, clinical supervision out of hours and reporting systems (Pontefract).

- Student nurses commented how clinical training was good on divisional wards however time with mentor supervisors varied due to ward pressures.
- Consultants confirmed access to training opportunities was good.
- Divisional matrons confirmed the setting up of the 'Matrons Forum' was a good way to share learning and expertise with this cohort.
- The division also commissioned specific training in response to updated guidelines such as sepsis, following clinical incidents such as nasogastric tube feeding and in response to local clinical audit outcomes such as NEWS compliance.
- Staff in the cardiorespiratory physiology service completed an internal training programme which provided competencies for all grades across all disciplines. This included heart rhythm recognition, transthoracic and cardiological investigations, interpretation of test results and safe use of equipment. The senior team approved competency sign-off.
- The spinal unit were developing multi-disciplinary team (MDT) competencies to ensure all staff had a sound foundation and understanding of care principles provided by other disciplines. The unit had also developed MDT relationships with other specialist spinal units where the teams were able to network to share developments and learning from wider MDT services.
- Staff in the chemotherapy day unit completed area specific competencies and an aligned preceptorship/ supervised programme covering relevant topics for their area such as disease processes, treatments, psychology, patient experience, clinical skills, signposting, laboratory tests and patient care.
- Staff working in ARCU completed specific competencies to care for acutely unwell patients with respiratory conditions. This included learning the equipment being used, the indications for use, clinical skills and escalation processes.
- Staff on ward 45 confirmed they had received NIV training from the PERT team.
- A number of specialist clinicians were part of wider regional collaborative groups such as stroke, dementia and TVNs. A number of the divisional staff attended national conferences to support professional development and share learning on site. Divisional specialist nurses provided practice updates and bespoke training for all grades of staff. In response to ward 32 becoming a substantive ward to specialise in diabetes care, the diabetes team are developing training to staff covering key topics around the use of insulin, vascular and foot care and ketoacidosis.
- Ward managers discussed formal learning and training needs with individual staff members at 1:1 sessions and during appraisal. Informally staff identified their own areas of interest and proposed study for consideration at a local level.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Divisional ward appraisal rates had improved since our inspection in 2015. Ward based records showed appraisal rates ranging from 75% to 100%.

Multidisciplinary working (MDT)

- We observed well attended informal and structured MDT throughout our visit. These meetings considered patient assessment, discharge planning and care delivery in hospital.
- There was recognition from all disciplines of the importance and value of MDT involvement in patient care. There was also a compassion and understanding of the pressures each discipline faced in providing optimal care.
- We found good examples of MDT working on all divisional wards at Pinderfields and a real strength in team working. This was particularly apparent in the spinal unit and across all therapy groups.
- We observed physical therapies being provided by the MDT on the divisional wards at Pinderfields. These included ward based activities, exercises and educational sessions. There was evidence of good co-joined therapy sessions with physiotherapy and occupational therapy on ward 41 and 42 where they accessed the on-ward therapy area.
- We also observed informal discussions between professional colleagues at safety huddles and ward meetings.
- Formal documented input from the MDT collective was recorded in the medical records. There had been an improvement made in the recording of MDT meetings and ward rounds on the spinal unit to ensure efficient

flow of care updates across the team. This included a copy of MDT entries made in nursing and medical records simultaneously by way of an identifiable adhesive note.

- The MDT entries highlighted involvement in care and treatment planning, discharge processes and social considerations relevant to the respective disciplines involved. Although variable in terms of timeliness of the initial MDT review, all records reviewed had formal documented MDT screening within 72 hours from admission.
- There was evidence of patient and family involvement in the process.
- On AAU, the MDT meeting was well established and well attended. The meeting was led by the AAU consultant with input from the MDT including in-reach services. Other ward MDTs and board rounds were equally well attended. The stroke rehabilitation unit which recently moved to Pontefract had a strong MDT however the ward manager confirmed the efficiency of board rounds had lost a little impetus since the move. The ward manager proposed linking with colleagues in Pinderfields to reenergise this forum for MDT communications.
- There were clear internal referral pathways to therapy and psychiatric services. Many wards had developed strong links with community colleagues when implementing discharge plans and care packages. This was particularly apparent in respiratory care.
- The dementia team had engaged with community colleagues and the local vanguard to share best practice and provide training on dementia initiatives. The team extended the remit to involve colleagues working in care homes, supported living and intermediate care.
- In accordance with Royal College Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients, the division ensured each patient had a named responsible consultant/clinician who took responsibility for their care throughout their stay (except where necessary to formally handover care due to clinical need). This was underpinned by the named nurse principle allocated to patients during a given shift. The responsible clinician and the allocated named nurse was noted above the patient bed and/or outside the bay.
- We found the display of the responsible clinician and named nurse was not afforded to patients in extra capacity beds due to no whiteboard being used at the bed head. We also noted the whiteboards occasionally displayed the name of the previous patient and had not been updated in a timely manner after a patient move or discharge.
- The cardiorespiratory physiology service worked closely with cardiology, stroke and respiratory colleagues to provide a raft of cardiorespiratory investigations to their patient cohort.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards.
- The division provided evidence to address the four priority clinical standards namely time to first consultant review, diagnostics, interventions and on-going review.
- The division engaged in the trust seven day service standards (7DS) audit published in September 2016. The review audited 196 case notes of which 139 (71%) were from the division.
- Auditors found reasonable compliance with patients being reviewed by a consultant within 14 hours of arrival at hospital. During weekdays this ranged from 63% to 86% and at the weekend averaged 63%. 88% of patients were seen by a consultant within 14 hours of admission during weekdays and 80% at the weekend. Overall, this was better than regional and national mean data.
- Findings confirmed an average of 58% of patients (and where appropriate family members) were made aware of diagnosis and management plan within 48 hours of admission during weekdays. This averaged 46% at weekends.
- Auditors confirmed 98% of patients requiring computerised tomography (CT) and 87% could access magnetic resonance imaging (MRI) when immediately required during weekdays. 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% (echocardiography) to 92% (microbiology). Overall, this was better than regional and national mean data.
- Auditors found patients had 24 hour access to consultant directed interventions 7DS either on site or by formal network arrangements in cardiac pacing (93%), critical care (98%), emergency general surgery (95%), thrombolysis for stroke (92%) and primary percutaneous coronary intervention (PCI – 88%).

Interventional endoscopy, interventional radiology, renal replacement and urgent radiotherapy figures were lower ranging from 50% to 75%. These figures were variable compared to regional and national mean data. At the consultant focus group, senior medical staff commented on the fantastic radiology support, particularly at weekends.

- Daily and twice daily consultant review figures were good. Overall, these were reported at 94% and 100% respectively. This was better than regional and national mean data.
- The CCOT service was available to the division at Pinderfields seven days a week up to 6.30pm.
- The cardiac catheter lab offered a seven day service (with on-call arrangements for out-of-hours and emergency requests). The cardiorespiratory physiology services provided cardiac device support 24 hours a day and seven days a week to assist patients with PCI devices and implants by way of remote monitoring.
- The endoscopy service provided a 24 hour, seven days a week gastrointestinal (GI) bleed rota.
- Therapy services in orthogeriatrics, respiratory and spinal services wanted to expand to provide routine seven day services however current resources disallowed this.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner.
- Staff informed us discharge-planning considerations commenced on admission with input from the discharge team in complex cases.
- Staff informed GPs of patient discharge in writing and always made themselves available in the event of any GP telephone queries.
- Staff identified what community services or on-going care needs would be required for the patient on discharge. Staff involved the patient, his or her family and the service providers in discharge planning.
- Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information and signposting for further support and guidance. This was especially effective on the chemotherapy unit.
- Staff confirmed discharge letters were given to the patient (or a carer on their behalf) at the time of discharge. The ward clerk followed up the patient discharge letter with the written discharge letter the next working day. The GP also received a copy of the discharge summary electronically via 'System 1'.
- Staff confirmed if there had been any specific treatment changes such as urgent medications, urgent reviews or complex care needs then the care team contacted the GP or district nursing services directly by telephone.
- Staff referred to a 'single point of contact' for referral into community nurse services. Some nurses suggested the community referral process would benefit from being standardised as it currently comprised a mix of paper referrals, electronic referrals and fax follow up.
- When divisional wards received queries from primary care colleagues, they stated it was not always easy to back track on System 1 to locate the relevant information and they didn't always have access to paper notes on wards. On ward 41, staff kept an electronic handover of discharges which the nursing team could access to provide any interim answers to queries whilst the notes were sought.
- Some consultants commented how they found accessing records on System 1 to be difficult at times which impeded the efficiency of consultations.
- Commissioners commented on the variability in quality and timeliness of discharge letters provided to GPs. We were also made aware of a small backlog of discharge letters on AAU. Of the discharge letters we reviewed, these appeared to contain relevant information detailing admission reason, treatment and investigations, diagnosis, plans for follow up and medications provided on discharge.
- Where GPs had queries around potential referral or investigation results such as those generated from the cardiorespiratory service, the cardiology service provided an e-consultation service to give immediate advice on treatment and management options.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the MCA.

- The initial medical clerking proforma and nursing assessment template contained reference to 'consent and capacity' issues.
- We found the completion of this element of the care documentation to be variable. In 28 patient records reviewed, there were five (18%) where the capacity assessment documentation was incomplete.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- The trust reported between April 2016 and March 2017, MCA and DoLS training had been completed by 92% of staff within the medical core service.
- Staff we spoke with had varying degrees of understanding around safeguarding policies and procedures and MCA principles. Staff were aware however this was underpinned by legislature and the significance of failing to consider such issues where patients may lack capacity and be unable to consent to treatment.
- We observed safeguarding and MCA guidance on all wards. Staff referred to the ward based documents and intranet site to show us the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues and detailed where they would go for advice or guidance if they had concerns. Staff contacted the Safeguard Team if concerned about a patient and they confirmed responses were prompt.
- Staff stated the DoLS referral process was lengthy and took in excess of 30 minutes to complete the necessary referral forms.
- We found assessment of capacity completion of MCA/DoLS documentation to be inconsistent and a 'Care Plan for a Vulnerable Patient who required help with Decision Making' to be completed incorrectly. It was unclear from a review of the patient records if the patient had or lacked capacity. However there was evidence to show the patient had attempted to leave the ward and was stopped from doing so. A ward manager confirmed the care plan was new and had been recently introduced. It was added that there had been no formal training surrounding the new document.
- This matter was immediately referred to the trust safeguarding team who confirmed the care plan was completed incorrectly and the patient concerned should have had a DoLS application submitted. The safeguard team confirmed there was some confusion around the completion of the new care documentation and assured us bespoke training would be put in place. The ward manager confirmed where consent and capacity issues may be of concern in the future, these would be picked up at safety huddles.
- We also noted a patient on a divisional ward who was potentially subject to restrictions of liberty practices by wearing hand restraint mittens. We reviewed the patient records and noted no DoLS application had been made and there was no reference in the care plan to why the restraints were being used. We referred this matter to the nurse-in-charge to review and follow up with the safeguarding team accordingly.
- On the stroke rehabilitation ward at Pontefract (recently moved from Pinderfields), we observed a patient had a DoLS in place however there was a lack of supporting documentation to confirm if an assessment had been completed or how the decision reached. The patient records confirmed the matter had been referred to the Independent Mental Capacity Advocate however there was no record of the visit.
- The division had access to trust specialist nurses who had particular expertise in dealing with vulnerable groups such as learning disabilities and those living with dementia.
- The division took part in the trust wide consent core audit 2016-17 looking at the consenting procedure for procedures (treatment or investigation) that required documented consent. Across the division there was a variability in compliance results against the key metrics. The detail of the intended procedure along with the benefits and risk were well documented however the designated doctor's name and job title was poorly recorded. Patient statements were completed well however there were inconsistent findings to support the doctor's explanation of the procedure and/or information leaflets provided.
- Divisional wards (41, 42 and 43) at Pinderfields took part in the trust MCA/DoLS case file audit in December 2016. The auditors sought to establish if the consent process was being followed, issues of capacity were being recorded, interventions made and to highlight current practices. Auditors found cognitive impairment to be referenced in all cases, good completion of 'consent forms', some examples where best interests had been considered and good documentation from therapy staff around consenting to therapy sessions. There were some areas highlighted for improvement. In 10 of 26

cases, there was no reference to the MCA or capacity issues. Auditors identified there was a lack of consideration about the consent process for care and treatment, restraint had been used without reference to capacity or best interests, nursing assessment documentation was not completed consistently, some 'consent forms' were not completed adequately and in some cases it was unclear if the patient had capacity or not. Auditors also found DoLS cases were not consistently identified and actioned. Safeguarding cases were identified however there was no consideration of making safeguarding personal and it was not recorded when referrals had been made to adult social care colleagues. Auditors concluded it could not be evidenced that the principles of the Mental Capacity Act are embedded across the three wards. There is a lack of clarity…and a lack of awareness of how capacity and consent impacts on the care. The safeguard team drafted recommendations and an action plan to progress the issues identified. These were on-going at the time of our inspection however we note the auditors commented there is a lack of capacity of the safeguarding team to be able to fully support the action plan.

- Staff on the stroke rehabilitation ward at Pontefract advised the safeguarding team had reviewed their use of the vulnerable patient pathway.

Are medical care services caring?

Requires improvement

We rated caring as requires improvement because:

- Privacy and dignity of patients being cared for in extra capacity beds was compromised. Staff commented, and we observed, how utilisation of extra capacity beds on wards restricted space to deliver care, impinged on neighbouring patients bed areas and was hazardous due to a lack of nurse call bells and inadequate screening. Divisional leaders recognised this impacted on the quality of the patient experience.
- Patients commented how some staff interactions were occasionally brisk and transactional where staff did not have time to engage at the bedside. Patients commented about the distressing nature of bed moves late at night. Patients added nurse call bells were not always answered in a timely manner.
- Patients and carers commented how they felt they were not fully informed about 'future' care and treatment plans such as follow up, review and discharge planning.
- The division reported poor response rates to the Family and Friends Test and recommendation rates were variable.

However,

- Staff were passionate and driven to deliver quality patient care which they considered a priority.
- Staff considered physical, social and emotional aspects of care to deliver a holistic package to patients and their family. We observed kind, compassionate and caring interactions with patients.
- Patients commented positively about the care they received and recognised the pressures faced by staff to deliver optimal care at all times.
- There were a number of considered and thoughtful examples of staff engaging with patients and their family members to improve the quality of care received.

Compassionate care

- The Friends and Family Test (FFT) response rate between February 2016 and February 2017 at Pinderfields was 21% which was lower than the England average (reported at 25%). Recommendation rates at Pinderfields General Hospital varied between 0% and 100%, with five of the reporting wards scoring 90% or higher.
- In papers prepared for board meeting (May 2017), March FFT data provided a range of response rates between 3.9% (ward 31) to 50% (ward 45) on divisional wards. Recommendation rates also varied between 75% (ward 20) and 100% (on nine of the divisional wards).
- Staff were committed and dedicated to their duties. There was a real desire and determination to ensure patients received quality care. Staff stated the primary purpose of their role was to ensure patients were cared for.
- Staff confirmed when they assess patient needs they always take into account personal, cultural, social and religious needs. Staff considered this as important as the physical assessment.

Medical care (including older people's care)

- Staff showed an awareness of the 6 C's (care, compassion, courage, communication, commitment and competence - an indicator of values underpinning compassionate care in practice) and we noted wards had posters displaying the core values.
- We observed care interactions between staff, patients and carers. Overall, staff were kind, compassionate and caring. On occasions, we found staff interactions were hurried and transactional. Patients commented how staff were busy and didn't always have time to engage.
- Staff endeavoured to ensure patient privacy and dignity was maintained at all times.
- We carried out formal observations of care delivery on five divisional wards where patients were being cared for in extra capacity beds. We found consistent themes in all areas. Patients did not always have access to a nurse call bell to summon assistance when required. One patient stated she relied on other patients in the bay to use their call bell on her behalf.
- We found the use and availability of screens to ensure patient privacy and dignity was variable; in some areas the screens were unavailable and in others the screens were not of a suitable size to allow care to be delivered in a private manner. One neighbouring patient informed us he had vacated his bed overnight to allow staff to use the fitted curtains while delivering care.
- There was insufficient space in between the extra capacity beds and existing beds in the bay. This restricted personal space, compromised the area for neighbouring patients, reduced the extent to which care could be delivered and disallowed personal furnishings in the area (such as bedside lockers, designated patient tables and patient/visitor seating).
- Staff from all disciplines commented about the frustrations they had in dealing with patients in extra capacity beds. Consultants found the screens (when available) did not provide the privacy required when holding ward rounds. Nursing staff commented how delivering care in the restricted space was difficult and therapists echoed these concerns.
- Patients and family members had raised concerns about extra capacity beds to ward managers and matrons.
- Divisional leaders acknowledged the additional beds open across the division and the current staffing shortage affected the patient experience.
- In the PLACE audit compiled in 2016, the privacy, dignity and wellbeing domain was rated at 78.8% (worse than national average of 84.2%).
- The division took part in the National Cancer Patient Experience Survey (NCPES) 2015 receiving 558 responses. Auditors reported patient satisfaction overall was 8.7 out of 10 with 83% or respondents reported they were always treated with dignity and respect.
- During September 2016, the division were involved in a patient satisfaction survey specifically looking at care provided by the doctor. The questionnaire comprised 12 questions and considered various elements of compassionate care. 37 patients responded and commented positively about the doctor's ability, being informed and being involved in decision making processes.
- The division were involved in the PERT service user evaluation report compiled in April and May 2017. The survey involved 173 patients using divisional respiratory services and comprised 15 questions. The report identified a high level of patient satisfaction across the service especially around the specialist nursing role and the development of specialist clinics.
- During a Healthwatch visit on ward 43 in June 2016, they received comments from staff about patients being discharged when medically stable rather than when medically fit which, in the opinion of staff, meant patients were discharged before they should be.
- We received feedback from a patient via 'share your experience' . The patient was readmitted into hospital after only two days following discharge. She felt staff blamed her for this as she had difficulties with her medication. The same patient commented how a move during the night onto ward 43 caused her some distress. This concern was echoed by three other patients with one commenting how his move at night caused disruption and distress to patients on his departing and receiving ward.
- We observed the timeliness of responding to patients nurse call bells varied. This was particularly apparent during period of increased activity such as morning rounds, meal times and overnight. We received a number of comments from patients and via 'share your experience' where the time taken to answer the buzzer was highlighted by patients.
- The dementia team had developed a 'dignity cupboard' which housed clothing and footwear for those individuals who may be without or have limited funds/ support to purchase their own items.
- Overall, patients spoke positively about the care they received. We received comments such as staff are

excellent, staff are lovely and they do all they can for you. Patients did recognise the pressures staff were under, the lack of nurses and commented why staff took a little while to respond to requests was because there was too much going on!
- Staff enjoyed sharing positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.

Understanding and involvement of patients and those close to them

- Staff recognised the importance of engaging patients, and those close to them, in care decisions, treatment options and care recommendations.
- Staff informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks and the likely time to be spent in hospital.
- Ward 41 had developed a 'welcome to the ward' letter for patients and carers which detailed information about staff, visiting times, ward procedures and contact details.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.
- The dementia team carried out afternoon ward rounds to avail themselves to patients and carers who may have questions or concerns.
- Divisional wards took part in the trust wide 'always events' initiative. This forum allowed wards to capture those aspects of the patient and family experience that should always occur. The feedback capture followed the prompt what matters to you most and took the format of informal interviews with patients and carers. On ward 45, patients commented they felt safe and well cared for generally however that they sometimes waited for buzzers to be answered and painkillers to be provided in a timely manner. Carers commented about being kept up to date and aware of what was happening.
- A number of divisional areas actively engaged patients and carers in care delivery.
- On the spinal unit, patients and carers were central to and involved with goal setting meetings. Therapists invited involvement in personalised therapy and education sessions. Patients and carers were also provided with a direct helpline number to the therapy team during the transition period from hospital to home in the event of concerns or worries.
- On the chemotherapy day unit, staff considered patient and carer engagement fundamental to care delivery. Patient consultations and meetings were arranged to encourage involvement. Staff provided time for patients and carers to ask questions, discuss concerns, take time out to reflect on treatment options and revisit when necessary before agreeing to undergoing treatment. Patients and carers were provided with a very informative individualised handbook detailing treatments, side effects, what to look out for, signposting information and frequently asked questions around finances, social and personal matters.
- We observed staff interacting with patients in meaningful activities such as quizzes, reading, table based games and distraction therapy. We observed carers also involved in some individual and group activities.
- The dementia team collated real-time feedback from carers of those living with dementia. The questionnaire comprised 12 questions about ward care, staff availability, dementia initiatives and care involvement. The dementia team reviewed findings monthly and reported feedback to the divisional wards involved. Overall, carer feedback was generally good however there was a consistency in comments around the lack of availability of nursing staff and an inconsistency in the application of the forget-me-not initiative. These findings were discussed with the relevant ward managers.
- Other divisional teams captured patient feedback specific to their service such as the Rapid Elderly Assessment Care Team (REACT) who provided questionnaires to patients and carers to provide comments on their input into the patient care and treatment plan. Whilst overall feedback was good, some identified a lack of involvement in care as an area for improvement.
- The division had developed 'comfort packs' for relatives who may be visiting for a long period or staying overnight.

- We received comments from a wheelchair user who was attending one of the divisional wards to see a family member. She found staff were helpful, accommodating and made every effort to assist her to ensure the time spent visiting was productive for her and her relative.
- Feedback from patients and carers regarding involvement in care was variable. Patients stated they were given time to speak with nurses and doctors about their care however commented how staff were very busy and did not always have time to spend at the bedside.
- Overall, they felt informed about current treatment plans and progress however many commented on how they were unclear about future plans such as on-going review, follow up and discharge arrangements.
- In NCPES, 76% of patients reported they were involved in their care as much as they wanted to be.

Emotional support

- We observed emotional support being provided by nurses and indirect care being provided by housekeeping and domestic staff.
- Staff introduced themselves to patients before care interactions and asked how they should address them.
- Patient care plans commented on individual patient social, emotional and spiritual needs and where relevant this was integrated into the care plan.
- Staff acknowledged hospitalisation could be distressing and frightening to a number of patients, especially more vulnerable patient groups. Staff endeavoured to spend time understanding particular individual concerns and environmental triggers which could exacerbate emotional stability and wellbeing. Staff added they could not always spend the necessary time with certain patients due to resource restraint and ward workload.
- Staff informed us patients received emotional support from all grades of staff and all disciplines. Staff added how this could be a ward nurse, a therapist or the housekeeper. Staff commented how patients had favourites which allowed them to build up a particular rapport with that member of staff. Ward managers confirmed this was not discouraged.
- Staff accessed chaplaincy and bereavement services, support groups, charity workers and volunteer staff where patients requested or following recommendations discussed with patients.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters. A number of wards had designated family rooms for such purposes.
- The division also completed additional patient satisfaction surveys on a monthly basis reported at ward and divisional level. The 'Plus 5' reports considered an additional five questions (information provision, confidence and trust in nurses, confidence and trust in doctors, emotional support and treated with respect and dignity. This was complimentary to the FFT. Between February and April 2017, divisional wards reported good findings. Patients felt they were given the right amount of information (90%) and were treated with respect and dignity (92%). Confidence and trust of the nursing and medical staff averaged 88% and emotional support averaged 83%. Scores on individual wards varied considerably, for example on ward 43 no question was rated above 67% and the spinal unit reported 100% satisfaction across all scores in April 2017.
- Staff invited patients to make their bed area their own and to bring in non-valuable personal items and clothing. This was not always possible for patients being cared for in extra capacity beds.
- The REACT team and the dementia team provided numerous examples of how they had intervened to provide additional emotional support to patients and carers during distressing times. This often focussed on listening to concerns, providing information of why a loved one was unwell and how this was impacting on their ability to interact, recognise and engage and providing guidance on where to get additional information and support.
- We received a variety of comments from patients regarding the emotional support they received from staff on divisional wards and overall, these were positive.
- One patient described how she felt as though they treat me as a person and pay attention to my fears and concerns. Another stated they respect me and don't treat me like an idiot.
- Two patients commented about being scared and frightened related to late night bed moves. One patient added, I may not have been so anxious if I'd had my hearing aids in.
- A Healthwatch report on ward 43 in 2016, highlighted how patients were complimentary about care. In

particular, one patient described how a nurse had spent considerable time with a patient overnight who was distressed and crying. She reassured the patient and stayed with her until she had settled to sleep.
- We observed how safety guardians and safety support workers cohorting or providing 1:1 care for patients spent considerable time proving physical, emotional and supportive care. Vulnerable patients appeared to react positively to the calm interactions with these staff members.
- In NCPES, 91% of patients confirmed they knew who to contact if worried about their care and treatment (lower than national average of 94%) and 85% stated they were given the name of a nurse specialist who would support them through their treatment (lower than national average of 90%).

Are medical care services responsive?

Inadequate

We rated responsive as inadequate because:

- Flow through divisional services was constrained leading to capacity and demand issues.
- There were significant numbers of patients medically fit for discharge where care could not progress outside the hospital setting due to multi-factorial variables. These included delays in social care assessments, a lack of community placement facilities, issues around securing funding approval for specialist equipment and slow engagement with patients and family members in the discharge process.
- Extra-capacity beds and medical boarders were impacting in all clinical areas. Specialist services considered their own patient cohort was disadvantaged.
- There was a considerable number of patient moves after 10pm causing distress, inconvenience and confusion to many patients. There was no upper time limit cut-off and patient moves during the night had become a normal feature in divisional flow.
- There were high numbers of 'on the day' cancellations across endoscopy services causing inconvenience to patients and delay in patients receiving necessary investigations.
- Changes to practice and opportunities to learn from complaints were not embedded across the division.
- Referral to treatment times, readmission rates and length of stay data was variable across divisional specialities.
- There had been a reported 10% increase in complaints across the division in 2016/17 compared with 2015/16 figures.

However,

- The division planned services to meet the needs of the local population and were actively involved in the on-going acute healthcare reconfiguration across the trust.
- The division involved commissioners and network colleagues when reviewing service delivery.
- The division had evolved ambulatory care services, in-reach teams and e-consultations to support the access and flow agenda.
- There were positive and dynamic initiatives to support vulnerable patients living with dementia and for those with additional needs as a result of learning difficulties.

Service planning and delivery to meet the needs of local people

- The division supported the trust in planning services to meet the needs of the people of Wakefield and Kirklees in conjunction with the local clinical commissioning groups (CCG).
- Divisional management staff attended meetings with local CCG representatives in order to feed into the local health network and identify service improvements to meet the needs of local people.
- The division were involved in the trust acute healthcare reconfiguration (AHR). This project plan engaged staff and involved North Kirklees and NHS Wakefield CCGs.
- The division had used surge wards and extra capacity beds to support periods of increased demand to meet the needs of local people.
- The division were monitoring a potential increase in demand for stroke services in view of wider regional changes. Divisional leaders had engaged support from older person's physicians to support stroke services.
- The division had appointed a number of specialist nurses and developed a number of specialist clinics.
- Patients at Pinderfields had access to an ambulatory care service. The service provided care to patients meeting 'referral criteria', (such as atrial fibrillation, cellulitis, low risk chest pain and pulmonary embolism) to avoid unnecessary admission where safe to do so.

Medical care (including older people's care)

- The division was working with colleagues in neighbouring trusts to support the neurology service at Pinderfields.
- The division had converted an extra capacity/surge ward into the substantive bed base to develop diabetes services.
- The Parkinson's service has been developed and is being reviewed in conjunction with older person's services to provide additional specialist MDT support and pathway transition between clinical teams.
- The division offered chemotherapy and oncology day services across all sites for ease of patient access.

Access and flow

- Pinderfields housed the majority of the divisional wards and divisional specialist services. These included stroke and neurology services, a regional spinal unit, ambulatory care services (AEC), an acute assessment unit (AAU), older person's services, haematology and oncology wards (including a chemotherapy day unit), cardiology and coronary care (CCU), diabetes and endocrinology, respiratory (including an acute respiratory care unit – ARCU) and gastroenterology. Pinderfields had 16 medical wards accommodating 475 beds and at the time of the inspection, there was a surge ward in use and 122 extra capacity beds above the designated bed base across the division (60 at Pinderfields and 62 at Dewsbury).
- The division had 72,684 medical admissions between December 2015 and November 2016 of which 41,848 (58%) were at Pinderfields. These were broadly categorised as emergency admissions accounting for 24,988 (60%), 16,017 (38%) were day case, and the remaining 843 (2%) were elective. The top three admitting medical specialties were general medicine, elderly medicine and respiratory.
- Between February 2016 and January 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently similar to the England average. In January 2017, this showed 93% of this group of patients were treated within 18 weeks versus the England average of 89%. Thoracic medicine, gastroenterology, neurology and cardiology all performed better than England average (for admitted RTT pathways). Geriatric medicine, general medicine, rheumatology and dermatology were below England average reporting.
- Between November 2015 and October 2016, patients at Pinderfields had a higher than expected risk of readmission for elective admissions and a lower 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.
- Between December 2015 and November 2016, the average length of stay for medical elective patients at Pinderfields was 6.2 days, which was higher than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 5.9 days, which was lower than the England average of 6.7 days.
- Divisional managers confirmed recent changes to extra capacity ward configuration. This had seen two temporary extra capacity wards being converted into the substantive bed base (ward 20 – older person's care and ward 32, designated as a diabetes and endocrinology unit).
- At the time of our inspection, the trust were working at 'OPEL 3' status (defined by NHS England as care system experiencing major pressures compromising patient flow and continues to increase). The division were involved in contributing to the trust 'full capacity plan' with senior staff attendance at bed meetings and extraordinary meetings to discuss current pressures (involving A&E activity, admissions, IPC risks, delayed transfers, critical care capacity, nurse staffing, theatre activity, outliers position, the use of extra capacity beds and the number of non-core beds in use). At the bed meeting on 17 May 2017 (10.30am), trust directors, senior managers, clinicians, matrons, patient flow, discharge lead and representatives from the CCG were in attendance.
- The discharge team lead allocated discharge coordinators to wards under greatest pressure and to support planned discharges. The division had ward based discharge teams across a number of divisional wards.
- The ward based discharge team liaised with community colleagues and support services to assist patients who were classed as medically fit for discharge (MFD). The team stated there were various obstacles to a smooth discharge transition and these included patient choice, complex needs, placement issues, delays in community assessments and lacking community beds due to recent decommissioning issues.

Medical care (including older people's care)

- At the time of our inspection, the discharge lead confirmed there were 45 patients at Pinderfields classified as MFD where discharge was delayed. 23 of these patients were on ward 41. Both the discharge lead and ward manager confirmed the main 'bottleneck' was due to patients awaiting social care assessment and planning. The ward manager added how patients discharges can fall through at very short notice and exampled this by referring to two discharges that did not go ahead 24 hours previously for this reason.
- The discharge team monitored patient discharge status across the division on the 'Electronic Discharge Management Team' system which was accessible centrally and on all divisional wards.
- The discharge team also focussed on 'stranded patients' (defined as patients who have been hospitalised for seven days or more) to see if care could be better provided to meet needs elsewhere outside hospital.
- At the time of the inspection, the discharge lead reported there was 15 patients where discharge had been delayed over 100 days. Nine of these patients were currently being cared for on specialist units where the delay was due to a lack of specialist community bed placements.
- The trust reported the main reasons for delayed transfer of care (DTOC) between March 2016 and February 2017 were patient or family choice (43.7%), followed by waiting further NHS non-acute care (14.8%).
- Senior staff in the spinal unit stated DTOC on their unit was caused by a number of variables. They considered this was due to the complex needs of their patient cohort, a lack of suitable community placements, delays in obtaining funding authorisation for necessary equipment and a lack of a dedicated discharge coordinator on the unit.
- Ward 45 were trialling nurse led discharges at the weekend to support patient flow through the division.
- The division had an ambulatory emergency care unit (AEC) at Pinderfields. The service provided over 30 treatment pathways to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included patients requiring assessment and treatment for cellulitis, syncope, chest and urinary infections, low risk chest pain and pulmonary embolism. These pathways provided criteria to help staff identify patients whom could be safely cared for in ambulatory care setting without hospitalisation.
- The AEC tended to see approximately 160 patients a week (range from September 2016 to March 2017 was 122 to 204). The streaming of appropriate patients into ambulatory care had brought a reduction in short length of stays in acute areas such as AAU (Highlight Report, March 2017). The total number of referrals received into AEC between January and May 2017 (up to 23 May) was 3,017.
- The AEC was open 24 hours, 7 days a week with consultant cover until 8pm during weekdays and until 5pm at weekend. The unit was manned by advanced nurse practitioners until 11pm thereafter referrals were made via the clinical decisions unit (CDU). The average length of stay on AEC was 5.9 hours up to 9pm and over 8 hours from 9pm until 8am.
- The AEC was often used to accommodate extra capacity patients overnight and staff confirmed they tended to cap numbers at a maximum of six. At the time of our inspection, we found 11 patients had been cared for overnight on AEC. This had an impact on patient attendance the following day as these patients needed care provided and arrangements made to have them accommodated into ward beds.
- The division reported a number of medical boarders (medical patients being cared for on non-medical wards). In February 2017, this was reported as 125, in March this had reduced to 65 and in April was reported as 6. The reduction at Pinderfields coincided with the move of two extra capacity wards to the existing bed compliment. At the time of our inspection, the patient flow team reported 16 boarders on the Pinderfields site (22 at Dewsbury). It was reported there were six medical patients being cared for in the surgical bed base and 10 surgical patients in the medical bed base. Specialist clinicians considered patients were being dumped into their beds when they ought to be cared for in the general or acute medicine bed base.
- Senior staff within the Regional Spinal Unit felt their specialist status had been eroded by being treated like any other medical ward across the division. Staff stated their unit had recently been used to house the infusions service and commented how specialist beds were often taken by medical boarders. Staff exampled this when a patient had been allowed home on weekend leave, only to return to the ward thereafter to find their bed had been taken by an outlying medical patient. They considered this potentially blocked specialist beds for patients requiring spinal care.

- The cardiology service in conjunction with the cardiorespiratory physiology department provided an e-consultation service to GPs to provide quick responses to treatment and care management issues in primary care. This offered prompt access to senior clinicians to address GP concerns and provided immediate guidance on treatment options. This helped facilitate unnecessary referrals and potential admissions into the system.
- The REACT team provided in-reach into acute areas and divisional wards to support their patient cohort. The team (consisting of dedicated therapists, social workers, nurses and clinicians) had forged good community links with enablement services, community placement providers and community matrons to ensure patients received the right care in the right place.
- The discharge lounge was currently situated in the reception area of AAU. The lounge provided 12 chairs for patients to use whilst awaiting discharge formalities such as medications and transport. Due to the current space restrictions, the lounge could not accommodate patients on beds. Discharge lounge staff informed us the service was underutilised however the current location did not lend itself to increased demand. The lounge accommodated an average of 10 -16 patients daily. The discharge lounge had been moved to various locations within the trust during recent months and staff commented how they had lost touch with the unit whereabouts. This had been compounded by repeated changes in the discharge lounge telephone details.
- 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. Staff on the stroke unit confirmed there was a lot of intra ward bed moves to accommodate extra capacity patients and when stepping down care from the hyper acute area to the general ward area within the unit.
- From November 2016 to March 2017, there were 1,417 patients moving wards after 10pm at Pinderfields. The greatest number of moves was recorded against ward 45, accounting for 330 (range of 42 to 66 monthly) moves and ward 31 with 303 (range 23 to 79 monthly). Ward managers confirmed moves at night were not helpful to staff and could lead to distress to patients. Staff confirmed where such moves were necessary this was generally due to clinical need, demand on acute beds and pressures in A&E. The site manager informed us there was no upper time limit where bed moves would be deferred.
- There had been no mixed sex breaches in the division in the previous 12 months.
- The endoscopy service provided detail of 'on the day cancellations' for 2016/17. There was a total of 1,516 cancellations across all sites of which 519 were logged against Pinderfields (499 from Pontefract and 558 at Dewsbury). The service confirmed the main causes for cancellation were patient not attending, treatment deferred by the hospital (including poor bowel preparation), staff sickness and equipment failure. During our inspection, endoscopy lists at Pontefract had been moved to Pinderfields due to staff sickness. The division deployed nursing staff on other sites to maintain services and to minimise impact on the recovery plan.
- In the Integrated Performance Report compiled in March 2017, the division 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.
- Commissioners had concerns around flow and the impact this has on quality and safety of patient care. They highlighted the prolonged use of additional capacity beds and impact on nurse staffing establishment. Staff also reported a lack of early patient and family involvement in discharge planning.

Meeting people's individual needs

- The divisional managers confirmed when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief were taken into account.
- Staff confirmed where patients required additional support, for example, those with complex needs or who were vulnerable, the division took all reasonable steps to ensure the care they required was uncompromised.
- The division had senior lead nurses for dementia and learning disabilities (LD).
- The trust had a three year dementia strategy (2015-2018). The vision to embrace a culture of compassion, dignity and respect by putting the patient first – dementia second was underpinned by five priorities. These were to identify and support patients

living with dementia, valuing and supporting their carers and families, to develop a skilled and effective workforce to champion and deliver excellent, individualised person centred care, to promote patient safety and minimise harm, to be recognised as a dementia friendly hospital and to develop partnerships to promote collaborative working.

- On a day to day basis, the dementia lead nurse and two support worker colleagues used variety of mechanisms to identify patients who would benefit from an assessment and specialist input from the dementia team. These included VitalPac identifiers (a red triangle with a 'D'), the 'FAIR' dementia assessment tool, professional referral based on presentation criteria, attendance at ward rounds and proactive in-reach into clinical areas.
- The three year dementia strategy re-established a training programme of improvement to deliver best practice in dementia care consistently across the trust. This consisted of a dementia training programme and ward based dementia champions to promote dementia awareness. Training figures had increased across the division from less than 10% compliance in 2014 to over 53% compliance reported in April 2017. The lead dementia nurse continued to work with all clinical areas to deliver training and hoped to have the strategy training package delivered in line with mandatory training requirements.
- During the course of our inspection at Pinderfields, we observed various dementia initiatives in place to improve the care for the cohort of patients. These included a carers passport initiative which was an agreement between the trust and the carer providing flexible visiting hours, personal care, meal time assistance and active involvement in care discussions. Some wards provided family support rooms which allowed carers to remain with the patient 24 hours a day where beneficial and where palliative care was being provided. The division implemented John's campaign (a programme to reinforce corroboration and partnerships in care), Forget-me-not (an awareness project to reinforce the needs of people living with dementia) and the butterfly scheme (a recognisable visual identifier which alerts staff that an individual has particular needs as a result of a dementia related memory impairment).
- We found all these initiatives in use across divisional wards however their application appeared to be inconsistent.
- A number of wards had made environmental changes to reduce conflict and anxiety such as pictorial signage, furnishings, decorations and reminiscence triggers. These included RemPods (pop-up rooms) including a 'tea room' and a 'potting shed' to stimulate engagement and interaction. The division also accessed the interactive 'My Life' computers which were pre-loaded with reminiscence software such as photographs, video clips and music as a means to further engage and interact with patients. These were also accessed by carers.
- The division also housed the Alzheimer's society ward visits where carers could access advice and support from the support workers.
- 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.
- The dementia and LD team carried out meet and greet with vulnerable patients at clinic appointments and pre-operatively to support those who need additional reassurance.
- In the PLACE audit completed in 2016, the trust dementia and disability scores were reported at 65.5% and 76.7% respectively (worse than national average of 75.3% and 78.8% respectively).
- The division used the 'VIP' passports to support patients who had particular needs as a result of a learning disability. This booklet, owned by the patient, detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which were helpful in supporting during difficult periods.
- 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 activity boxes were borrowed by wards and volunteers for use with their patients. The boxes were donated from volunteer charitable funds.
- Staff commented how bed moves and the addition of extra capacity beds had a particular impact on vulnerable patients, such as those living with dementia, who became anxious and disorientated.
- The division housed the REACT team who prioritised care for older persons. The dedicated REACT MDT targeted patients over 80 years or age (or over 65 years

of age residing in a care facility) to ensure they received a thorough holistic assessment of care needs (Comprehensive Geriatric Assessment). Where appropriate, the team involved community services and other agencies to provide on-going support outside the hospital setting.

- Staff stated there were no particular additional adjustments or services made available to those persons with visual impairment or hearing difficulties. Staff indicated however they always considered visual or hearing problems as part of their assessment of the patient.
- Staff we spoke with explained that they could access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs.
- The division accessed psychiatric services through agreement and in conjunction with South West Yorkshire Partnership NHS Foundation Trust. The psychiatric liaison team operated 24 hours a day from Pinderfields to provide priority to A&E and acute admissions into the division requiring mental health assessment. The local operational policy detailed referral criteria and service level agreements for divisional patients.
- Staff informed us they had ease of access/referral into psychiatric services for those patients requiring this care, in particular when needing assessment under the Mental Health Act and for DoLS guidance.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward and general useful signposting on where to get further information such as PALS, complaints and support groups.
- The division accessed interpretation and translation services when required to support patients where English was not their first language. The division also accessed British Sign Language interpreters when required.
- Staff confirmed there were chaplaincy and prayer rooms on site. Staff had 24-hour access to chaplaincy services (on-call out-of-hours) and they could provide bedside support when required. The chaplaincy service offered spiritual, pastoral and religious information and support to staff, patients and carers from multi-faiths.

Learning from complaints and concerns

- The division reported 1,624 complaints in 2016/17, an increase of 10% from 2015/16 figures.
- 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 division also reported 23 active reopened complaints. There were meetings booked or being arranged to discuss the issues with the complainant.
- The majority of these complaints were logged against Pinderfields (75%) and originated from the medicine specialities (older person's medicine with the greatest number). The wards generating the greatest number of complaints in March 2017 were ward 43 and ward 4 (excluding A&E).
- Senior staff identified complaint themes to be broadly related to treatment, staff attitude and time to appointments.
- 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).
- The division acknowledged all complaints within three days and responded to 80% within 30 days.
- The Patient Experience Team provided a monthly dashboard to divisional staff detailing outcomes from key metrics such as FFT results, complaints data, patient feedback and NHS Choices commentary to support staff in identifying key areas for improvement.
- The wards we visited displayed leaflets and posters outlining the complaints procedure and escalation processes and how to access further support from Patient Advice and liaison Services (PALS). We saw that the trust had a complaint policy and staff were aware of it.
- Healthwatch Wakefield shared feedback from service users. During 2016/17, there were 226 comments received about trust services, 143 negative and 83 positive. There were some comments relating to divisional wards which sat in both. Positive themes were around the quality of treatment and staff attitude however these also appeared in the negative themed comments. Additional negative comments also included a number categorised as 'dignity' and 'staffing levels'.

- Staff discussed feedback from complaints at ward meetings however stated the process of implementing changes to practice as a result of lessons learnt were not embedded.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Divisional managers recognised the additional beds currently in use across the division compounded by staffing shortages caused dissatisfaction with staff and destabilised ward leadership. Staff morale was variable across the division.
- Governance and assurance processes for the care and management of patients did not support the provision of safe care, quality outcomes and positive patient experience on divisional wards.
- Staff reflected how the unsettled divisional leadership was a causative factor in the endoscopy service having its status amended by JAG. Additionally, senior staff in the Regional Spinal Unit considered they required more autonomy to lead and develop the service.
- Divisional meetings lacked consistent agendas, structure and content was variable. A number of agenda items were not discussed and some divisional meetings were not quorate.
- The shift in divisional culture and staff engagement initiatives were not fully embedded.

However

- There were clearly defined leadership structures across the division. The triumvirate core was replicated across all divisional specialisms.
- There was a vision and strategy for the division which aligned to the trust agenda.
- The division had clear governance channels into the wider organisational executive management structure. Divisional meetings considered safety, risk and quality measures.
- The division had a live risk register which was reflective of real issues faced across divisional services impacting on patient care, staff wellbeing and service quality.
- There was evidence of positive progression being made within the divisional ethos underpinned by a number of public and staff engagement projects.

Leadership of service

- The divisional leadership had undergone some changes since the previous inspection with a new senior management team now in post. This was bringing stability to the division.
- 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 division management structure was further underpinned with support from a Performance and Operations Manager, Clinical Governance Manager, Finance and a Human Resources Business partner.
- The management team covered all sites.
- The leadership team had an understanding of the current challenges and pressures impacting on service delivery and patient care.
- The leadership team had worked to address a perceived disconnect between the Executive and the Heads of Service. There was better engagement with Non-Executive Directors who had taken special interest in some divisional activities and were championing key areas such as falls improvement.
- Senior staff in the Regional Spinal Unit considered they required more autonomy to lead and develop the unit. The found the current leadership under the division of medicine structure unsuitable for the needs of their service. The senior clinicians were from a surgical background.
- Divisional leaders valued their staff and recognised the work they did in often difficult circumstances and with current service pressures. They considered their workforce to be a real strength. Leaders recognised the

additional beds currently in use across the division compounded by staffing shortages caused dissatisfaction with staff and destabilised ward leadership.
- The leadership team were appointed to attend leadership courses in the coming year.
- The senior staff focus groups (matrons and consultants) confirmed a positive and fundamental change in leadership and the attitude of senior managers. They stated this had been underpinned by improving engagement, greater visibility, being more receptive to staff concerns and active in current issues faced across the division.
- Staff confirmed local ward based clinical leadership to be good however support from the divisional matrons varied. Staff on the stroke unit stated their matron rolled her sleeves up in times of need.
- Staff considered the lack of consistent leadership across endoscopy services was fundamental to the change is JAG accreditation status. This was not highlighted by JAG as a reason for the change in status. The division had responded to this by bringing together an endoscopy task force to work with staff to develop an action plan to address identified shortfalls.
- Divisional leadership recognised their cross-site responsibilities and encouraged staff to engage with colleagues on other trust sites to build team networks. Some roles provided staff with the opportunity to work cross-site and liaise with the wider divisional team.

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 was formed following dialogue and consultant with staff.
- Staff understood the aims and objectives of the organisation which was mirrored in the divisional '12-point plan'.
- Staff considered there had been a shift in recognition of the importance of the work they undertake and how this impacted on the status of the organisation.
- Staff commented how there was much more noise around what the trust and the division were trying to achieve which was underpinned by communications from trust and divisional leaders.
- We observed various displays and posters around the hospital detailing the vision and strategy for the organisation and what specific services were doing to help achieve this.

Governance, risk management and quality measurement

- The division had clear governance channels into the wider organisational executive management structure. This flowed through the Medicine Division Management Team, Risk and Clinical Executive Group and the Quality Committee to the Board. The medical division had a designated governance lead with multi-specialism clinician input.
- We reviewed monthly divisional and specialist services, clinical governance and NCEPOD meetings. The standard agenda framework varied across specialisms however 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 specialisms. 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. The team 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

PUs, falls and the team considered SIs and RCA 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. There was also a bi-monthly leadership forum for clinical divisional leads. These forums allowed divisional risks, clinical updates and improvement plans to be discussed.
- We were provided with sight of the divisional risk register dated 22 March 2017. Divisional managers confirmed the risk register to be a live document with on-going review, actions taken and progress. The register detailed the risk type, risk title, risk descriptor, control assurances, current and target risk ratings and action plan summary detailing 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.
- Some of the inclusions in the risk register dated back to 2013 however 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 top three rated risks according to the risk register did not mirror exactly the managers top three concerns (stated to be endoscopy and JAG accreditation, patient harms and nurse staffing) however there was some correlation to those rated as 'major'.
- Ward 43 was recently added to the risk register following discussion held at the divisional governance meeting in December 2016. This was in response to quality and risk indicators which identified worrying levels of incidents and complaints regarding patient care. The division planned to undertake a corporate walk around to start a process of improvement strategies on the unit.
- The risk register was live to the central issues impacting on service across the division. The division supported the trust risk stratification processes in identifying areas of highest risk. The pressures on A&E services and current capacity and demand issues across the division were having a negative impact on staff morale, patient safety, patient experience and service quality. The current governance and assurance processes behind workforce management, staffing escalation and the management of extra capacity beds were unsustainable.
- We were concerned about the divisional ability to maintain meaningful services under current pressures in the short to medium term, whilst ensuring staff wellbeing, patient safety and quality care outcomes remained priority.
- The division were involved in the trust-wide acute hospital reconfiguration (AHR). This process to deliver changes to reflect demand was on-going at the time of our inspection. The division had been involved in phase one (April – May 2017) with the transfer of the stroke rehabilitation ward from Pinderfields to the Pontefract site. The division planned further changes later in the year involving frailty and gastroenterology services.
- The division had representation in the sepsis group established in June 2015. The group lead was a divisional consultant. The group aimed to improve care for patients with sepsis, to develop sepsis pathways and to implement national guidance on sepsis care. This group met monthly and outcomes fed into the trust mortality group. The group developed trust global sepsis guidelines and neutropenic sepsis pathways. Training around sepsis care was progressed at a sepsis awareness day and a sepsis intranet site was developed which held information for all grades of staff. The group have sought funding to appoint a sepsis lead nurse.
- The sepsis group reported CQUIN findings for 2016/17. This showed 98% of in-patients needed sepsis screening received this, 98% of patients who required antibiotics were administered these in the hour and 99% had antibiotics reviewed within three days of prescribing.
- The division had involvement and contributed to the trust improvement plan presented to the executive improvement board. We were provided with sight of the quality risk profile updated in April 2017. The same detailed progress made across a variety of actions under patient safety, patient experience, regulatory action, 'Monitor' and leadership and management domains. A

number of the items therein were on-going (staffing, RTTs and mortality) however the majority of the domain items listed showed signs of improving such as patient harms.

- The division drafted an 'Urgent Care Improvement Programme' which was updated on 6 March 2017. The same covered a number of areas within the division including frailty pathways, ward discharge processes, patient flow and professional standards. There was evidence of progress being made however a number of elements had been subject to timetable slippage (Embedding SAFER), some have been deferred (Interim Profession al Standards in AEC) and some redirected (AHR programme).
- The division were involved in reviewing procedures caught within the National Safety Standards for Invasive Procedures (NatSSIPs) agenda, revised in September 2015. The division had reviewed local safety standards in endoscopy (LocSSIPs) and were working with colleagues in dermatology to prioritise specific procedures for development. This work was on-going at the time of the inspection.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division reported involvement in 28 division specific priority – level 1 audits and 24 cross divisional audits in 2016/17. These included a number of the divisional specialisms such as cardiology, respiratory, neurology, older person's care, acute medicine, endoscopy and gastroenterology.
- Audit activity was current, relevant and aligned to recognised national and European standards such as NICE, BTS and Royal Colleges. These included epilepsy, headaches in adults, rehabilitation, adult bronchiecstasis, acute pulmonary embolism as examples.
- The 2017/18 level 1 – priority audit programme has been compiled which includes additional divisional specialism audit activity in the coming year. The division are also involved in a number of level 2 and 3 projects to look at the deteriorating patient, acute kidney injury, oxygen prescribing and involving wider divisional services in palliative care and dermatology.

Culture within the service

- Divisional leaders reported a positive cultural shift in the past 12 months with more focus on recognition, reward and improvement.
- Staff at all levels spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made over the last 18 months.
- Staff described how the organisational and divisional culture was evolving and becoming more open, honest and transparent.
- Staff also reported a shift away from a culture, of what they considered historically, to be blaming. Staff added how there was more focus on understanding why things may have gone wrong or on how things could be bettered in the future.
- Divisional leaders and senior clinicians described their colleagues as good people, good teams. Staff considered there was real strength and support for colleagues on wards. They described a comradery and togetherness across disciplines.
- Staff morale was variable and the amount of goodwill shown by staff was wavering. This did not detract from the staff's desire and determination to ensure patient's received the best care possible. Staff recognised the issues impacting on performance and morale but also considered there no quick fix for many challenges faced by the organisation.
- Junior nursing and medical staff described their senior peers to be supportive, approachable and willing to spend time with them when necessary and when able.
- Matrons recognised staff on wards were getting stressed and tired with the constant pressures faced.
- Staff considered their immediate managers to be approachable and part of the team. Staff felt as though leaders were staring to listen to this and take on board staff feedback.
- Staff felt a palpable proactivity of trust and divisional leaders to improve the culture within the working environment. This was underpinned by staff describing how the Chief Executive had been visible on divisional wards, attending board rounds and engaging in discussions with staff.

Public engagement

- The division had compiled a 'Listening to you' – Patient, Family and Carer Experience Strategy 2016-2018. The aim of the project was to reinforce the importance of patient, family and carer focussed care driven by what matters to them. The divisional priorities aligned to trust

objectives of respect and dignity, patients being informed about care and treatment, staff communications to build trust and confidence and consideration of patient's emotional needs.
- The division had implemented a number of projects to meet these aims, such as changing meal service, development of a SOP for the management of additional patients on wards, ward based initiatives (ward 42 neck of femur improvement project and educational sessions for patients with spinal injuries to support skin care) and refurbishment plans. All projects were on-going at the time of our inspection. The division proposed measuring the effectiveness of the engagement strategy by way of improved FFT scores and complaint reduction.
- Some divisional services developed their own patient and family feedback surveys as a means to capture local public feedback on services. The dementia lead nurse captured patient and carer feedback for the service to identify themes.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.
- The division had good links with numerous volunteer organisations, charities and national support groups.
- The division supported the organisation and wider health community agenda with the consultation surrounding the future of healthcare services across the region.
- The dementia team had two general public members on their steering group who were involved in debate, service development and patient initiatives.
- The REACT team displayed an information stand in the public atrium of the hospital to engage with patients and carers.
- The spinal unit held a lunchtime journal club and teaching sessions for patients and carers. They also hosted external events where current and past families and carers could attend. The unit had forged strong links with 'Spine', a registered charity described as the voice of Pinderfields spinal patients'. The group provided inclusive activity support, funding donations, supported educational sessions and acted as an interface for current and former patients of the unit. The charity maintained links with other spinal units and national spinal organisations to widen the reach of the spinal network locally.
- Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing PALS. Additionally, wards provided signposting information for patients and family members on where to get additional support outside the hospital setting.

Staff engagement

- Staff commented how there had been an increased effort by divisional managers and the leadership team to engage with staff cross-site.
- Staff had developed good links with external professional colleagues, support organisations and volunteer groups.
- Staff said they felt supported when they had personal or family issues which impacted on their ability to work. Staff commented how their line managers and clinical support network showed understanding, empathy and kindness during the difficult time. Manager supported staff returning to work following a leave of absence.
- In the NHS Staff Survey 2016, the division of medicine engagement score was better than trust average (3.62 compared to 3.58) but below national average (at 3.8). Across acute and elderly care services, the engagement score was considerably lower at 3.45. The speciality medicine engagement score were better at 3.92.
- Of the 125 responses in the NHS Staff Survey compared to national average, the division of medicine performed better in 29 (23%) areas, with acute and elderly services only better in 20 (16%) scores. The specialist medicine area was better in 69 (55%) of the metrics. There was a reported improvement overall in 50 of the metrics and deterioration in 24 compared to 2015 data.
- There was a disparity in findings between the division of medicine, acute and elderly medicine and those results from specialist medicine however there were some common themes; from a positive perspective, local leadership and career development opportunities stood out. The negative themes related to inadequate staff to do the job properly, discussing team effectiveness and an ability to provide the care they aspire to.
- The negative themes highlighted in the NHS Staff Survey were also highlighted in the 'Freedom to Speak Up Guardian' report which highlighted the impact of staffing levels on the patient experience and exacerbation of existing nurse staffing shortfall due to the accommodation of extra-capacity beds.

- Divisional staff were invited to attend local meetings to discuss reconfiguration plans. This process engaged staff from all disciplines.
- Staff at all levels and in all disciplines reported better engagement. This was particularly noted with the junior doctor cohort who held bi-monthly meetings with senior divisional clinicians.
- Divisional staff had been recognised in the 'MY Star Awards' and the 'Celebrating Excellence Awards'.
- The Head of Nursing had compiled a newsletter for staff entitled 'Medicines Grapevine'. It was hoped this publication would become a forum to engage staff on professional issues and social interests.
- Staff in physiology services felt as though there was a lack of consultation around new service development where this would impact on their service provision such as ambulatory care services.
- Staff morale was variable across the division however they acknowledged efforts to improve engagement and initiatives to support health and wellbeing. Some staff were 'on the fence' about such programmes however were keen to see a sustained and concerted effort to promote the staff agenda.

Innovation, improvement and sustainability

- The division had engaged in a number of innovations, improvement activities and sustainable projects since our last inspection in 2015.
- The Assistant Head of Nursing implemented the roll out of 'SAFER' across five divisional wards at Pinderfields. This improvement project approved by NHS Improvement aimed to improve patient flow through divisional services and minimise unnecessary waits.
- Staff on ward 42 had been involved in a fractured neck of femur improvement project to improve outcomes and patient experience on their unit.
- The dementia team secured funding for 'MY Life' computers and 'REMPODS' to promote engagement and stimulation for vulnerable patients living with dementia.
- Ward 45 implemented the 'Always Events' programme to source patient and carer opinion on improvement initiatives.
- The spinal unit in conjunction with psychology colleagues set up a Spinal Injuries Patient Partners Support Group (SIPPS).
- A specialist therapist in the spinal unit was nominated for a National Spinal Association Award for liaison work across the service.
- The cardiorespiratory service lead set up a Healthcare Sciences Group to bring together this cohort of staff to share learning, best practice and to consider service improvement initiatives. The physiology service were currently working toward IQIPS accreditation (Improving Quality in Physiology Services).
- The AEC team were recognised by the Ambulatory Emergency Care NHS Elect Network and received an award for best use of innovation.

Surgery

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

Information about the service

Pinderfields General Hospital is a designated Major Trauma Unit and the main hospital of the Mid Yorkshire Hospitals NHS Trust. Pinderfields General Hospital has a regional adult's burns centre, which serves a population of approximately 3.5 million people across West, North and East Yorkshire. Pinderfields General Hospital provided surgical services for general surgery, head and neck, ENT, elective orthopaedics, trauma & orthopaedics, urology, gynaecology, burns, plastics and ophthalmology. There were seven wards, an operating suite containing 15 theatres, a day-case unit, and a surgical assessment unit. Pinderfields General Hospital surgical division had approximately 170 inpatient beds including extra capacity beds.

Across the trust, there were 54,683 surgical admissions from December 2015 to 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 across the surgical division of the Mid Yorkshire Hospitals NHS Trust.

During this inspection, we visited all surgical wards, the surgical assessment unit, and the day surgery unit. We observed care being given and surgical procedures being undertaken in theatres and recovery areas.

We spoke with 27 patients and relatives and 65 members of staff. We observed care and treatment and looked at 17 care records. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

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 the May 2017 inspection we rated surgical services as 'good' because:

- There were systems in place to identify themes from incidents and near miss events. The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed, and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines

Surgery

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.
- Venous thromboembolism (VTE) screening audits showed assessment compliance was 98.5% as of January 2017.
- Surgical site infections were lower than the national average.
- Policies and procedures incorporating national guidance were in place and available to all staff.
- During 2015/16, 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 Friends and Family Test (FFT) response rate for Surgery at the trust was 31%, which was better than the England average of 29% between February 2016 and January 2017. At Pinderfields General Hospital, the response rate was slightly lower at 28%. 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.
- The trust separated emergency and high risk surgery from routine surgery in September 2016 and all emergency (unplanned) surgery moved to Pinderfields General Hospital. This was undertaken to meet 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 to reduce infection risk.
- Between December 2015 and November 2016 the average length of stay for surgical elective patients at trust level, as well as at Pinderfields General Hospital, was lower than the England average.
- For surgical non-elective patients, the average length of stay was lower than the England average at all sites, and trust level.
- The National Cancer two week wait target of General Practitioner (GP) referral to first appointment confirmed performance was 97.7% between February 2016 and January 2017 across the trust surgical division. This met national targets.
- For the period Q4 2014/15 to Q3 2016/17, the trust cancelled 726 surgeries. Of the 726 cancellations, 1% were not treated within 28 days. The trusts performance has been consistently better than the England average for the period. Across the trust, there were 54,683 surgical admissions from December 2015 to November 2016.
- Readmission rates had reduced and improved.
- Complaints were responded to in a timely manner and learning was taken forward to develop future practice. Information was available for families on how to make a complaint. Staff actively invited feedback from patients and their relatives and were open to learning and improvement.
- There were clear and embedded 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.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff had confidence in the new leadership and felt they were be listened to.
- There had been an improvement in culture. 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 department with staff speaking highly of their colleagues. They showed commitment to the patients, their responsibilities and to one another.

However:

- 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

Surgery

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 variations in the quality of recording and in completeness of some assessments such as National Early Warning Score (NEWS) risk assessments and sepsis screening tools.
- The qualified nursing staff levels required across all surgical wards at Pinderfields General Hospital was 335.9 whole time equivalent (WTE) for March 2017. The areas with the largest staffing vacancies were in theatres, the plastics and burns surgical services and Gate 33. The average divisional 'fill rate' was 90% for nursing staff and 100% for health care assistants.
- As at 28 February 2017, the trust reported a vacancy rate of 8% in surgical care.
- Nursing staff had not met the mandatory training targets for medication management level 2, infection prevention and control, resuscitation, fire safety or governance training.
- Medical staff did not reach the 95% target for any of the trusts core training including safeguarding.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE) 2016. The results showed the surgical division at Pinderfields General Hospital scored 78.8% for providing privacy and dignity for patients and 66.5% for dementia care.
- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- We were informed of delayed discharges from the Post-Anaesthesia Care Unit **(**PACU) with some patients boarding for six to ten hours. On occasion patients were discharging from PACU to home directly.

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- The qualified nursing staff levels required across all surgical wards at Pinderfields General Hospital was 335.9 whole time equivalent (WTE) for March 2017. The number of qualified staff in post was 309.87 WTE. The areas with the largest staffing vacancies were in theatres (16.2 WTE), the plastics and burns surgical services (6.23 WTE) and gate 33 (4.17 WTE).
- NEWS audits in March 2017 showed that 59% of observations were recorded which was down from 67% in the previous audit cycle. The sample audit was 325 patients. We were told that of 104 of these patients who triggered escalation, 86.5% were escalated appropriately or had a plan in place.
- There were 108 missed medications recorded between March 2016 and February 2017 across the surgical division.
- As at 28th of February 2017, the trust reported a vacancy rate of 8% in surgical care.
- Nursing staff had not met the mandatory training targets for medication management level 2, Infection prevention and control, resuscitation, fire safety or governance training.
- Medical staff did not reach the 95% target for any of the trusts core training including safeguarding.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed, and changes to practice identified.
- 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.
- Venous thromboembolism (VTE) screening audits showed assessment compliance was 98.5% as of January 2017.

- Surgical site infections were lower than the national average.

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 one serious incident, which was classified as a never event for Surgery. It was a 'Surgical/invasive procedure' which saw a gallbladder of a patient, which had been excised from the liver, left in a retrieval bag which had not been removed before closing. There was evidence of trust wide learning recorded in minutes of surgery ward meetings, clinical governance minutes and directorate operational team meeting minutes.
- In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in Surgery, which met the reporting criteria set by NHS England between March 2016 and February 2017. 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 of a Root Cause Analysis (RCA) Investigation Report regarding a patient who had an unwitnessed fall when mobilising to the bathroom. The fall resulted in moderate. The RCA was detailed and comprehensive highlighting immediate actions taken; chronology of events; RCA meeting and analysis findings; care and delivery problems; root cause; recommendations; lessons learned and action plans.
- Staff told us how they reported incidents through the electronic system and most said learning was shared through ward meetings, safety huddles, team briefings, and handovers.
- Matrons 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 and staff were able to articulate action they would take.
- Mortality and morbidity meetings were in place in all relevant specialities. All relevant staff participated in mortality case note reviews with joint surgical and anaesthetic reviews and reflective practice. Specialties also discussed cases at the governance half-day meeting.

Safety thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- We saw that the safety thermometer was displayed in clinical areas, together with details of 'harm-free days', which indicated how long it had been since particular types of incident had occurred in that area.
- Data from the Patient Safety Thermometer showed that the trust reported 16 new pressure ulcers, seven falls with harm and eight new catheter urinary tract infections between February 2016 and February 2017. There have been no more than one fall per month in surgery and there have been no new catheter urinary tract infections since September 2016.
- Venous thromboembolism (VTE) screening audits showed assessment compliance was 98.5% as of January 2017, which was better than the target of 95%.

Cleanliness, infection control and hygiene

- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, norovirus and methicillin resistant staphylococcus aureus (MRSA). These were available on the trust intranet.
- The surgical services reported one incidence of MRSA between March 2016 and February 2017. Nine cases of clostridium difficile were reported in the same period; however, five of the cases were non-trust acquired. The trust reported seven incidences of MSSA between March 2016 and February 2017.

- Surgical site infection (SSI) at Pinderfields General Hospital rates was zero for total hip replacements. The national SSI rate is 1.1%.
- There were 12 incidences of E. coli at Pinderfields (trust attributed) 2016/2017.
- 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 targets were met for all departments between March 2016 and February 2017. The target for hand hygiene was 98%. Bare below the elbows targets were met for all departments 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 told us that 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.
- We observed clean equipment throughout surgical areas and completed cleaning records.
- 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. Wards 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.
- 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.
- Medicines requiring refrigeration were stored securely, with maximum and minimum temperatures recorded in accordance with national guidance.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately.
- Medication audits were undertaken on a monthly basis. Outcomes showed that the vast majority of prescriptions had illegible signatures.
- There were 108 medication errors 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 17 sets of medical records across eight surgical wards. We saw most files were appropriately completed, legible and organised. Most files checked were signed and dated, clearly stating named nurse and clinician. However, some files lacked dates and times. All files lacked medical GMC numbers.
- The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Most records we looked at were completed accurately. However, there were variations in the quality of recording and in completeness of some assessments such as NEWS risk assessments and sepsis screening tools. Staff we spoke with told us that they were aware of escalation procedures.

- We found that documents were loose in several files. Daily entries of care and treatment plans were clearly documented and care plans and charts we reviewed had observation charts and evaluations, with consent forms and mental capacity assessments where necessary.
- All records reviewed included a pain score and most had allergies documented in the notes.
- 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.

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 on the surgical wards 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.
- Nursing staff in the surgical core service achieved the 95% target for Safeguarding Adult's level 1 and Safeguarding Children Level 1; they did not achieve the target for other modules.
- Medical staff in the surgical core service did not reach the 95% target for mandatory safeguarding training.

Mandatory training

- Nursing staff within surgical care achieved the target for 95% compliance for health and safety, diversity awareness, manual handling level 1, mental capacity level 1 and health and safety level 1 training. Records showed 79% of surgical ward staff at Pinderfields General Hospital had completed governance information training. Additionally, 83% of staff had attended medication management level two, 83% infection, prevention and control training. Resuscitation training records showed 77% of staff had completed training, 77% of staff had completed fire safety training. The trust set a mandatory target of 95% for completion of mandatory training.
- Medical and staff in surgical care service did not reach the 95% target for any of the trusts core training. Completion rates varied from 85% for Mental Capacity Act Training Level 3 to 0% for MCA Level 2. However, there was only one member of staff eligible for this module. Records showed 80% of staff at Pinderfields General Hospital had completed health and safety training, with 60% having completed governance information training. Additionally, 61% of staff had attended medication management level two, 60% infection, prevention and control training. Resus training records showed 41% of staff had completed training, 80% had completed level one manual handling and 58% of staff had completed fire safety training.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and by trainer delivered sessions. Staff said they were supported with professional development through education and revalidation.
- Most staff we spoke with confirmed they were up to date with mandatory training. However, some felt they were behind with their training due to staff shortages.
- Staff said they had a robust induction mentorship and preceptorship programme.

Assessing and responding to patient risk

- The trust had recently introduced the National Early Warning Score (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 67% in the previous audit cycle. The sample audit was 325 patients. We were told that of a 104 of these patients who triggered escalation, 86.5% were escalated appropriately or had a plan in place.
- The Mid Yorkshire NHS Trust have been flagged as a mortality outlier for rates of septicaemia. The target is 90% of patients for both emergency and inpatient settings would be screened for sepsis, as per the national CQUIN guidance. The Trust achieved 98% for inpatient areas in 2016/17. Sepsis has been included in induction, mandatory training and continuous development for doctors and nurses and is promoted

through handover communications. An extensive Trust Wide awareness promotion campaign was launched to advertise use of the new sepsis screening documentation (December 2015).

- Risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments. Staff knew how to highlight and escalate key risks that could affect patient safety.
- A trust audit for Pinderfields General Hospital (November 2016) measured compliance with the 'Five Steps to Safer Surgery' procedure. This showed 97.4% compliance for the undertaking of the team brief before surgery. The audit also showed 91.4% 'time out' opportunities taken by all members of the theatre team to stop and listen to patient safety information. Debrief was recorded at 97.7% attendance rate. Theatre briefing were launched in December 2014.
- We observed the checklist being used appropriately in theatre, saw completed preoperative checklists, and consent documentation in patient's notes. On one occasion we saw checklist documentation had been fully completed indicating the surgical pause and debrief had taken place when we observed it had not.

Nursing staffing

- 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.
- As of 28th Feb 2017, the trust reported a vacancy rate of 10% at Pinderfields General Hospital for qualified and unqualified nursing staff. National and international campaigns were in place to address the recruitment gap. Sickness rates as of 28th Feb 2017 were 5%.
- The qualified nursing staff levels required across all surgical wards at Pinderfields General Hospital was 335.9 whole time equivalent (WTE) for March 2017. The number of qualified staff in post were 309.87 WTE. The areas with the largest staffing vacancies were in theatres (16.2 WTE), the plastics and burns surgical services (6.23 WTE) and gate 33 (4.17 WTE).
- The average divisional 'fill rate' was 90% for nursing staff and 100% for health care assistants. As at February 2017, the trust reported a turnover rate of 12% for all staff groups in the surgical division. Between March 2016 and February 2017, the trust reported a bank usage rate at Pinderfields General Hospital of 13%.
- The theatre staffing levels required was 92.04 whole time equivalent (WTE) for March 2017. The number of staff in post were 75.84 WTE across the trust.
- The lowest monthly level of agency usage for surgery was 10% in May 2016 and December 2016 and the highest monthly agency usage of 14% in July 2016, Aug 2016 and September 2016. The average level of agency use in theatres was 12% across the 12 month period from March 2016 and February 2017.
- In line with the rest of the trust, the division of surgery collects acuity data daily using an electronic application whereby the ward sisters indicates how many patients are at specified levels of acuity. They also enter "red flags" into the system to indicate any concerns such as falls, inability to respond to patients due to staffing levels etc. Staffing reviews were carried out annually, based on data from SafeCare and on clinical judgement based on activity and demand. There was a process in place for reassessing staffing levels when services changed. 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.
- The trust aimed to staff areas on a 1:8 ratio of qualified nurses to patients for general wards, with a co-ordinator outside of these numbers. The trust were moving towards "Care Hours per Patient Day" as a more informed methodology for providing care at peak times of demand but were not yet using this data in this way.
- 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.
- There were processes in place to move staff from other wards and departments when possible to ensure safe staffing levels. The trust also used agency staff to mitigate staff shortages.

Surgical staffing

- 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 trust reported a turnover rate of 6% and a sickness rate of 1% at Pinderfields.
- 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.
- 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.

Major incident awareness and training

- The trust major incident response plan was in place and available to staff on the trust intranet.
- 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.

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. The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- During 2015/16, 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. The trust reported that 129 surveys were completed and returned. The survey results 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.

However;

- There remained delays in sharing information and sending discharge letters to GP's within 24 hours. Performance data for 2016 showed 40% of letters had been sent, which was below the target of 90%. This had improved from the last inspection when data showed 25% of letters were sent within 24 hours.

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. The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- During 2015/16, 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 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, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place.
- An audit of pain management in the recovery room recommended the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief. Staff asked patients regularly if they had any pain, so they could administer analgesia promptly.
- 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 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 and returned. The survey results showed that overall 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 on each ward. 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 included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales. Information we saw recorded on patient files during inspection was good but variable in detail from file to file
- We observed 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 to all wards as required.
- Arrangements were in place for when enteral feeding was required out of hours as part of a protocol to ensure that patients did not have to wait a lengthy period.
- We saw a range of food choice, meals and snacks. Patients who required nutritional support were identified.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.
- We reviewed 17 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. On a site level, Pinderfields General Hospital has a higher risk of readmission for elective admissions and a lower risk of readmission for non-elective admissions.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.9%, which falls within the expected range. The 2015 figure was 5.5%. The proportion of patients having surgery on the day of or day after admission was 38.8%, which does not meet the national standard of 85%. The 2015 figure was 61.2%. The perioperative surgical assessment rate was 93.7%, which does not meet the national standard of 100%. The 2015 figure was 92.5%. The proportion of patients not developing pressure ulcers was 95.7%, which falls in the middle 50% of trusts. The 2015 figure was 90.4%. The length of stay was 20.9 days, which falls in the middle 50% of trusts. The 2015 figure was 21.6 days. The hospital met best practice criteria 38.2% of the time.
- According to the National Joint Registry Report covering 2016, the Pinderfields General Hospital had performed 156 hip and 100 knee replacements. Year to date, the hospital has undertaken 22 hip and 26 knee procedures.
- In the 2016 Bowel Cancer Audit, 81% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 80%. The risk-adjusted 90-day post-operative mortality rate was 5.4%, which was within the expected range. The

2015 figure was 2%. The risk-adjusted 2-year post-operative mortality rate was 18.9%, which falls within the expected range. The 2015 figure was 24.6%. The risk-adjusted 30-day unplanned readmission rate was 6.5%, which falls within the expected range. The 2015 figure was not recorded. 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 aggregate. This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level with better co-operation between hospitals within a network would be expected to produce better results.
- In the 2016 National Emergency Laparotomy Audit (NELA), Pinderfields General Hospital achieved an amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 119 cases. The Pinderfields hospital achieved an amber (50-79%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 86 cases. The Pinderfields hospital achieved an amber (50-79%) rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 65 cases.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2016 to March 2017, three indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Four indicators showed fewer patients' health improving and more patients' health worsening than the England averages, and four were in line with the England averages.
- Theatre utilisation at Pinderfields ranged from 72% to 106% during the period October 2016 to December 2016. The operating time is calculated as time between anaesthetic being induced and operating ending.

Competent staff

- At February 2017, the trust reported that 73% of nursing staff appraisals had been completed against a target of 85%. The percentage of medical staff appraisals within the surgical division was 80.1% completion rate against a target of 91%. We saw evidence to confirm appraisal rate data. There a plan in place to ensure that all appraisals would be completed. Staff told us that every effort was being made to meet the appraisal target as soon as practicable.
- Staff we spoke with felt able to discuss their training needs with their line manager. Many discussed opportunities to further their career and stated they were encouraged to undertake modules appropriate to their training needs. However, many felt continued professional development was limited due to staff shortage and an inability to attend development training.
- Support was provided for nursing revalidation by identifying expectations and continued education required.
- Junior doctors in surgery 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.
- Pinderfields General Hospital had simulators on site in the education centre, which allowed the training of doctors on knee arthroscopy. Within the consultant, team there was a training programme director for regional registrar training and junior doctors were taught core skills on the "Core Surgical Skills Course" every year. We were advised that Mid-Yorkshire Hospitals would be hosting the exit examination FRCS (Trauma & Orthopaedic) in February 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.
- 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.
- Staff advised that there were good working relationships between wards and 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 7 days per week at Pinderfields General Hospital.
- Staff explained to us that the wards worked with local authority services as part of discharge planning. We saw that discharge planning commenced at pre-assessment.
- We observed staff, including those in different teams and services, become involved in assessing, planning and delivering people's care and treatment.
- 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.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with the patient, their family, allied health professionals and the local authority when planning discharge of complex patients to ensure the relevant care was in place and that discharge timings were appropriate.
- There remained delays in sharing information and sending discharge letters to GP's within 24 hours. Performance data for 2016 showed 40% of letters had been sent, which was below the target of 90%. This had improved from the last inspection when data showed 25% of letters were sent within 24 hours.

Seven-day services

- 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.
- There was a 24 hour dedicated acute operating theatre, a daily all day trauma theatre, plastics theatre and a number of expedited acute theatre lists throughout the week.
- There were general surgery 'hot clinics' five days per week for ambulatory general surgery. The clinic was a dedicated clinic for those patients needing a review by the surgical team but who did not require an immediate admission to hospital.
- Pinderfields General Hospital ran Saturday clinics to provide joint injections.
- All surgical wards were looking at undertaking 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 for each ward available Monday to Friday. There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need.
- The Pharmacy Aseptic service and the Pharmacy Medicines Information service are provided during weekdays from 9am to 5pm. The Clinical Pharmacy services to wards are currently provided during weekdays from 9am to 5pm. From 1st April 2017, the Clinical Pharmacy service will be extended to include Saturdays, Sundays and Bank Holidays from 9:30 am to 4:30 pm for the PinderfieldS Medical Assessment Unit (Pinderfields General Hospital, Gate 12).
- An emergency drugs cupboard was available for access to medicines out of hours and an on call pharmacist is available for urgent advice and supplies when the pharmacies are closed.
- The elective orthopaedic service operated electively up to six days of the week. Elective admissions were planned based on consultant availability and complexity of the procedures. We found the trust had plans in place to increase the service with a daily extra theatre list and by extending hours at the weekend.
- The elective surgical ward had daily consultant led ward rounds, Monday to Friday.

Access to information

- 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.
- We saw surgical wards utilised a new electronic observation monitoring system. This allowed for immediate access by any other clinician or professional providing care for that patient. The system was not fully embedded but actively used on all surgical wards.
- 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.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found policy and procedures in place, ensured that capacity assessments and consent was obtained. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. However, most patients consented on the day of procedure.
- Mental Capacity Act (MCA) assessments were undertaken by the nurse or consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team. MCA and DoLS assessments were included in risk assessments.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The completion rated 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 effective as good because:

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Pain relief

- Patients told us they were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.

- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place.
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- The elective surgical ward had daily consultant led ward rounds, Monday to Friday.

Access to information

- 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.
- We saw surgical wards utilised a new electronic observation monitoring system. This allowed for immediate access by any other clinician or professional providing care for that patient. The system was not fully embedded but actively used on all surgical wards.
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Surgery

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- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The completion rated 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.

We rated caring as good because:

- The Friends and Family Test (FFT) response rate for Surgery at the trust was 31%, which was better than the England average of 29% between February 2016 and January 2017. At Pinderfields General Hospital, the response rate was slightly lower at 28%. The FFT results for patients who would recommend the trust was 97%.
- 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.
- 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.
- 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.

However;

- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2016). The results showed the surgical division at Pinderfields General Hospital scored 78.8% for providing privacy and dignity for patients and 66.5% for dementia care.

Compassionate care

- The Friends and Family Test (FFT) response rate for Surgery at the trust was 31%, which was better than the England average of 29% between February 2016 and January 2017. At Pinderfields General Hospital, the response rate was slightly lower at 28%. The FFT results for patients who would recommend the trust was 97%.
- 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 at Pinderfields General Hospital scored 78.8% for providing privacy and dignity for patients and 66.5% 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.

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to

them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out, and did their best to keep patients reassured.
- 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 should they prefer to.
- 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, offering individual detail to give that personalised approach.
- 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 took time to talk to them and explain processes and procedures to reduce any anxiety or worry.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially.
- 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 access to 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 and apoint of contact with the appropriate faith community, Christian and Muslim worship and prayers in the hospital chapels and prayer rooms, Holy Communion at the bedside by request 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 separated emergency and high risk surgery from routine surgery in September 2016 and all emergency (unplanned) surgery moved to Pinderfields General Hospital.
- Between December 2015 and November 2016 the average length of stay for Surgical elective patients at trust level, as well as at Pinderfields General Hospital, was lower than the England average.
- For surgical non-elective patients, the average length of stay was lower than the England average at all sites, and trust level.
- The National Cancer two week wait target of GP (General practitioner) referral to first appointment confirmed performance was 97.7% between February 2016 and January 2017 across the trust surgical division. This met national targets.
- For the period Q4 2014/15 to Q3 2016/17 the trust cancelled 726 surgeries. Of the 726 cancellations 1% were not treated within 28 days. The trusts performance has been consistently better than the England average for the period.
- Patients felt well informed about the procedure and what to expect during their recovery.
- Complaints were responded to in a timely manner and learning was taken forward to develop future practice. Information was available for families on how to make a complaint.

However;

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- We were informed of delayed discharges from the Post-Anaesthesia Care Unit **(**PACU) with some patients boarding for six to ten hours. On occasion patients were discharging from PACU home.

- Performance as of January 2017 was 70% for getting formal complaint letters to the Chief Executive Officer (CEO) within three days before closure with one breach that month. Telephone contact with patients making a complaint within three days was 53% in the same month.

Service planning and delivery to meet the needs of local people

- The Mid Yorkshire Hospitals NHS Trust runs a network of hospital services across three sites at Pinderfields, 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 emergency surgery. Further service changes are planned for 2017.
- The division of surgery business plan for 2017/18 to 2018/19 supports the division to develop a comprehensive, clear and logical operational plan, which delivers the trust strategic aims and links directly with capacity plans, workforce and finance, 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.
- The trust separated emergency and high risk surgery from routine surgery in September 2016 and all emergency (unplanned) surgery moved to Pinderfields General Hospital. This was undertaken to meet 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 to reduce infection risk.

Access and flow

- Between December 2015 and November 2016 the average length of stay for Surgical elective patients at trust level, as well as at Pinderfields, was lower than the England average at 3.1 days and 2.6 days respectively, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was lower than the England average at all sites, and trust level. At trust level, it was 3.1 days, at Pinderfields it was 2.9 days compared to 5.1 for the England average.
- 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 created 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 trust felt this action was helping with improvement.
- The National Cancer two week wait target of General practitioner (GP) referral to first appointment confirmed performance was 97.7% between February 2016 and January 2017 across the trust surgical division. This met national targets.
- The National Cancer two week wait target of GP referral to breast first appointment confirmed performance was 97.4% between February 2016 and January 2017 across the trust surgical division. This met the target of 93%.
- The National Cancer 62 days from diagnosis to treatment target confirmed performance was 82.2% between February 2016 and January 2017 across the trust surgical division. This did not meet with the target of 85%.
- 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.

Surgery

- For the period Q4 2014/15 to Q3 2016/17, the trust cancelled 726 surgeries. Of the 726 cancellations, 1% were not treated within 28 days. The trusts performance has been consistently better than the England average for the period.
- Cancelled operations as a percentage of elective admissions include only short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q4 2014/15 to Q2 2016/17 at the trust were lower than the England average.
- Theatre utilisation at Pinderfields General Hospital ranged from 72% to 106% during the period October 2016 to December 2016.
- The trust had created extra capacity beds in response to demand and capacity issues. Two extra beds were located on the general surgery ward which reduced space in the bay. We were advised this was a response to acute flow issues and not a long term plan.
- Two consultant led ward rounds were undertaken for general surgery per day to increase discharge and flow.
- The clinicians and management team plan to introduce ultra sound sonography provision on the Surgical Assessment Unit at Pinderfields General Hospital on a Monday to Friday basis. This would provide a 'one stop' session for patients that require an ultra sound and review with the general surgery team.
- The surgical division were recruiting a co-ordinator to support the active discharge of patients within the Pinderfields General Hospital bed base.Patient discharge had increased in urgency since the centralisation of the acute service in September 2016.
- We were informed of delayed discharges from the Post-Anaesthesia Care Unit **(**PACU) with some patients boarding for six to ten hours. On occasion patients were discharging from PACU home.

Meeting people's individual needs

- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.
- The surgical division applied the 'This is me' personal patient passport/health record to support patients with dementia. Plans were in place for all patients admitted acutely 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. There was a Band 7 dementia lead and two healthcare assistants who provided support and information for staff as necessary.
- We were told the trust had implemented and mostly embedded the Forget-me-Not Scheme across all areas of the surgical division and on discharge, home Forget-me-Not fridge stickers would be provided in the community and nursing homes.
- The surgical wards followed the Vulnerable Inpatient Scheme (VIP). The VIP symbol was used on the VIP hospital passport. The passport helped the hospital staff to understand the patients additional needs and was accessible in the patients notes and a VIP sticker was placed above the patients 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 Mid Yorkshire Hospitals trust had recently updated its translation and interpreting policy and have interpreting and translations services available to patients whose first language is not English. Patients were encouraged to ask a member of staff to help organise this for themselves and their families.
- We saw that surgical teams' personalised patient care in line with patient preferences, individual and cultural needs.
- There were no mixed sex accommodation breaches over a 12 month period.

Learning from complaints and concerns

- As of May 2017, there were 392 complaints about surgical division across the trust. There were seven high, 146 medium and 239 low level complaints. The trust handled 97.1% of complaints within timescales, with a target of 95%. There was an average of 8.79 complaints per 1,000 bed days as of January 2017. Orthopaedic surgery received the highest number of complaints overall (134) across all three sites.
- Performance as of January 2017 was 70% for getting complaint letters to the Chief Executive Officer (CEO) within three days before closure with one breach that month. Telephone contact with patients making a complaint within three days was 53% in the same month.

- Ward meetings discussed complaints received 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 and embedded 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.
- 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 they were be listened to.
- 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 department 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.

However:

- The staff friends and family survey results published Q2 2016/17 showed 44% of staff would recommend the trust as a place to work, with 32% not recommending the trust as a place to work. The response rate was 22%.

Vision and strategy for this service

- The Trust Board was responsible for the leadership, direction, control and risk management of the Trust. This included setting the strategic aims and ensuring that the necessary financial and human resources were in place for the trust to meet its objectives. The Trust Board was made up of voting and non-voting members, which included the Chief Executive, Non-Executive Directors and Executive Directors.
- 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 on a monthly

basis. The risk register, incidents, complaints and lessons learned were discussed and fed back. Matrons disseminated information with ward staff at ward meetings and safety huddles.
- 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. There was alignment between the recorded risks and what staff told us was 'on their worry list'. The main concerns were cancelled procedures due to staffing, not meeting four week standard for ophthalmology, ward 36 inability to sustain access and flow, failure to meet RTT's and risk to 62 day cancer performance.
- Governance meeting minutes evidenced regular risk register reviews.
- 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 the monitoring of 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

- The director of operations, deputy director of operations, divisional clinical director, director of nursing and quality, led the surgical division. The surgical division comprised of five patient service managers, five assistant patient service managers and one group manager.
- The team were involved in specific strategies, such as the hospital reconfiguration, to meet the challenges within the division and had signed up to the changes to facilitate improvements.
- At the time of inspection, the reconfiguration was in the early stages of implementation, impacting upon some areas but not fully embedded within the division.
- 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.
- Staff we spoke with told us that the new leadership of the service was better but required further improvement. Staff were happy with immediate line management but felt disengaged from senior leadership.
- Divisional matrons met regularly with the deputy director of nursing. Information from these meetings was shared with ward managers, clinical leads and ward staff as necessary.
- We were told that meetings were productive and accountable, with dissemination of progress and opportunity to interchange ideas. It was felt that the management team had 'done a good job' changing culture, communicating, making improvements, and managing engagement with medical staff.

Culture within the service

- During interviews with staff, they told us the division had strong leadership and most of the senior managers were more visible. We interviewed 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 spoken to were clear about their roles and responsibilities, were patient-focused, and worked well together.
- 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 generally, the organisation they worked for, staff morale was variable but had increased greatly in theatres with the advertising of new staffing posts.

Public engagement

- 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 Patient Advice Liaison Service (PALS). 'Tell us what you think?' questionnaires were available on all ward areas.
- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- The Friends and Family Test (FFT) survey (February 2017) was used to elicit patient feedback on how likely patients are likely to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Test performance (percentage response rate) was 97.5%. The response rate was 33.1%.
- Patients were very complimentary about the care and treatment received at Pinderfields General Hospital and were supportive of the services provided.

Staff engagement

- Staff friends and family survey results published Q2 2016/17 showed 61% of staff would recommend the Mid Yorkshire Hospitals NHS Trust as a place to receive care and treatment. Figures 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 staff friends and family survey results published Q2 2016/17 showed 44% of staff would recommend the trust as a place to work, with 32% not recommending the trust as a place to work. The response rate was 22%.
- 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 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.
- Outpatient tattoo clinics were created for breast reconstruction and scaring.
- The trust development and implemented a trauma dashboard for trauma and orthopaedics acute theatres to improve monitoring and flow. This helped to forward plan. A daily trauma meeting was held in which patients were discussed, issues of concern raised and a plan put in place and operations from the day before can be reviewed.
- The urology department had been working with the local Clinical Commissioning Group (CCG) for the last five years with an aim of keeping patients out of hospital whilst having their treatment. The local GP practices are involved and the trust monitors activity daily.
- There were many quality improvement projects underway 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 Pinderfields Hospital (PH) and Dewsbury and District Hospital (DDH). The division of surgery manages the service.

There is one critical care unit at Pinderfields Hospital. The unit is a combined level three (patients who require advanced respiratory support or a minimum of two organ support), level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) and regional burns unit. It is staffed to care for a maximum of nine level three patients, two level three burns patients and six level two patients. The unit has two bays of six beds and three side rooms. The two beds for burns patients are located across the corridor from the critical care unit on the regional burns unit.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April and 31 December 2016 there were 525 admissions with an average age of 59 years. Seventy eight percent of patients were non-surgical, 5% planned surgical and 17% 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 one patient, four relatives and 21 members of staff. We observed staff delivering care, looked at three patient records and three 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, continuity of care from consultants 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 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.
- Mandatory training was worse than the trust target in a number of areas, for example, medicines management, information governance and safeguarding adults and children level two training.
- 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.
- 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.
- Staff received a trust award for their high quality and compassionate care.
- 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 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.
- Antibiotics were not prescribed in line with national guidance, for example, none of the prescriptions included an indication or a stop date for the antibiotics.
- 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.
- Mandatory training was worse than the trust target in a number of areas, for example, medicines management, information governance and safeguarding adults and children level two training.

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, 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 Pinderfields 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 spoke with individual staff that reported incidents and shared lessons learnt from incidents by email and at staff meetings. The nurse in charge shared information from incidents at the safety briefing that nurses and doctors attended at the beginning of a shift.
- Staff we spoke with in the critical care outreach team told us they received feedback from incidents they submitted themselves but there was no process for them to receive feedback from incidents that had occurred on the critical care unit or on the wards. Members of the multidisciplinary team we spoke with told us information from incidents would be shared at the multidisciplinary team meeting. We reviewed two sets of minutes from the 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.

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 and labelled with the date it had been cleaned.
- 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 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 98 to 99%.
- 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.
- The level three burns beds were located on the burns unit, separate to the critical care unit.
- Staff checked the emergency equipment daily. The records for this were up to date and completed in line with the trust policy.
- 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 seven pieces of medical equipment; five were past the service review date. We discussed this with senior staff who told us the records for servicing of medical equipment were held by a different department.
- 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 unit did not have an adequate air exchange system. This had been identified by staff, recorded on the risk register and appropriate controls put in place. Major building work was required to rectify the problem which required the critical care unit to be relocated for a prolonged period of time. A project group had been set up to plan this.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- 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 the prescription of four antibiotics on three medication charts. Antibiotics were not prescribed in line with national guidance, for example, none of the prescriptions included an indication or a stop date for the antibiotics.
- We reviewed three prescription charts. Apart from the antibiotics prescription the rest of 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 68% of staff in the service had completed medicines management level two training. This was worse 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 74% 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.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Information provided by the trust showed 97% of staff on the unit had completed safeguarding adults level one training. This was better than the trust target of 95%. Sixty nine 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 99% of critical care staff had completed safeguarding children level one training. This was better than the trust target of 95%. Sixty three 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.
- Information provided by the trust showed that 92% of staff on the unit had completed resuscitation training and 93% of staff had completed practical manual handling 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).
- Senior staff had completed a staffing review and the establishment had been increased to meet GPICS standards, for example, to provide an additional supernumerary nurse as the unit had more than 10 beds, an additional nurse due to the number of side

rooms on the unit and to provide a 1:1.5 patient to nurse ratio for burns patients. At the time of the inspection the unit was unable to staff these additional posts due to vacancies.
- The unit displayed the planned and actual staffing figures.
- Information we reviewed during the inspection, showed the unit's establishment for registered nurses was three whole time equivalent (wte) band seven, 10.4 wte band six, and 54 wte band five.
- The service had15 wte vacancies cross site.
- The unit had one wte lead nurse, one wte trainee advanced critical care practitioner and one wte clinical educator who worked across site. This was in line with GPICS standards.
- The establishment at the time of the inspection allowed for one supernumerary coordinator who was a band six or seven. The service split the unit into two teams and each team had a nursing team lead, however, the team lead was not always supernumerary. 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, 85% in February 2017 and 71% in March 2017.
- The trust provided the planned and actual staffing figures for registered nurses on the unit for March and April 2017. 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 7.9%.
- Information provided by the trust showed the agency usage for registered nurses from December 2016 to March 2017 was between 0.7 and 16.4%. 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.
- 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 led by a consultant in intensive care medicine which was 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.
- 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.
- The patient to resident doctor ratio was not in line with GPICS standards out of hours as the ratio exceeded 1:8.
- 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.
- The unit had not completed a major incident or evacuation training session.

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.
- 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.
- We observed staff assessing pain using the trust scoring system and giving support to patients who required pain relief.
- The records we reviewed showed evidence that staff 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.
- 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 risk adjusted hospital mortality was 1.13. This was within the expected range.
- The ICNARC data from 1 April to 31 December 2016, showed the unit had a 0.5% unplanned readmission in 48 hours rate. This was better than similar units' rate of 1.2%.
- 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. This was better than the trust target of 90%. Staff we spoke with found their appraisal a useful process.

Critical care

- 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. A part time support educator role had been introduced who was based on the unit working with new staff and supporting the clinical educator with teaching.
- 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 (CCOT) 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, tissue viability and infection prevention and control.
- Staff completed three yearly updates on some medical devices, for example, infusion pumps. The records for equipment training and updates were not stored on the unit. 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 CCOT 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 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. The pharmacy was open seven days a week with a 24 hour on call service.

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.

Critical care

- Staff we spoke with showed an understanding of the Mental Capacity Act (MCA). They told us they would complete a capacity assessment and speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- Staff could access the MCA and deprivation of liberty safeguards (DoLs) specialist nurse for advice and support.
- We saw evidence in two patients' records that staff had completed a capacity assessment.
- 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%.

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 a trust award for their high quality and 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.
- We observed curtains being drawn around patient's beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- During our inspection we observed that all staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- The patient and relatives we spoke with told us staff were courteous and kind and they felt patients were safe and well cared for.
- A doctor had nominated a group of staff on the unit for the team of the week award as a result of the high quality and compassionate care they provided to a patient. The award was presented to the staff by the chief executive.

Understanding and involvement of patients and those close to them

- The unit offered open visiting.
- Patients and relatives we spoke with told us all staff introduced themselves and explained their treatment in a way they could understand.
- 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 had access to a 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 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.

Critical care

- 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 non clinical transfers 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.
- 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 out of hours discharge to the ward 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 critical care operational delivery network.
- Critical care provision was flexed to meet the differing needs of level two, three and burns 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.
- 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 service was piloting a critical care patient and relative support group at Dewsbury and District Hospital. At the time of the inspection this was not available at Pinderfields Hospital.

Meeting people's individual needs

- The unit had a spacious visitors' waiting area which contained information and leaflets for visitors, drink making facilities, a television and radio. There was a separate room for staff to meet with relatives for private conversations.
- The unit had two rooms with en-suite facilities available for overnight accommodation for relatives.
- 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 encouraged relatives and carers to stay with the patient to assist with care and communication. 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 and had not experienced delays to patient care.
- A visitors information booklet was available in the waiting area and gave unit specific information about staff, car parking, a glossary of frequently used terms and photographs of the bed space and equipment with easy to understand explanations.

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 0.6% of patients due to non-clinical reasons. This was in line with similar units' rate of 0.4%.
- The ICNARC data from 1 April to 31 December 2016 showed the bed days of care post eight hour delay rate was 2.3%. This was better than similar units' rate of 6.9%.
- The ICNARC data from 1 April to 31 December 2016 showed the bed days of care post 24 hour delay rate was 1.1%. This was better than similar units' rate of 4.5%.
- The ICNARC data from 1 April to 31 December 2016 showed the out of hours discharge to the ward rate was 3.1%. This was worse than similar units' rate of 2.2%.

Learning from complaints and concerns

- The unit displayed information on how to make a complaint.
- The unit had received three 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.
- 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 recorded on the risk register, for example, the non-compliance with some of the Guidelines for the Provision of Intensive Care Services (GPICS).
- 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.
- Staff on the unit were supporting senior staff from Dewsbury and District Hospital's critical care who 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 merge with Dewsbury and District 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 the ventilation system in critical care and not meeting the standards for clinical education on the unit. We did not see evidence that the areas of non-compliance with GPICS 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 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.
- Staff morale was affected by the movement of staff from the unit to cover staffing vacancies on the ward. Staff understood the reasons that this was done and felt

supported by the senior staff in critical care. They acknowledged the process was managed fairly by senior staff on the unit and staff moves were recorded in a diary.

Public engagement

- The unit displayed thank you cards from recent patients and relatives.
- In the waiting area there was a relative feedback sheet requesting information about one thing the unit did well and one thing that could be improved.
- A 'you said, we did' board was on display in the waiting area. Examples of changes staff had made in response to this feedback was patients felt disorientated and did not know the time of day so clocks had been placed to be visible to all patients on the unit. Relatives felt the private room in reception was bare and not pleasant to sit in when speaking with doctors; the room had been refurbished and felt warm and welcoming.
- 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 engagement

- Staff we spoke with told us communication on the unit was good, they received information by email, at handover and on the notice board in the staffroom.
- Staff told us engagement had improved, for example, staff felt managers were more open regarding the acute hospital reconfiguration and shared information with staff in a more timely manner.
- The unit held staff meetings every two to three months. We reviewed the minutes from the meeting and saw evidence that incidents, infection control, education and movement of staff to the wards were examples of topics discussed.

Innovation, improvement and sustainability

- The service was actively involved in the regional operational delivery critical care network.
- The service had one advanced critical care practitioner and had recruited to trainee posts.
- Staff on the unit had been nominated for, and won some trust awards; for example, the support staff gave to newly qualified nurses, the excellent front of house the ward clerk team provided and for the compassionate care staff provided to an extremely unwell patient.

Maternity and gynaecology

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

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 inpatient and obstetric led maternity services were amalgamated on the Pinderfields General Hospital site. There are two stand-alone midwifery led birth centres at Pontefract General Hospital and Dewsbury and District Hospital, there is also an alongside birth centre at Pinderfields General Hospital.

The trust offered a range of services for women and families at the Pinderfields General Hospital site. These included, early pregnancy and gynaecology assessments, antenatal and postnatal inpatient care for women with low-risk pregnancies; to specialist care for women who need closer monitoring; antenatal day unit, maternity triage and enhanced recovery following planned caesarean section and high dependency care. The gynaecology service also saw emergency admissions. However, there was no specific gynaecology ward and patients were admitted to female surgical wards. The service did not undertake any termination of pregnancy.

Between April 2016 and April 2017, there were 4,793 babies born in the consultant led unit. Between September 2016 and April 2017, there were 492 babies born in the alongside birth centre.

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

During this inspection, we visited antenatal clinic, early pregnancy assessment and gynaecology assessment unit, antenatal day unit, triage unit, birthing centre, ward 34, ward 18 (antenatal/postnatal) and labour suite. We review 17 health care records, 16 prescription records and spoke with 16 patients, nine relatives, 34 staff including midwives, nurses, student midwives, health care assistants, ward clerks, volunteers and receptionists. We also spoke with eight medical staff.

Maternity and gynaecology

Summary of findings

The overall maternity and gynaecology rating from the 2015 inspection was good. Actions the trust was told it 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.

Following the May 2017 inspection we rated the service as requires Improvement because :

- Midwifery staffing was below nationally recommended levels, at 1:31. Following our previous inspection the service reviewed staffing using a recognised acuity tool and this identified a shortfall of 18 WTE maternity staff.
- Attendance of midwifery and medical staff at obstetric emergency training was below required levels.
- Since the reconfiguration of services at the Pinderfields site, staff told us there had not been any skills and drills in clinical areas namely the birth centre and ward 18. There was also a lack of clinical audit since the reconfiguration of services.
- 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.
- Staff voiced concern about the monitoring of vulnerable women on the antenatal and postnatal ward; this was due to a lack of ward rounds by some consultants.
- The risk register contained a large number of risks, and many had a review date in the past. This led to concern that there was a lack of oversight by senior managers.

However:

- The service had successfully reconfigured to provide consultant-led maternity care on one hospital site.
- Following our previous inspection there were robust practices in place to check emergency equipment.
- The service had successfully bid for Department of Health Safety training and had allocated the funding appropriately.
- We found good multidisciplinary working between midwifery and medical staff.
- Women were positive about the care they received; 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.
- The community midwifery caseloads were the same as national recommendations, and the services had plans in place to improve midwifery staffing by 2020

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.
- Audit results showed documentation for peri-operative care pathway and safe surgical checklists were not being fully completed by medical and theatre staff.
- Data provided by the service showed poor attendance at mandatory obstetric training for both hospital midwives and medical staff.
- There were no visual signs of electronic safety checks on equipment.
- Action plans were not completed following mortality and morbidity meetings.
- Midwifery staffing was worse than national recommendations.

However:

- There were good infection prevention and control practices observed, and actions taken when the number of maternal infections increased.
- There were robust processes in place to check emergency equipment.
- The service had plans are in place to improve midwifery staffing.
- Community midwifery caseloads were in line with national recommendations.
- There was a lack of assurance in relation to medical device competencies, however, this was due to the number of responses and the trust was working to improve this.

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 including near misses. 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, three serious incidents were reported in women's services compared to two in 2014/15. We saw these related to a neonatal death, a stillborn baby and failure to recognise the extent of perineal damage. A root cause analysis (RCA) had taken place in all cases, which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important lessons are learned to prevent the same incident occurring again. Action plans and recommendations were shared with all staff. This was by e-mail, face-to-face communication, in team meetings and the weekly safety brief, which was discussed during handover.
- Between March 2016 and February 2017, there were 1,623 incidents reported by women's services. The obstetric service reported 1,509, of these 1,185 incidents were reported as no harm, 306 were reported low harm, two were reported as minor and13 moderate harm. However, 12 were additionally identified as short term harm caused and three were identified as severe harm. Themes identified included staffing and the reporting of obstetric emergencies (e.g. post-partum haemorrhage over 1000mls). The gynaecology service reported 114 incidents, 98 were categorised as no harm, six were reported as low harm and 10 were reported as moderate harm. There were no specific themes identified.
- We saw evidence of specific learning events and investigations posted in clinical areas for staff to review. 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 that the service was not associating amendments in practice with incidents and informing the staff of this. This meant the service was learning from incidents, but, were not informing staff why practice had changed.
- 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 the bulletin discussed at midwifery and medical handovers and displayed in clinical areas. Staff we spoke with informed us that this was usual practice.
- Obstetric and neonatal staff attended quarterly perinatal mortality and morbidity meetings. We reviewed minutes of meetings from May 2016 to January 2017 and found examples of case reviews and discussion highlighting notable practice and areas of improvement. There were no recommendation of changes to practice and actions plans arising were not completed.
- We spoke to staff that 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.

Safety thermometer

- The service used the national maternity safety thermometer. This allowed services check on harm and record the proportion of mothers who had experience harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, postpartum haemorrhage and infection, babies born with a low Apgar score (a method used to summarise the health of a newborn) and patient's perception of safety.
- 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. The maternity unit was visibly clean and all staff reported they had infection prevention and control training. Trust policies were adhered to in relation to infection prevention and control; these included hand hygiene and arms bare-below-the-elbows.
- 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 Methicillin-Sensitive Staphylococcus Aureus (MSSA).
- In November 2016, maternity services identified an increase in postoperative infections. This included six cases of sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). We found the service had undertaken a thorough investigation with the infection prevention and control group, developed an action plan and monitored progress.
- All clinical areas were visibly clean and well organised.
- We saw 'I am clean' stickers on most equipment.
- We found fully completed cleaning rotas in clinical areas. However, we found inconsistent weekly cleaning rotas in antenatal clinic and there was no evidence of daily cleaning in the triage unit.
- 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.
- There was adequate equipment on the wards to ensure safe care – specifically, cardiotocography (CTG), resuscitation equipment and directional lights. Staff confirmed they had sufficient equipment to meet patient needs.
- The birth centre had six en suite rooms. Two of these rooms were used for parents to stay overnight prior to and/or following delivery. The remaining four rooms were used for midwifery led births, two of which had birthing pools.
- The labour ward had 13 en suite delivery rooms. One room had a birthing pool and telemetry CTG monitoring. This meant that high-risk women would be able to labour in the pool. It also had an electronic ceiling hoist, which could be used to evacuate the pool in an emergency. The labour ward had three theatres, one for elective and two for emergency caesarean sections.

There was a four bedded enhanced recovery bay for women following elective caesarean, and a four bedded recovery bay for women for women following emergency caesarean and two high dependency beds.

- There was a dedicated room away from the labour suite for women and their families who had experience a stillbirth. This room was sympathetically decorated but elements for example a clinical bed, meant it remained a clinical space.
- The triage unit had five couches divided by curtains. The waiting area for the triage unit was in the corridor just before the doors to the unit. Staff recognised this was not ideal but the service was tied to the physical footprint of the building. Staff could observe this waiting area using closed circuit television surveillance (CCTV). The CCTV did not cover the whole of this seating area; there were no signs to advise those waiting what to do in an emergency.
- The day assessment unit had five couches and chairs, divided by curtains.
- We observed electronic equipment and found a large amount of equipment showed no visible evidence of electronic safety checks. We raised this concern with staff who informed us infection prevention and control (IPC) had advised stickers were an IPC risk. However, information received from the trust indicated that all electronic equipment should have visible evidence of safety testing displayed.
- The early pregnancy assessment (EPAU) and gynaecology assessment unit (GAU) was a self-contained unit had one scan room, three clinic rooms and an assessment room. There was a waiting area adjacent to the reception desk, which enabled staff to observe women who were waiting.
- The labour ward had a fetal blood analyser and calibration and quality control records were complete. All delivery rooms in the birth centre and labour ward had piped Entonox® (Nitrous Oxide and Oxygen). The triage unit, EPAU and GAU had access to mobile Entonox®.
- 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.

Medicines

- We reviewed 16 prescription charts and found them completed in line with trust policies.
- The service had undertaken an antimicrobial audit and results showed that 88% (8) peri-operative patients had received the appropriate antimicrobial prophylaxis in line with Trust guidelines. It also showed 100% of patients had received antimicrobials within the appropriate period.
- 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 and action taken when the fridge had gone out of range. During our unannounced inspection, we observed staff attending the ward and escalating concerns observed from the weekend. Staff had quarantined all of the drugs in line with trust policy.
- Records showed the administration of controlled drugs were subject to a second independent check. After administration, the stock balance of an individual preparation confirmed to be correct and the balance recorded.
- Records showed controlled drugs were checked in line with trust policy. However, we found two occasions on the birthing centre where the drugs had not been checked during between the handover of staff. We raised this concern with senior staff, and were assured that appropriate action had been taken to reduce the risk of a reoccurrence.
- There were processes in place to record all medicines supplied 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.
- Women carried their own records throughout pregnancy and postnatal periods of care.

- We reviewed 19 medical records found that antenatal risk assessments were not always completed (four records).
- The service completed bi-annual record keeping audits. We reviewed the audit undertaken between June and November 2016, where 242 antenatal, intrapartum (Labour) and postnatal records had been checked. We found 17% (n29) of the areas assessed were not compliant. 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%)
  - 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 records in January 2017.

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 safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns. Staff told us 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 a trust target 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. Hospital based midwives were offered safeguarding 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. This was above the trust target of 95%.
- The organisation had anInfant abduction policy for maternity services. There was a video call entry system onto the unit with a green 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. Babies stayed with mothers at all times. When mothers and babies transferred between wards staff undertook a formal handover using the situation, background, assessment and recommendation (SBAR) tool, this included checking the baby identification bracelets.

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 49% of hospital midwives and 86% of community midwives between April 2016 and March 2017 had attended this training against a target of 85%.
- Medical staff attendance at YMET training was monitored through appraisal. However, between April 2016 and March 2017, 38% of the consultant body were recorded as attending the study day. This had been escalated to the head of clinical service; however, we were not told what actions were being taken against a target of 85%.
- 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 two days of mandatory training. We reviewed data, which showed 88% of midwives, nurses, and HCAs allocated attended day one of the mandatory training and 82% of staff attended day two of the mandatory training this was worse than the trust target of 90%.

Assessing and responding to patient risk

- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in theatres of a trust wide World Health Organisation (WHO) surgical safety checklist. The service did not use the maternity specific WHO checklist but had developed their own version of the checklist. Staff we spoke with were aware of this document.
- Audits undertaken in 2015/2016 and 2016/2017-showed documentation for peri-operative care pathway and

safe surgical checklists were not being fully completed by medical and theatre staff. We reviewed four safe surgery checklists and found three of them were not completed appropriately.

- Midwifery staff identified women showing signs of early deterioration by using an early warning assessment tool known as the Modified Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed 14 records and saw all contained appropriately completed MEWS tools.
- 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.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review electronic foetal heart rate tracings, which indicated a proactive approach in the management of obstetric risks. We reviewed 11 patient records and found fresh eyes were documented in nine showing a compliance of 82%.

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 whole time equivalent maternity staff. The service had plans in place to recruit to these posts between 2017 and 2020.
- We found staffing levels displayed on each ward we visited. We reviewed staff "off duty" and found a correlation between planned versus actual staffing numbers. The birth centre had a floating midwife on every shift that would be the nominated to go to labour ward if needed.
- Community midwifery caseload numbers were reported as being 1:98 which was in line with national recommendations
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported the percentage of women given one-to-one support from a midwife was good.
- The service had a break midwife who covered staff for lunch breaks during the day. This supported the provision of 1:1 care in labour. Between April and December 2016, 1:1 care in labour was an average of 93% this was above the trust target of 80%.
- 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, this provided continuity.
- We observed handover on both the labour ward and ward 18. Both midwifery handovers were clear and concise. Ward 18 used a recorded handover and labour ward began initially with handover between coordinators and then midwifery staff were allocated patients where they then had a 1:1 handover with the midwife on the previous shift.
- The service had registered nurses as part of the theatre and high dependency team. They were supported midwifery colleagues.

Medical staffing

- The delivery suite had consultant cover 98 hours per week. This was based on an onsite consultant presence for 14 hours a day seven days a week. This was in line with recommendations in Safer Childbirth (2007)
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours' work when they were on call. There was a separate consultant-on-call rota for gynaecology; this meant there was a second consultant on site in emergencies if needed.
- Multidisciplinary ward/board rounds took place at 8.00am and 8.00pm for all women and review of critical care women as their condition dictated. The labour ward coordinator also took part in the medical handovers.
- Consultants discussed complex cases as required and provided cover for annual leave if needed.

- There was a dedicated anaesthetic team for elective caesarean sections. There was a separate team for emergency caesarean sections and epidurals as required. Anaesthetists took part in the medical handover at 8.00am.

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.
- 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. Staff reported skills and drills had not been carried out on the birthing centre since it had opened in September 2016. However, plans were in place to begin a full programme of skills and drills following our inspection.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- There was not a regular programme of skills and drills in all areas of the obstetric department.
- Internal audit showed that compliance with the completion of consent forms was poor.
- The caesarean section rate was worse than the trust target, additionally both the rates of emergency and elective caesarean sections were worse than the England average.
- The induction rate was worse than the England average.
- MBRRACE-UK identified the perinatal mortality rate was 10% lower than trusts of the same size and demographic.
- The numbers of mothers experiencing post-partum haemorrhage was worse than the trust targets.
- The results of the General Medical Council National Training Scheme Survey 2016 showed educational and clinical supervision, induction and adequate experience for junior doctors needed to improve.

However:

- 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.

Evidence-based care and treatment

- From our observations and through discussion with staff we saw 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.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32.
- 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.
- There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU) and a transitional care ward, which was staffed jointly by neonates and maternity.
- We were told staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. However, 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 guidelines.
- We found the care of women using the services were in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.

- The unit was implementing the NHS funded Saving Babies in North England (SaBiNE) which was a care bundle for stillbirth 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 amalgamation of services on the Pinderfields site we found a lack of additional audit activity. For example, there were no pain audits, the number of women reviewed in 30mins of arrive to the unit and time to consultant review.

Pain relief

- Women received detailed information of the pain relief options available to them, this included Entonox piped directly into the delivery rooms.
- The obstetric led unit had a birthing pool, with a ceiling hoist in case of emergency. Women who required additional monitoring during labour were also able to use this pool.
- The service provided a 24-hour anaesthetic and epidural service.
- From April 2016 to March 2017, the percentage of women given epidurals during labour ranged from 16.6% to 20.2% with a mean of 18.4%, which was better than the national average (20.7%).
- The birthing centre had had two birthing pools and equipment to support active labour. Pharmacological pain relief options included diamorphine and meptazinol (meptid). Women attending the birthing centre who requested epidural analgesia were transferred to the labour ward.
- The trust did not undertake pain relief audits or collect this data.
- The service did not actively promote alternative therapies for example hypnobirthing. We were told they supported women who chose this method of pain relief and one member of staff had been trained across the service.

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 national average at 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.
- 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 throughout their stay on the ward.
- The choice of meals took account of individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.
- The service had introduced a token system to identify which women were able to have a hot meal whilst on the labour suite.

Patient outcomes

- Between April 2016 and March 2017, the service reported a trust wide caesarean section rate of 25.4% which is better than the 26.2% target set by the service. Emergency caesarean section rates where 15.5%, which was equal to the trust target of 15.2%. For elective caesarean sections the service achieved 9.9%, which was better than the England average of 11% The instrumental vaginal delivery rate was equal to the England average at 13%.
- Between April 2016 and March 2017, the trust wide induction of labour rate was 32.7% this was worse than the England average of 24%.
- Trust data showed the antepartum stillbirth rate over 24 weeks between April 2016 and March 2017 as 24. This is equal to the number in the previous financial year. The service dashboard showed that there were nine stillbirths at term. This was worse than other comparable trusts. Data for April 2016 to March 2017 showed there were four neonatal deaths.
- The service was identified by MBRRACE-UK (2017) as having a perinatal mortality rate which was 10% lower than the average for trusts of the same size and demographic. This was in improvement from the

previous MBRRACE-UK (2016) report, which, showed a stabilised and extended perinatal mortality rate, which was 10% higher than the average for trusts of the same size and demographic.

- Between April 2016 and March 2017, 10% of mothers birthed had a blood loss measured at greater than 1000ml. Of the women birthed during this time 0.6% of women experienced, a life threatening blood loss of 2500mls or more.
- During 2014 to 2015, the services reported an average of 4% of avoidable repeated newborn blood spot tests, which was worse than the national indicator at 2%.
- The service achieved a trust wide normal vaginal delivery rate of 63%, which was better than the national average of 60%.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2015 indicated the location achieved 100% compliance with temperature taking of babies born at less than 28 weeks and 6 days. The unit scored 83% for the percentage of mothers given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6-week's gestation. This was worse than the NNAP standard of 85%. The unit scored 33% for the proportion of babies born at less than 33 weeks gestation who were receiving any of their own mother's milk at discharge from the neonatal unit.
- The number of 3rd and 4th degree perineal tears was 2.4% of mothers birthed between April 2016 and March 2017, this was better than the trust target of 3%.

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, eclampsia and neonatal life support.
- Newly qualified band 5 midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. Staff reported the level of support and training was "good".
- Some staff told us that had not taken part in real time skills and drills training on the labour suite and birth centre.
- There was minimal to no rotation of staff around all areas of the service. We were told plans were being developed to facilitate this. Labour ward managers were being rotated to ward 18 to improve their understanding of the constraints on the antenatal and postnatal ward.
- Revalidation was part of appraisal process for medical staff. Staff we spoke with reported no difficulty in getting an appraisal done.
- 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 be called for independent advice and support as required.
- The results of the General Medical Council National Training Scheme Survey 2016 showed educational and clinical supervision, induction and adequate experience for junior doctors needed to improve; there was no evidence of an action plan to address this.
- The service had successfully bid for department of health safety training funding and were in the process of allocating courses for staff such as the advanced obstetric life support (ALSO), neonatal life support (NLS) and critical care courses. There was some confusion between staff regarding who was prioritised for training.

Multidisciplinary working

- There was good multidisciplinary working. All staff, including those in different teams and services, were involved in assessing, planning and delivering women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as foetal medicine.
- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.

- 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.
- Patients and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals, medical and surgical specialities to support women during pregnancy and childbirth.

Seven-day services

- An obstetric theatre team was staffed and always available.
- There was medical staff presence on the labour ward and triage unit 24 hours a day, with consultant presence 14 hours a day.
- The early pregnancy service and gynaecology assessment was open Monday to Friday 08.30 – 17.00 with 20 appointment slots a day and allowance for walk in appointments. There were plans in place to increase the EPAU/GAU to a seven day service.
- The triage unit was open 24 hours a day, seven days a week.
- The antenatal day unit was open 07.30am to 8.00pm Monday to Friday.

Access to information

- 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.
- Copies of the delivery summary were sent to the GP and health visitor to inform them of the outcome of the birth episode.
- Results from investigations were easily available throughout the trust via an electronic system. There were mobile computer stations which would allow results to be viewed by the bedside.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- The service carried out an audit of 20 consent forms in 2016 in obstetrics and gynaecology. 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%); and Clinician contact details (Obstetrics 10% Gynaecology 0%).
- We reviewed ten consent forms and found them to be completed appropriately.
- Staff had a good 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.

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, 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.

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.

Maternity and gynaecology

- Women using maternity services told us that they had named midwives, 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 staff at Pinderfields General Hospital (PGH) caring but that her community midwife was very difficult to deal with and made her feel very uncomfortable.
- Women admitted for gynaecological surgery were cared for on ward 34, which was a mixed speciality, surgical ward. At the time of our inspection, only one gynaecology patient was being cared for. She described staff on this ward as caring and supportive.
- The population served by PGH was culturally and ethnically diverse, and women attending the hospital and birthing centre during our inspection were from a variety of backgrounds. None of the women we spoke with expressed any concern about staff understanding of their personal, cultural, social, or religious needs.
- We observed staff in the midwifery-led birthing centre, in the antenatal and gynaecology clinics, and on the wards interacting with women, their partners, and other relatives in a polite, friendly, and respectful manner.
- From February 2016 to February 2017, the FFT (antenatal) performance (% recommended) was worse than the England average, the trust's performance for antenatal was 87%; the national average was 96%.
- From February 2016 to February 2017, the FFT (birth) performance (% recommended) was worse than the England average, the performance for birth was 95%; the national average was 97%.
- From February 2016 to February 2017, the FFT (postnatal ward) performance (% recommended) was worse than the England average, the trust's performance for postnatal ward was 91%; the national average was 98%.
- From February 2016 to February 2017, the trust's Maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average. In February 2017, the trust's performance for postnatal community was 92%; the national average was 94%. The percentage recommended for this trust showed a decline in August 2016 that was rectified by September 2016.
- The trust performed about the same as other trusts for all of the 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, birth, and postnatal periods. We observed staff involving women in the planning of their care, and the women we spoke with said they felt involved in their care and understood choices available to them.
- Women were encouraged to visit the Pinderfields 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 PGH 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 Pinderfields Birth Centre.
- We spoke with women at the antenatal and gynaecology clinics and shadowed some of them throughout their visit to PGH. They told us that they found staff helpful and caring and they understood what had been explained to them and what was to happen next. We observed staff giving clear and appropriate explanations, checking understanding, and reassuring women who were worried or distressed.

Emotional support

- A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss.
- 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.
- The trust had a perinatal mental health pathway which included antenatal and postnatal assessments for anxiety and depression. This also included referral pathways 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.
- There was a dedicated room available for bereaved parents. However, we observed that this was a very clinical environment and so was not especially suitable for caring for grieving families.
- Guidance was available for the management of foetal loss under 24 weeks, and direct support was also available to staff from the relevant team within pathology. Standard operating procedures were in place for the sensitive disposal of foetal and placental tissue.

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.
- Pinderfields General Hospital (PGH) labour ward offered outpatient inductions for women with low-risk pregnancies, allowing them to choose to begin labour at home if they preferred.
- The trust had held a listening workshop for new mothers and staff aimed at improving the experience of all women using its maternity services. An improvement plan was being implemented.
- There was a dedicated 'flow midwife' within the maternity service at PGH.
- 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 no evidence that the varied needs of the diverse populations served by PGH were prioritised by the service.
- All written information we saw was in English and not all staff were aware that information in other languages was available on the intranet.

Service planning and delivery to meet the needs of local people

- The maternity service at PGH provided both consultant-led and midwifery-led care via an antenatal service, including pregnancy screening, clinics, and an antenatal day unit, maternity triage, a labour ward, antenatal and postnatal wards, and a midwifery-led birthing centre. The premises and facilities at PGH were appropriate for the services provided there.
- 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.
- 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 provided an outpatients clinic and both planned and emergency gynaecological surgery and procedures. There were a number of nurse-led and consultant-led clinics.
- The population served by PGH was culturally and ethnically diverse, and women attending the hospital and birthing 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 of their personal, cultural, social, or religious needs.
- 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 trust had introduced open visiting within the maternity service in March 2016, in line with the rest of the organisation. Staff told us that this had had a positive impact for most patients and their families. The facility for partners to stay with mothers and newborn babies in the birthing centre remained in place. However, in January 2017, the trust had decided to restrict overnight visiting on the hospital wards to those accompanying women whose clinical/social circumstances suggested a particular need, in order to lessen impact on other patients.
- There was a milk kitchen on the postnatal ward. This provided a dedicated space for families to prepare formula milk for their babies away from the traditional pantry. The milk kitchen was used to give families privacy, one-to-one demonstrations, and opportunities to ask questions, in order to support good artificial-feeding practice.
- The service worked with community services and public health to provide continuity of support for breastfeeding once women had left the hospital. The trust supported three local, volunteer-run, weekly, breastfeeding cafes, which women could attend for support and advice.

Access and flow

- From July 2015 to December 2016, bed occupancy levels for maternity across the trust were generally higher than the England average, with the trust having 89% occupancy from October to December 2016 compared with the England average of 88%.
- From April 2016 to March 2017 the average monthly transfer rate from the Pinderfields Birthing Centre to the labour ward was 42%. Staff told us that all reviewed transfers had been clinically appropriate and that 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 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.
- The service had a 'flow midwife'. This senior midwife monitored flow across the maternity department, including staffing. Staff told us that this was a very helpful role.
- From April 2016 to March 2017, the maternity service at PGH was closed on four separate days. The closures were due to capacity issues in the neonatal unit, workload, capacity, and/or acuity issues on the labour ward. Staff told us that Pinderfields Birthing Centre closed whenever the consultant-led service was closed to ensure that there was no risk of being unable to transfer any woman who might develop the need for obstetric care.
- The hospital did not monitor the percentage of women in labour seen by a midwife within 30 minutes of arrival. However, at the birth centre it was normal practice for midwives to greet women immediately on arrival, and none of the women we spoke with said that they had been left unattended at any time.
- The hospital did not monitor the percentage of women in labour seen by a consultant within 60 minutes of arrival.
- 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 mean monthly percentage across the trust for that year was 90.5%.
- We found that the flow of the antenatal clinic was disjointed and staff were task-orientated.

Meeting people's individual needs

- A 'Birth Matters' clinic, promoting normal birth, was held at PGH 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.
- PGH labour ward offered outpatient inductions for women with low-risk pregnancies, allowing them to choose to begin labour at home if they preferred.
- Some midwives we spoke with expressed concern about the lack of ward rounds by some consultants on the antenatal and postnatal wards. This led to concern about sufficient provision of care for vulnerable women.
- Named midwives were responsible for providing support and ensuring policy implementation in areas such as substance misuse and the reporting of female genital mutilation.

Maternity and gynaecology

- 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 in March 2017.
- There was a weekly, specialist, antenatal clinic for women with diabetes. A midwife and 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 for women with learning disabilities in the 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.
- Translation services were available in person and via the telephone. Staff we spoke with assured us that they would never rely upon patients' friends or family members to translate. Furthermore, we saw evidence, following an RCA, that staff used professional, independent, translation services to communicate with patients who did not speak English.
- Leaflets on display were in English only. Staff told us that these could be requested in other languages, but there was no notice to inform patients about this.
- The trust reported that the percentage of babies examined under NIPE criteria within 72 hours of birth was 98%, which exceeded NIPE's acceptable performance figure of 95%.

Learning from complaints and concerns

- Leaflets explaining the complaints process were available. 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 38 complaints relating to maternity services at PGH from March 2016 to March 2017. Of these, six were upheld, 27 were partially upheld, and five were not upheld. Themes identified included staffing levels and poor attitudes of some members of staff.
- 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 directed that one-to-one feedback should be given to staff who had been directly involved in any matter triggering a complaint. Those staff should then be given an opportunity to reflect and supported to undertake any additional learning needed.
- The head of midwifery told us that, although learning from complaints was disseminated amongst staff, the service did not necessarily make it clear to staff when practice had changed following the addressing of a complaint.
- Following complaints from patients surrounding their privacy and dignity when partners had been allowed to stay on the postnatal ward at PGH overnight, the trust had decided to restrict overnight visiting to those accompanying women whose clinical/social circumstances suggested a particular need, in order to lessen impact on other patients.
- We were advised that a 'hot couch' dedicated to speeding up triage had been introduced following a

complaint about the impact of a very long waiting time. However, staff advised us that in practice this was not a good solution, as some women assessed on the hot couch would subsequently stay there because their conditions indicated that they should not be moved, meaning that the couch was no longer available for triage.

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 Committees based in Wakefield and 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:

- We observed the head of midwifery was visible on the consultant led unit and attended for handover at times, however, we were told she 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 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) and matrons were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff we spoke with informed us the matrons worked clinically if needed. Staff told us the HOM was visible on the consultant led unit. However, we were told they were not seen on the birthing centre often. Staff were clear about who their manager was and who members of the senior team were.
- Staff we spoke with informed us the consultant body would take into account the views of all staff in the care of women. This was dependant on where the midwives had worked previously; midwives originally from Pinderfields felt more confident to challenge the Pinderfields consultants and likewise for those who had transferred from Dewsbury and District Hospital.

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 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 met monthly to discuss outcomes 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 risks to the service. 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. There 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) with existing controls and identified gaps and action necessary. 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 this action plan 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 that 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 team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered. Some junior doctors commented that at times, the needs of speciality trainees were prioritised over GP trainee doctors. Although it was a big unit with complex patients, they said it was a "good" to work in.
- 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.
- We spoke with newly qualified band five nurses who felt fully supported through the induction programme and senior staff were eager to support them through the process. Throughout our inspection, we observed positive interactions and support from preceptors to band five midwives.
- Staff we spoke with informed us they had been student midwives at the trust and elected to stay in the organisation, as they felt valued.

Public engagement

- The service actively sought the views of women and their families. There were two maternity services liaison committees (MLSC) one for each Kirklees and Wakefield. These were functional groups, which met bi-monthly and quarterly respectively.
- The members of the MSLC we consulted in respect of the reconfiguration of services, including the provision of services, transfer arrangements and decoration of the units.

- The service 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 attended the hospital for routine appointments and also to visit 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 was worse than trusts of a similar size.
- We spoke with staff in all areas. Staff were very engaged and felt involved 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 guidance, changes to practice and updates of developments within the trust.
- We observed staff being read the weekly safety brief at morning handover, which informed them of changes to guidelines and evidence from within maternity services.

Innovation, improvement and sustainability

- There was a flow midwife to ensure oversight over the whole unit and to ensure the flow of women across the service was seamless.
- There was a break midwife to relieve staff on the labour suite for breaks; this helped to support one-to-one care in labour.
- 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 and 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

Pinderfields General Hospital provided a range of services for children and young people. The trust's acute hospital reconfiguration had seen the centralisation of inpatient services from Dewsbury Hospital on to the Pinderfields site in August 2014 and the centralisation of neonatal services in September 2016.

Gate 46 (inpatient ward) had 23 beds, including eight day surgery beds and three high dependency beds. The children's burns unit was situated next to Gate 46 and had five beds. The neonatal unit had 22 beds: two for intensive care, four for high dependency and 16 for special care.

The children's assessment unit was located next to A&E and had 12 beds where patients could stay for up to 24 hours.

Also situated on the ground floor was the children's centre, which consisted of children's outpatients and paediatric therapy services.

During this inspection, we visited Gate 46, the children's burns unit, children's assessment unit, the neonatal unit and the children's centre.

We spoke with 34 members of staff, including nursing staff, medical staff, administrative staff, play staff and service leads. We spoke with 11 parents and two children. We reviewed 21 sets of records and 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 this service as good because:

- Staff understood their responsibilities for reporting incidents. There were incident reporting mechanisms in place and staff received feedback.
- There were safeguarding systems and processes in place and staff were accessing the required level of training.
- 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, young people and their parents were involved with their care, given information in a way they could understand and allowed time to ask questions.
- Staff were friendly, caring, helpful and provided emotional support.
- Services were planned and delivered in a way that met the needs of the children and young people.
- Children and young people could access the right care at the right time.

Services for children and young people

- There were processes in place for the transition in to adult services and they had recently appointed a lead nurse for transition services.
- There were effective governance processes in place and the leadership team understood the risks to their service.

However:

- Staffing numbers did not meet national recommendations on a number of occasions. Staffing levels and patient acuity were reviewed twice a day and staff were moved between the different children's areas to provide support where needed. However, although this provided support to some areas it meant that other areas were not meeting the national recommendations
- Staff 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.
- The menus provided were not child friendly and staff had difficulties accessing food suitable for children out of hours.
- 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:

- Nurse staffing was not planned in accordance with recognised acuity tools, although service leads told us they were looking at a tool to use. Staffing levels were not meeting Royal College of Nursing (RCN) and British Association of Perinatal Medicine (BAPM) guidance on a number of occasions. Staffing levels and patient acuity were reviewed twice a day and staff moved between departments to provide support; however, this still left some departments without the recommended ratio of staff to patients. Staff told us they did not always report staffing issues as an incident as they felt it was a waste of time.
- Staff did not receive regular safeguarding supervision as recommended in RCN guidance, although it was offered on a case need basis.
- During our inspection, we noted that equipment did not have any indication of when electrical testing was due; this meant staff could not be assured that testing had taken place unless they contacted the medical physics department. Service leads told us that there were plans to reintroduce the labelling of equipment once testing had taken place.
- Records on the neonatal unit showed that daily checks of resuscitation equipment had not been recorded on a number of occasions, therefore, we could not be assured that regular checks had taken place.

However:

- Staff understood their responsibilities for reporting incidents and raising concerns. Staff received feedback about incidents and they were discussed at ward and governance meetings. Thorough reviews were undertaken when serious incidents took place and children, young people and their families received an apology when things went wrong.
- 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 that were classified as never events for children's services.
- In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in children's services, which met the reporting criteria set by NHS England, between March 2016 and February 2017.
- We reviewed completed root cause analysis reports. These were comprehensive with reference to contributory factors and root causes. Lessons learned, recommendations and action plans were included.
- Children's services reported 340 incidents between March 2016 and February 2017; however, 194 of these related to community services that were no longer provided by the trust. The most common incidents related to 'administration or supply of a medicine from a clinical area', 'communication between staff, teams or departments' and 'adverse events that affected staffing levels'.
- Staff were aware how to report incidents using the electronic reporting system. However, some staff said that they did not always report staffing issues as an incident as they felt it was a waste of time.
- Staff told us, and we saw evidence in meeting minutes, that they received feedback about incidents that had taken place in their area of work. However, they were not sure whether they would receive feedback about incidents that had taken place in other areas.
- Staff gave us examples of learning that had taken place following incidents and changes made in practice. For example, staff had been given extra training in the use of the paediatric early warning scores.
- Although staff on the neonatal unit told us they had discussed incidents at team meetings, some staff we spoke with seemed unsure about what had changed as a result.
- 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. For example, in one case discussed it had taken a long time to gain intravenous (IV) access and a learning point that came from this was that an intraosseous needle should be used if IV access is taking a long time in a child with suspected sepsis.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We saw evidence of a letter written to a parent following an incident, which complied with the duty of candour requirements. The letter contained an apology, information that had been provided to them verbally, the results of enquiries made and the investigation.

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 the 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%. The neonatal unit scored 100% for overall compliance with the 10 key elements, hand hygiene and bare below the elbows. The burns unit scored 99% for overall compliance and 100% for hand hygiene and bare below the elbows. Gate 46 scored 96% for overall compliance and 100% for hand hygiene and bare below the elbows. The children's centre scored 98% for overall compliance and 100% for hand hygiene and bare below the elbows.

- All areas we visited were visibly clean and equipment had 'I am clean' stickers in place to indicate that cleaning had taken place. However, in the assessment unit we found a set of drawers containing equipment that was thick with dust inside the drawers. We brought this to the attention of the nursing staff who took action to rectify it.
- 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 assessment unit and Gate 46, we saw child friendly posters about infection prevention and control.
- Regular cleaning of toys took place. We saw records to indicate this cleaning had taken place.
- On the neonatal unit, we observed nursing staff challenging medical staff appropriately about infection control. They asked medical staff not to bring their own stethoscope on to the ward but to use the designated one for each baby.
- Staff on the neonatal unit told us that babies were brought to the neonatal unit from the maternity unit to be given intravenous antibiotics. We asked if a risk assessment had been done for this, due to the potential increased risk of infection. We were told that it had been placed on the risk register and was done in response to a capacity issue in midwifery. It had been agreed with the heads of service in conjunction with infection prevention and control, who monitored and reviewed the situation. The cubicle used had been tested in April 2017 and not grown any organisms.

Environment and equipment

- Gate 46 was a large ward split into three clusters. Each cluster had a nurse's station and emergency buzzers could be heard in all clusters so that staff could access support required in an emergency.
- The children's burns unit was located next to Gate 46. It had facilities for five inpatients and a separate outpatient area within the unit.
- Access to gate 46, children's burns unit, children's assessment unit and the neonatal unit was by intercom. On the neonatal unit, there had been a change in location of the ward clerk desk to be near the entrance. However, the location of the intercom to allow access to the unit had not been changed, which meant visitors had to wait until nursing staff were free to access the intercom. There were plans to move the intercom to the ward clerk desk but staff were unsure when this would be.
- Children's outpatients and paediatric therapists, such as occupational therapists and physiotherapists, were located on the ground floor in the children's centre. There was a play area, but there were no specific activities for older children. The charge nurse told us that the play specialist was looking at different activities that could be offered.
- Theatres had a separate recovery area for children. The anaesthetic room and recovery area were both child friendly.
- Resuscitation equipment was available in all areas. Staff carried out daily checks; however, records on the neonatal unit showed that daily checks had not been recorded on a number of occasions. In February 2017, there were 20 dates, March had four dates, and April had nine dates with no record of checks having taken place.
- 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.
- In the treatment room on the children's assessment unit, we found a number of items that had passed their expiry date or the sterile packets were opened or torn. We raised this with staff on the unit at the time of our inspection, who took steps to remove the items.

Medicines

- The trust had introduced electronic monitoring of fridge temperatures in June 2016.
- We saw records of the electronic fridge temperature monitoring from 2 May 2017, all fridge temperatures were within acceptable limits.
- 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.
- We saw controlled drugs kept in separate locked cupboards with appropriate checks recorded.

- On Gate 46, we found two bags of patient specific intravenous fluids that had expired. We raised this immediately with the ward manager, who took steps to remove them.
- We reviewed 15 prescription charts. All charts had the weight of the child recorded, this allowed for correct prescribing of medication based on weight. All, apart from one, had allergies documented on the prescription.
- On the neonatal unit, we saw that a special prescription chart was used for prescribing a particular antibiotic.
- Staff had access to paediatric and neonatal antibiotic guidelines. These gave recommendations for antibiotics to be used for certain conditions, doses and appropriate monitoring.
- Staff worked to patient group directions (PGD's) for prescribing certain medications. At the time of our inspection, staff on the assessment unit provided us with PGD's that were not signed and were out of date. However, following our inspection we were provided with the correct PGD's that were up to date.

Records

- We reviewed 21 sets of records. Overall, they were clear and accurate. However, there were two sets of records where the name and grade of doctor reviewing the patient was not clearly documented. Five sets of records had illegible medical signatures. Nursing and medical records were not integrated. The Department of Health (2010) suggested that best practice was for a single multi-professional record, which supports integrated care.
- Care plans contained within the nursing records were pre-printed care plans that were not individualised. Best practice would be for the care plans to be individualised and reviewed regularly.
- 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 were able to tell 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 showed that 97% of nursing staff had completed safeguarding children level 1, 100% had completed level 2 and 95% had completed level 3. The trust had a target of 95% for level one training and 85% for level two and level three 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 safeguarding nurse visited the ward areas regularly and was available to contact via a mobile phone if there was an urgent concern.
- 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 all children's areas was secure with entry intercoms for patients and visitors. Staff had access to

an up to date abduction policy, although not all staff we spoke to on the neonatal unit were aware of the policy. However, they could tell us about an episode when they had to act when there had been a self-discharge/ near miss abduction, although no regular practice scenarios took place.
- Staff told us that the electronic system would flag if any child was subject to a child protection plan.
- The children's outpatient department contained a treatment room, which was used specifically for safeguarding screenings.

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 were meeting the trust target of 95% for diversity awareness, health and safety, mental capacity and manual handling. Compliance with fire safety training was 72%, information governance was 72% and infection control was 80%.
- 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 being 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 reviewed 10 nursing records and saw appropriately completed PAWS charts.
- An active simulation group led by the consultants provided simulation training to all staff. Regular simulations were undertaken. Figures provided by the trust showed that 21 members of staff from the inpatient ward, 12 staff from the burns unit, 13 staff from the assessment unit, six staff from accident and emergency and six staff from the post anaesthetic care unit had attended the training within the last year.
- All paediatric nursing staff were paediatric intermediate life support (PILS) trained, 28 staff had completed the European paediatric life support course (EPLS) and 39 staff were still to complete the course. All neonatal unit staff had completed the newborn life support course.
- The inpatient ward had three high dependency beds. One member of staff had completed a high-dependency training course and two further staff were starting the course. The plan was for all staff to attend the training.
- 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. There were link nurses on the assessment unit and Gate 46 who attended regional meetings; this allowed them to share good practice.
- We saw evidence of pressure care risk assessments undertaken on admission.

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. They had over recruited by six Band 5 nurses in order to support plans to increase paediatric nurse presence in A&E to 24 hours a day.
- There was always a Band 6 nurse on each shift on Gate 46; this ensured that more junior members of staff had the support of a more experienced nurse. Royal College of Nursing (RCN) (2013) guidance says that a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team.
- The children's unit was not always meeting the 2013 RCN guidance on staffing. The shift supervisor was not supernumerary and there was not always the required nurse to patient ratio for the age of the child. The RCN recommend a ratio of one nurse to three patients for

under twos and one nurse to four patients for over twos. Service leads told us they did not work to this guidance but looked at patient dependency to determine staffing numbers.

- We reviewed staffing rotas and bed occupancy for three months on Gate 46. We found that for 65 shifts out of 180, the RCN recommended ratios were not met for under two's, if working on a ratio of one nurse to four patients then this ratio was not met on 26 shifts out of 180.
- Twice-daily assessments of staffing levels took place where patient acuity was taken in to consideration. Staff were moved between the different units to provide support, although this would leave some areas without the appropriate nurse to patient ratios. No acuity or dependency tool was used in this process, but relied on staff experience.
- Staff had access to an escalation policy to refer to in the case of short staffing.
- One trained member of staff would be allocated to the high dependency beds, but worked on the other clusters if no high dependency patients were on the unit.
- A couple of members of staff told us that staffing could be challenging and that they were accepting more children with high dependencies now, particularly since the acute hospital reconfiguration when inpatient services had transferred to Pinderfields General Hospital. Service leads told us they had done a training gap analysis and their focus was around the high dependency unit and training needs.
- RCN guidance (2013) recommends a minimum of two registered children's nurses at all times in inpatient areas. Two trained nurses and one health care assistant staffed the burns unit during the day and two trained nurses staffed the unit on a night. However, if Gate 46 required support then staff from the burns unit would be moved to help; for example, on 12 night shifts in January 2017 a trained member of staff on the burns unit was swapped with a health care assistant from Gate 46. We reviewed bed occupancy and found that on most of these shifts the burns unit had one or two inpatients.
- British Association of Perinatal Medicine (BAPM) guidelines recommend nursing ratios of 1:1 for intensive care, 1:2 for high dependency and 1:4 for special care. Data provided by the trust for three months showed that for 54 shifts out of 178 the neonatal unit was not meeting these recommended ratios. We noted that on two occasions the ratios would have been met but a member of nursing staff was moved to help on Gate 46. We did not find any evidence that there had been an impact on care when these ratios were not met.
- Staff on the neonatal unit gave us examples of when they had not met the recommended BAPM ratios due to staff being moved. For example, a band 6 sister was moved from the neonatal unit to Gate 46 and this meant that another band 6 sister was caring for an intensive care baby and a high dependency care baby.
- At least one registered nurse always staffed the outpatient department. An advanced nurse practitioner had overall responsibility for the outpatient department.
- Staff told us that since the acute hospital reconfiguration and the move of the acute beds to Pinderfields their workload had increased and they felt that they needed more staff.
- A full staffing review was to take place at the end of May. Service leads were looking at an acuity tool to use. They felt that the PANDA tool developed by Great Ormond Street Hospital was too specialised and were looking at using the Calderdale tool.

Medical staffing

- There were separate rotas for medical cover for Gate 46, the assessment unit and the neonatal unit. The assessment unit therefore had access to the opinion of a paediatric consultant at all times and children did not have to wait to be seen by medical staff working elsewhere.
- One junior doctor told us that there were some gaps in the rota and it was difficult at times getting locum cover but the management team risk assessed this and were trying to address it. Another told us that sometimes there were too many hours added to their schedule, which was affecting the quality of their home life.
- 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.
- Medical handovers took place three times a day. We attended a handover and found the format to be structured and well organised. Discussions maintained confidentiality.

Services for children and young people

- Every child admitted with an acute medical problem was seen by a paediatric consultant within 14 hours of admission as recommended in the Royal College of Paediatrics and Child Health (RCPCH) guidance Facing the Future: Standards for acute general paediatric services (2015).

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 better than the England average.
- Staff were qualified and had the skills required to carry out their roles effectively. Children's services employed advanced paediatric nurse and advanced neonatal nurse practitioners.
- Our observation of practice, review of records and discussion with staff confirmed effective multi-disciplinary team (MDT) working practices were in place.

However:

- Staff appraisal rates were low. However, service leads acknowledged this and had plans in place to increase compliance.
- Food choices were not child friendly.

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.
- The UNICEF Baby Friendly Initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK. Although the maternity services had been awarded UNICEF Baby Friendly accreditation, the neonatal unit had not.
- The neonatal unit took part in the BLISS family-friendly accreditation scheme and information about the 'Mid-Yorkshire neonatal family-centred care group' was displayed on the ward.
- 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.
- Burns unit staff followed guidance from the Northern Burn Care Network. The sister on the burns unit attended the lead nurse meeting for the Burn Care Network every three months.

Pain relief

- Children's services used a paediatric pain scoring tool. This was incorporated within the PAWS charts.
- We discussed pain relief with three parents; they told us that their child's pain had not been assessed with the use of a tool but staff frequently checked with the parents as to whether they felt their child was comfortable.
- Children and young people were prescribed appropriate pain relief as required. On the burns unit the consultant anaesthetist saw the patients every morning to check their pain control.
- Play specialists were available in all areas for distraction during painful procedures and reassurance for the child and parents.
- The children's burns unit used a 3D television to distract children when undergoing painful dressing changes.

Nutrition and hydration

- Gate 46 had a dining room where children and young people were encouraged to eat their meals if they were well enough to leave their bed.
- The menu for children and young people to choose their meals from was a general menu and did not contain child friendly meals. Staff told us they had previously raised this issue and parents told us they did not think there was a good choice of food for their children. However, one parent on Gate 46 told us they felt the food was good and that their normally fussy child was eating the food provided.

- Staff described difficulties in obtaining child friendly food out of hours, such as a plain sandwich, and the ordering system was felt to be difficult, with the catering department requiring many details about the ward and the patient.
- We saw feedback on the children's assessment unit where families had asked staff to consider dietary options for children with allergies and those needing gluten free food as the child had been unable to eat breakfast.
- We saw appropriate nutrition and hydration plans for those children that required them. However, we saw some nursing records for a child that had been admitted with abdominal pain and there was no fluid balance chart seen within the records.
- Milk kitchens were available on Gate 46 and the neonatal unit for storage of breastmilk and formula feeds. However, these milk rooms and fridges were not locked, which meant that anyone could access them.
- Breastfeeding mothers were offered meals during their stay in the hospital.

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 2015/16 diabetes audit Pinderfields General Hospital performed similar to the England average. The proportion of patients having an HbA1c value of less than 58 mmol/mol was 27.1%, similar to the England average of 26.6%. The mean HbA1c level was also similar to the England average.
- 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
- In the 2015 National Neonatal Audit Programme (NNAP) Pinderfields General Hospital's performance was better than the England average, with 100% of eligible babies received Retinopathy of Prematurity (ROP) screening in accordance with guidelines compared to the England average of 98%. Concerning a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission, the trust scored 100% compared to the England average of 88%. At the age of two years, 50% of babies had no level of impairment compared to an England average of 26% and of those babies born at less than 32 weeks gestation, 59% did not develop any form of bronchopulmonary dysplasia compared with an England average of 53%.

Competent staff

- All staff attended the trust induction programme upon joining the trust.
- Band 5 staff worked in rotational posts, rotating between accident and emergency, Gate 46 and the children's assessment unit. This meant that staff became skilled in all areas.
- Staff on the neonatal unit told us that if they were moved to Gate 46 to cover a shift they did not always feel confident caring for older children. The ward manager on Gate 46 told us that they would try to give staff from the neonatal unit the younger children but would particularly use them for the HDU patients as they had the skills and experience to care for these patients.
- The trust employed one advanced neonatal nurse practitioner (ANNP) and one advanced paediatric nurse practitioner (APNP). There were a further three ANNP's in training. These nurse practitioners supported medical staffing at the middle grade level.
- There were specialist nurses employed for diabetes, asthma, epilepsy, continence and neuro-disability.
- Staff appraisals had been identified by the trust as an area for improvement. Appraisal rates in children's services were 68.9% overall. There were variations between the different wards, for example in March 2017, Gate 46 had a staff appraisal rate of 67.6%, the neonatal unit had a rate of 58%, the children's burns unit had a rate of 80% and the children's assessment unit had a rate of 35.7%.
- When we spoke with service leads, they explained that the ward manager for the assessment unit had been on sick leave and there were now plans in place for staff to have their appraisals completed. They told us they were meeting with staff and talking with them about the benefits of appraisal.

- We spoke with junior medical staff who told us they received regular supervision and were given enough time for this. They felt well supported on the wards by consultants.
- Staff undertook skills and practice competencies such as medicines management, patient group directions (PGD's) and clinical observations. The burns unit staff also undertook a competency pack for burns care.
- Staff on the assessment unit and Gate 46 had received training on high flow oxygen and blood gases.
- Children and young people had access to paediatric dieticians. On the burns unit they were seen by both paediatric and burns dieticians.
- Staff on the burns unit had all received psychosocial training in order to be able to provide children and their families with the support they needed.

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. The burns unit had their own dedicated burns play specialist.
- The schoolroom on Gate 46 was staffed by a teacher and teaching assistant from the local authority, who worked closely with the ward staff.
- We heard examples of co-ordinated planning of care between various staff groups. For example, nursing staff, anaesthetists and play specialists, worked together to devise individual care plans for children with learning disabilities who were having surgery.
- An orthotist worked one day a week in the outpatient department. This allowed for immediate liaison with a consultant and prompt treatment.
- Staff worked closely with the Child and Adolescent Mental Health Services (CAMHS), they gave us an example of working on a joint care plan for a patient who had been admitted whilst waiting for a CAMHS bed.
- Consultants told us that they attended regular radiology meetings with a paediatric radiologist to review cases.
- The burns unit had multi-disciplinary ward rounds twice a week, which included psychologists and dieticians.
- The play specialist from the burns unit worked closely with schools, devising care plans for when the child returned to school.

Seven-day services

- Consultant presence on a weekend had been improved, with a consultant present at the morning and evening handovers.
- Children's services had access to diagnostic services, such as x-ray and laboratory services during the weekend.

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.

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.
- We saw evidence of consent forms appropriately completed. Parents we spoke with said they had been fully involved in the consent process.
- 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.

Are services for children and young people caring?

Good

We rated caring as good because:

- Feedback from children, young people and their parents was positive, with staff described as friendly, caring and helpful.
- Parents were encouraged to be involved in their child's care and treatment. They were communicated with and were given information in a way they could understand.
- Children, young people and their parents were helped to cope emotionally with their care and treatment.

Compassionate care

Services for children and young people

- Parents we spoke with said staff were friendly, caring and helpful. They felt safe leaving their child in the care of the staff.
- One parent commented that all staff, including cleaners, had been excellent.
- We saw staff respecting privacy and dignity and talking to children, young people and their families in an appropriate manner.
- Parents told us that staff always introduced themselves and spoke to the child as well as the parent.
- Parents on the neonatal unit told us that staff were reassuring and responded appropriately in difficult times.
- Friends and family responses were consistently positive. On Gate 46, 98% would recommend the service to friends and family. On the assessment unit, 97.9% would recommend the service. On the neonatal unit 100% would recommend the service and in the children's centre, 97.4% would recommend the service.

Understanding and involvement of patients and those close to them

- Parents told us they were fully involved in their child's care, they were kept informed and up to date on what was happening.
- Parents told us that staff listened to children's and parent requests and would work with them to provide the best care for that child. They were encouraged to ask questions.
- Two parents that we spoke with felt there was inconsistency with the plans of care for their child from the medical staff. They told us that when different doctors had seen the child, different decisions had been made as to what investigations should be carried out.
- Parents in the neonatal unit told us that the medical and nursing staff explained the plans for care and prepared the parents for what may happen. Staff arranged care around the parents, so that they could feed and bath their baby when they were on the unit.

Emotional support

- Children and young people on the burns unit had the support of a psychologist.
- Play specialists were able to provide support to children and young people to alleviate their anxieties.
- The play specialist on the burns unit ran a burns club, which provided psychological support to children, young people and their families.
- Parents told us that staff had supported them emotionally. On the neonatal unit, parents told us that the staff looked after them as well as their baby.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- 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.
- Services were planned and delivered in a way that met the needs of the local population. The needs of different people were taken in to account. Gate 46 had a 'chill out zone' for older children.
- 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; a lead doctor and nurse were in place.
- Information was available to parents on how to make a complaint. Parents we spoke with felt confident to raise any issues with the staff.

Service planning and delivery to meet the needs of local people

- As part of the acute hospital reconfiguration, in September 2015 there had been centralisation of the inpatients on to the Pinderfields site. In September 2016, in the second phase of the reconfiguration there had been centralisation of the neonatal unit on to the Pinderfields site.
- The children's assessment unit was open 24 hours and there were plans in place to have paediatric nurse cover in accident and emergency 24 hours a day.
- Gate 46 had a 'chill out zone', a room for children older than 11 years, which contained a television and computer gaming systems. Children and young people could access the internet via the hospital Wi-Fi, there were strict controls in place as to sites that could be accessed and there was information available on the ward about internet safety.

- Gate 46 admitted young people up to the age of 17 years 364 days. Young people aged 16-18 years were given a choice of whether they were nursed on the children's ward or an adult ward.
- Parents of children on Gate 46, the assessment unit and the burns unit could stay with their child on a bed next to their child. The neonatal unit had two bedrooms in a separate flat located next to the unit for parents to stay before their child was discharged.
- Gate 46 had a separate parent's room, which had a fridge and facilities to make drinks and warm food. This room also contained shower and toilet facilities. Parents of children on the burns unit could also use this room.
- Children and young people were seen in a dedicated outpatient's area. The outpatient area contained a quiet room for breastfeeding mothers who wanted some privacy. It could also be used for children with additional needs who needed somewhere quiet to wait.

Access and flow

- 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.
- Children's therapy services had average waiting times, between April 2016 and March 2017, of seven weeks for occupational therapy, six weeks for speech and language and three weeks for physiotherapy. Some waiting times were seen to exceed 18 weeks, however these were patients waiting for specific groups to be run or through parental choice for a specific therapist or location.
- Between October 2016 and March 2017 there were 1353 elective operations carried out on patients aged 0-16 years. There were 63 cancelled operations, of these 29 were because surgery was not required, 15 were due to staffing problems, 10 were due to no beds being available, seven were due to running out of theatre time and two were because the surgeon was unavailable.
- The children's assessment unit accepted referrals from GP's, accident and emergency and direct from families. Paediatric consultants took phone calls from GP's to determine whether the child needed to be seen. A child could be on the assessment unit for 24 hours; this meant that not every child needed to be admitted as an inpatient.
- A new referral process for community paediatrics had led to a reduction in waiting times. For example, attention deficit hyperactivity disorder ADHD clinics had reduced from a 16 week waiting time in May 2016 to an eight week waiting time in April 2017. Bowel management clinics had reduced from a 17 week waiting time in May 2016 to seven weeks in April 2017 because of the introduction of nurse led clinics. Enuresis clinics had seen an increased waiting time due to an increase in referrals and additional clinics had been arranged.
- The children's outpatient department ran a clinic for blood tests, which had improved the flow through the children's assessment unit.

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.
- Staff had access to hoists for those children that required them.
- The burns unit had a calm room and the children's centre had a Snoezelen room, which were multi-sensory environments that could help reduce agitation and anxiety.
- The burns unit had a motorised car, which patients could drive down to theatre in. This helped alleviate some of their anxieties.
- Staff could access interpreters if required, either face to face or by telephone. We saw information on how to access telephone interpreters and staff understood the importance of not using family members to interpret. We saw in records that the family's first language was recorded on the paediatric MDT assessment sheet.
- We did not see any information sheets provided in other languages, although the patient menu did say that it was available in other languages if required.
- The burns unit play specialist visited other hospitals to see patients who were due to be transferred to the burns unit at Pinderfields. This allowed discussion with the child and parents as to what would happen once they arrived and the differences between the units.
- Integration back in to school for burns patients was made easier by the play specialist preparing teachers and school friends for the child's return to school.
- There was a lead doctor and lead nurse in post for transition. The lead nurse had been in post since the beginning of April 2017 and was in the process of developing the transition services. There were good transition processes in place for those children with

diabetes, epilepsy and ADHD with joint clinics and liaison with adult services. Services were using the Ready, Steady, Go transition programme. The lead nurse was looking at all services using the same documentation for transition and wanted to improve and standardise compliance.

Learning from complaints and concerns

- Between March 2017 and February 2017, there were 17 complaints; the key themes of these complaints were access to services (including assessments and cancelled operations) and staff attitudes.
- Staff could tell us about changes made as a result of complaints, such as sending information with the outpatient appointment, to inform parents that if they had any questions they should speak to the nurse during their child's appointment.
- We saw leaflets available for patients/carers informing them how to make a complaint.
- Parents we spoke with told us they felt confident to address any concerns they had with staff on the wards.

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. Staff spoke positively about them and said they were visible and supportive.
- 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. They felt respected and valued.

Leadership of service

- Children's services belonged to 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 spoke positively about the senior leaders and the matron; they were described as visible, approachable and supportive.
- Staff felt they had seen a change since the new chief executive had come in to post. They felt he was supportive, interested in the staff and was trying to do things to improve.
- We spoke to a member of staff who was doing the RCN clinical leadership programme. The trust were supporting the staff member in attending this.
- Medical staff we spoke with said the clinical lead was responsive and supportive. They felt that the voice of paediatrics was heard at board level.

Vision and strategy for this service

- 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 were passionate about the services they provided for children, young people and their families.
- Staff felt there was good morale and they felt part of a team. However, some staff felt that morale was affected by the frequent movement of staff between units.
- Staff felt respected and valued, and believed their views were listened to. They were encouraged to be open and honest.

Public engagement

- We saw child-friendly versions of the friends and family test available, on the assessment unit there were pens and a feedback book provided with these. However, on Gate 46 these were not immediately visible as they were in a basket and staff commented that children were often too young to fill them out themselves.
- We saw 'listening to you' boards displayed in each area that showed feedback that had been received from patients and their families and the response from the hospital staff. For example, on the neonatal unit, parents had said the nurseries were too cold in the evening; staff had called the engineers to increase the temperature.
- The burns unit had a comment book for children and parents to leave comments.

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.
- Focus groups had been held with staff to find out staff concerns. Staff told us they felt listened to by the chief executive.

Innovation, improvement and sustainability

- Staff in the burns unit were undertaking a service improvement project that was looking at the introduction of nurse led clinics.
- The play specialist on the children's burns unit had been awarded a British Empire Medal in the New Year's Honours List 2017 for services to children with severe burns.

End of life care

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides acute and community end of life care services to around half a million people living in the Wakefield and North Kirklees districts of West Yorkshire. It is a consultant-led service providing specialist care and support to patients 18 years and over and their families and carers, with palliative care needs for life-limiting conditions. The service is based at Pinderfields General Hospital. The trust had 2,099 deaths between December 2015 and November 2016.

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

The Specialty Medicine directorate within the Division of Medicine operationally manages the end of life care service. The service is made up of the specialist palliative care nursing team and a team of four palliative care consultants.

During our inspection at Pinderfields General Hospital, we visited 11 wards, the bereavement office, the mortuary, the discharge liaison office, the chapel and multi-faith prayer facilities and the on-site Macmillan support information booth. We observed care being delivered by the acute specialist palliative care clinic team and spoke with 24 members of staff including the divisional clinical director, director of nursing and quality, deputy director of nursing and quality, deputy director of operations, three consultants in palliative care, the end of life care facilitator / team leader, portering lead, Macmillan nurses, ward managers, nurses, health care assistants and administrative staff. We spoke with two patients and three relatives and looked at the records of six patients receiving end of life care. We reviewed 21 forms recording do not attempt cardiopulmonary resuscitation orders.

End of life care

Summary of findings

At the previous inspection visits in 2015, 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.

The previous ratings for this service were requires improvement overall with inadequate for safe and requires improvement for effective, responsive and well-led. Caring was not rated, as the previous inspection was a focused inspection.

Following this inspection, we rated this service as good overall 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.
- We saw evidence that compliance with infection control and environmental cleaning standards were monitored regularly and maintained in the mortuary.
- There was standardised use of one model of syringe drivers on the wards and clear guidance on symptom management and prescribing of anticipatory medicines for end of life patients.
- Risks to people, who use services were assessed, monitored and managed on a day-to-day basis.
- 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.
- End of life care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. There was a comprehensive audit programme in place against national standards for end of life care.
- 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.
- 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.
- We observed a caring and compassionate approach from palliative care team members and ward nursing staff during their interactions with patients and family members.
- The specialist palliative care team (SPCT) had a dignity champion who fed into speciality governance meetings and other trust initiatives.
- We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the specialist palliative care team during their assessment of the patient in the hospital.
- The chaplaincy 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.
- Drop-in services were accessible to palliative care patients and families for emotional support and therapies.

End of life care

- 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.
- Patients and families received facilities such as palliative care beds and overnight stay rooms for relatives positively.
- Arrangements were in place for people to complain or raise a concern and there was openness and transparency in how complaints were dealt with.
- 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.
- Risk issues such as achieving rapid discharge were escalated to the relevant committees and the board through clear structures and processes.
- The leadership was knowledgeable about quality issues and priorities within end of life care, understood what the challenges were and took action to address them.

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.
- 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.
- People were supported to make decisions about resuscitation but, where appropriate, their mental capacity assessment was not always recorded.
- 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 78% of all new referrals were seen within 24 hours of being referred to the specialist palliative care nursing team. At the time of inspection, this was a Monday to Friday service.
- There was no regular internal performance reporting to directorate or board management to demonstrate improvement in areas such as quality of care, achieving preferred place of death, referral management and rapid discharge of end of life patients.

End of life care

Are end of life care services safe?

Good

We rated safe 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.
- We saw evidence that compliance with infection control and environmental cleaning standards were maintained in the mortuary and monitored regularly.
- There was standardised use of one model of syringe drivers on the wards and clear guidance on symptom management for end of life patients.
- Risks to people, who use services were assessed, monitored and managed on a day-to-day basis.
- 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.
- 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

- No never events were reported by the service between March 2016 and February 2017 and there were no severe harm incidents during the reporting period. 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.
- Policies relating to the management of incidents were in place and all staff we spoke with knew how to report incidents via the electronic reporting system. Staff told us they were confident that incidents were acted upon promptly, investigated thoroughly and the outcome fed back to the team.
- 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.
- We saw examples of managers investigating incidents and appropriate action taken to alert staff to incidents and the outcomes. Feedback was provided by discussing incidents and the actions taken in the monthly operational meeting for all members of the specialist palliative care team. Incidents were also discussed at the monthly palliative care clinical governance meeting.
- As no moderate or serious harm had been reported, there were no examples of implementing the Duty of Candour. Duty of Candour is the legal duty to be open and honest when things go wrong. Staff we spoke to had a broad understanding of the need to be open and honest but were less clear about when the Duty of Candour would be applied.
- Mortality and morbidity reviews were included in the weekly multidisciplinary meetings and any issues arising were escalated to the governance meeting.

Cleanliness, infection control and hygiene

- We saw that the mortuary 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 mortuary trolleys were cleaned after every use according to best practice and trust policy. We saw completed cleaning schedules for the mortuary equipment and the environment, which confirmed 100% compliance with the trust cleaning standards.
- We saw hand hygiene and bare below the elbows audit results for October 2016 to March 2017 which showed 100% compliance.
- Personal protective equipment (PPE) was readily available and staff were able to tell us how this should be used.

Environment and equipment

End of life care

- The mortuary was a store for deceased hospital and community patients and had a designated area where post mortem examinations took place. We saw the mortuary area was secure and fridges were locked.
- 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.
- We saw the concealment trolley for adults had been replaced since the last inspection and the concealment trolley for infants had been replaced with an adapted cot on wheels.
- There was standardised use of one model of syringe drivers on the wards and these were available from the medical physics department. Staff told us there were no difficulties with supply. Syringe drivers were electronically programmed to alert users when the equipment was due for service; this was in addition to "service due" labels attached to the outside of the equipment. The medical physics department monitored the service history of all syringe drivers.

Medicines

- Medicines were well managed. Policies for medicines management were in place and accessible to staff and symptom control medicines were prescribed using guidance from the regional palliative care and end of life groups. Staff were updated on medicines management by a trust newsletter. The pharmacy also issued medication safety alerts when required.
- We reviewed six medication administration charts and saw that the documentation was completed clearly including times of administration for 'as required' drugs. We saw that all symptom control medicines were prescribed as per NICE clinical guidelines (CG140: Palliative care for adults: strong opioids for pain relief). These were legible, dated, and signed.
- Five of the SPCT team were qualified as non-medical prescribers and their prescribing supervisors were nominated palliative care consultants.

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.
- 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 end of life care plan had been introduced but uptake by nursing staff was still in development. We saw this document to be present for six out of nine case notes.
- We reviewed 21 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in case notes. Completion of the DNACPR form can be the responsibility of the GP in the community or the consultant in hospital. The resuscitation team audited the quality of these records annually and had noted several areas of improvement from the previous year's audit. Those we reviewed were appropriately authorised by a consultant or GP.
- The bereavement office kept records of all funerals arranged by the hospital when there was no next of kin or no means for families to arrange a funeral.
- The number of inpatients across the trust with end of life care plans was 33 in February 2017; however, there was no regular audit to determine what percentage of end of life inpatients had an end of life care plan in place.
- An audit of 18 end of life care plans was conducted in April 2017and 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 education sessions in end of life care for nursing staff.

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.
- The trust set a target of 95% for completion of safeguarding Level 1 training and 85% for safeguarding Level 2 training. 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 2016April 2016 and March 2017March 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 100%.
- All qualified nurses in the end of life services were trained in syringe pump training. Palliative care education had been introduced as part of mandatory training for all nursing staff at the trust.

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.
- For inpatients newly referred to the SPCT, the specialist palliative care nurse visited the patient and made a holistic assessment of needs. An advanced care plan including assessments for areas such as mobility, pain management, and nutrition was available for use; however, the lead for palliative care told us implementation of this document by ward staff was still developing. All ward staff we spoke with were familiar with the documentation; a completed plan was found in six out of nine case notes we reviewed.
- On wards with a high proportion of patients likely to be in the last year of life, a member of the SPCT attended board rounds to give advice and identify patients who required face-to-face input.
- Any patients, who were currently under the care of the SPCT or had had prior input, automatically triggered an alert to the SPCT on admission to hospital. The team then made contact with the ward to identify those patients who required face-to-face input.
- 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.
- Nursing staff made referrals to the specialist palliative care team when their expertise was required to manage complex symptoms such as support with changes in prescribing anticipatory medications or management of mouth care. We spoke to nursing staff on the wards, in critical care and in the accident and emergency department and all were familiar with making referrals to the team when required.
- 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.

End of life care

- We saw that risk assessments were completed in the nursing records including those related to skin integrity, nutritional needs, falls risk and pain assessments. We saw a national early warning score (NEWS) in use 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.

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 (Whole Time Equivalent) 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.
- There was no designated palliative care ward but seven designated patient rooms for nursing end of life patients at Pinderfields General Hospital.
- 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.
- We observed the handover process, which was attended by the lead palliative care consultant, specialist palliative care team (SPCT) team leader and two SPCT nurses. Discussions included new referrals, condition and symptom management of current palliative care inpatients, capacity for decision-making and discharge planning.
- The specialist palliative care team did not use agency or bank nurses. When activity increased or staff shortages occurred, staffing was flexed between the acute and community teams to meet service demand.

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 consultant lead or deputy attended a daily handover with the nursing team. We attended the weekly multidisciplinary meeting and saw that it was well attended by the palliative care consultants.
- There was no use of locums in the end of life care service.

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?

End of life care

Good

We rated effective as good because:

- End of life care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, and legislation. There was a comprehensive audit programme in place against national standards for end of life care.
- 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.
- 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%.
- 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.
- People were supported to make decisions about resuscitation but, where appropriate, their mental capacity assessment was not always recorded. An action plan was in place to improve the documentation.

Evidence-based care and treatment

- End of life care needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines including Actions for the End of Life 2014/ 2016 (NHS England). The service used the Hospital Anxiety and Depression Scale (HADS), which determines the levels of anxiety, and depression that a patient is experiencing. They also used the Distress Thermometer. This is a tool that can help the patient and staff begin a conversation with each other about the wide range of physical, social, psychological and practical challenges that can present during end of life care, together with the services and resources that may be helpful in addressing them.
- A new end of life care plan document was introduced in 2015. This was adapted for use from a similar document developed by a neighbouring NHS trust. This replaced the Liverpool Care Pathway (discontinued in 2014) and was for use in the trust, local hospices, the patient's home, or care home. The document provided an assessment of the patient's needs and wishes including their choice of environment, comfort and symptom management and support, an individualised care plan and daily allied health professional and medical review. The service provided guidance on how to use the care plan to staff and to the patient and their family/carer.
- 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.

- Patients who were identified as requiring end of life care were prescribed anticipatory (or 'just in case') medications to manage symptoms that commonly occur at the end of life. These medicines were administered as and when needed. Guidance on use and dosage of anticipatory medicines was available in the end of life care plan. It was also included on a pocket guide to the five priorities of care of the dying patient, which had been issued to ward nurses. The guidance was based on regional palliative care and end of life care group guidelines.
- The service was planning to introduce the Gold Standard Framework to hospital staff on eleven wards in 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.
- The lead palliative care consultant led the annual audit programme, which included auditing practice against relevant palliative care guidance from the National Institute for Health and Care Excellence (NICE). Standards being reviewed on the 2016/17 programme included NICE Quality Standard 13: End of life care for adults and NICE Guideline 140: Palliative care for adults: strong opioids for pain relief. It also included participating in the National Care of the Dying audit.

Pain relief

- There was clear guidance on pain management and prescribing of anticipatory pain relief medicines for end of life patients. This was printed in the end of life care plan. There were suggested medicines and doses to manage pain, restlessness, nausea and excess secretions as required and for administering symptom relief via continuous sub-cutaneous infusion. The information also recommended contacting the specialist palliative care team for advice on specialist palliative care drugs.
- Nurses assessed patients' pain levels by using a pain assessment scale within the national early warning score assessment tool used throughout the hospital.
- We saw palliative care nurses assessing and recording levels of pain during clinical visits to patients and evidence that pain was assessed as part of regular observations of end of life patients by ward nursing staff.
- The trust undertook patient satisfaction surveys in relation to pain management. The trust reported that 129 surveys were completed and returned. The survey results showed that overall patients were happy with their pain management and associated support, information and guidance.
- A patient and relative told us that pain was generally well managed, but that on some wards, staff did not always manage pain needs in a timely way, and pain medicine had to be requested.
- The specialist palliative care team had developed a morphine and strong opioid information leaflet for patients and carers to help their understanding of the use and possible side effects of these pain medications. This was dated 2014, but we saw that the leaflet had recently been reviewed and updated.
- The specialist palliative care team were planning to conduct an audit to assess the time lapse between prescribing a syringe driver to the time the syringe driver was started, to provide information on the quality of pain control for end of life patients in the hospital.

Nutrition and hydration

- The end of life care plan included assessments of nutrition and hydration needs and patient choices about their food and drink preferences. We also saw evidence in nine patient records of nursing staff completing the malnutrition universal screening tool (MUST) risk assessments. Where required, staff could make a referral to dietician services.
- Ward audits included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales.
- 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 and doctors on the use of the plan. The pending introduction of the Gold Standard Framework was also expected to support improvement and SPCT provided support at board rounds to both medical and nursing staff. We saw ward noticeboards listing nutrition and hydration documentation as a priority to be included in daily briefings with ward staff.

Patient outcomes

End of life care

- 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.
- Between April 2015 and March 2016, the hospital reported that 1,209 trust-wide referrals were made to the SPCT. 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. The training included a video on the 'five priorities of care' for end of life care patients. These include recognising dying, sensitive communication, patient and family involvement in decisions, recognising the needs of family and others and individualised care planning. 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'.
- Porters completed a competency assessment after receiving training from a senior porter on management of patients after death including transfer to the mortuary and infection control guidelines.
- 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 on the wards 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 SPCT 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.
- The weekly SPCT multidisciplinary meeting to discuss the caseload and new referrals provided opportunity for teaching by the palliative care consultants. We observed a discussion about transdermal analgesia patches during the MDT. The palliative care consultant lead attended the regional palliative care group and provided updates to the team.
- Two members of the 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.
- Five of the SPCT were qualified as non-medical prescribers and eight 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. Educational objectives were supported by access to external courses.
- We were told that staff had monthly one to one meetings where clinical supervision was available. The team could also attend psychological clinical supervision support. Revalidation to maintain professional registration was supported by the SPCT team leader when required and staff had access to the trust revalidation workshop.

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 (such as oncology, respiratory and cardiac specialists), 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 Pinderfields General Hospital 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. Messages received when the phone was not manned or out-of-hours were responded to as soon as possible. The nursing team was not available out-of-hours or at the weekend at the time of inspection but had submitted a business case to extend to a seven-day service. There was no single point of access for the palliative care services provided by the trust; however, this was also in the planning stage.
- There was a 24-hour seven-day rota for palliative care consultant cover and nursing staff in the hospital accessed this 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 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.
- The end of life care plan was held in the patient's case notes and used by the team to record changes and assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Policies were in place and accessible to staff proving guidance on obtaining consent and assessing mental capacity.
- Staff received training on mental capacity within adult safeguarding training. We saw that mental capacity was considered in the discussion with patients about end of life, preferred place of care and end of life care planning. We saw no instance of implementation of Deprivation of Liberty safeguards (DoLS) but staff we spoke to were aware of the legislation through their training. Training compliance for Mental Capacity Act and DoLS was 83%.
- We reviewed 21 DNACPR forms in patient records across the hospital. These were all placed at the front of the patient record. Ten patients were recorded as not involved in the decision-making and of these; two DNACPR forms referred to lack of capacity but associated medical notes were unclear as to whether mental capacity was assessed and two forms provided no evidence as to why the patient was not involved in discussions. All forms were authorised by a doctor 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:

- We observed a caring and compassionate approach from palliative care team members and ward nursing staff during their interactions with patients and family members.
- The SPCT had a dignity champion who fed into speciality governance meetings and other trust initiatives.
- We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the SPCT during their assessment of the patient in the hospital.
- The chaplaincy 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.
- Drop-in services were accessible to palliative care patients and families for emotional support and therapies.

Compassionate care

- We observed a caring and compassionate approach from palliative care team members and ward nursing staff during their interactions with patients and family members. Patients were addressed appropriately and their dignity protected. The SPCT had a dignity champion who fed into speciality governance meetings and other trust initiatives.

End of life care

- One of the palliative care consultants was surveying bereaved family members at the time of inspection and the results of the audit were due in July 2017. The previous audit was in 2014.
- One relative told us that they were very happy with the timeliness and level of support and the quality of care provided. They felt that their loved one received "excellent care" and good communication from everyone on the ward. They told us that they received immediate attention to requests and that they "could not ask for better care" for the patient or the family.
- We saw thank you cards on the one of the elderly medicine wards, one of which stated: "We will always remember that time as being so peaceful, and the care and respect shown to our family member and all the family was exemplary".
- Staff told us of an end of life patient who was bed-bound and asked to go outside for fresh air during the last hours of life. Staff arranged for the patient to be taken outside on the bed to fulfil this final wish.
- We were informed of an emergency wedding that had been conducted in the hospital for an end of life patient. The trust chaplaincy team facilitated this.

Understanding and involvement of patients and those close to them

- We saw how family members were supported in understanding and managing symptoms by being involved in discussions with members of the SPCT during their assessment of the patient in the hospital.
- We saw the palliative care nurse explain changes in medication to the patient and family members before starting symptom control medications via a syringe driver with the benefits and side effects clearly stated in terms they could understand.
- One relative told us that they had met a palliative care doctor on the ward who explained the treatment plan and discussed with the family aspects of quality of life and the patient's wishes. The relative told us they felt that the doctor "listened to her and the family and took their views on board".
- A survey of patients (n37) 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

- The chaplaincy 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.
- We saw the palliative care nurse carry out a full psychological and emotional support assessment and discussion of preferred place of care and death. A formal psychological support service was not available at the trust but could be accessed through the local hospice.
- 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.

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Following the previous inspection, 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. 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 care 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 (Monday to Friday) of being referred to the team, February to April 2017.
- The service did not audit data on preferred place of death and the percentage of people who achieved this.

However:

End of life care

- 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

- The specialist palliative care (SPCT) team and local hospices participated in the local multiagency strategic 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 care homes and prisons.
- 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. Representatives attended it 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.

Meeting people's individual needs

- 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.
- There were seven palliative care beds at Pinderfields General Hospital; these beds were run by the ward on which they were based. Six were located in elderly medicine and one in respiratory medicine. We visited one of these rooms and saw that it was pleasantly decorated, light, and spacious, and included a drop-down bed for overnight stays by relatives during the last days of life.
- Following a refurbishment of the accident and emergency department, the number of side rooms had increased from one to three. Staff told us that this had improved their ability to provide privacy and dignity for end of life patients and their relatives.
- 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 MND (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.
- End of life care support was offered to local prisons and mental health units by the team. Nursing staff at these units had access to the end of life care training given to all trust nurses and were invited to the end of life care link nurse meetings to provide support and multi-agency working. The SPCT also worked with people with learning disabilities.
- The end of 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 were admitted in the last stage of life. 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 viewing room, for relatives to be with a patient after death, had been redecorated and was being refurbished to improve the experience for relatives. Out-of-hours viewing was available as mortuary staff were on an on-call rota.
- Following the death of a patient, SPCT nurses made a bereavement call to each family and offered a visit and further support if needed. The service had an agreement in place with a local hospice to provide further bereavement support and staff recommended local support groups.
- Ward staff and mortuary staff were familiar with how to deal with deaths from different faiths and cultures. These procedures were covered in end of life mandatory training and the end of life trust policy.
- Staff were aware of the arrangements to access language translators and British Sign Language translators and felt these were accessible when required. A translator attended at one of the patient visits by the SPCT during 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.
- A Macmillan support service was based on the first floor landing of Pinderfields General Hospital and manned by volunteers. The service could provide information leaflets and advice or time to talk over a cup of tea to patients, family members, or visiting members of public. Advice on benefits to people with life-limiting illnesses was supported by a weekly drop-in session run by a representative from the Department of Work and Pensions .
- 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.
- There were six family support rooms at Pinderfields General Hospital to enable families to stay together when a family member had dementia or was at a palliative-care stage of their life. Staff at the hospital gathered feedback from families, which showed that the vast majority of families wanted to be physically close with their loved ones at the end of their life to provide personal comfort and support. Family sleep-over rooms were based on each floor level in the hospital; these were not ring-fenced for family use and could be used for patient care if required. Feedback on the availability and use of the rooms was positive.

Access and flow

- The service reported that February – April 2017, a monthly average of 78% of new referrals 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 1225 discharges from the service.
- The service did not audit data on preferred place of death and the percentage of people who achieved this.
- During the previous inspection, it was identified that there were problems facilitating a rapid discharge process for end of life patients with evidence of extended delays. This was in part due to lack of discharge liaison capacity, low staffing levels in the SPCT and external factors relating to funding and community support. Following the inspection, 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.
- We spoke to the ward staff, the SPCT and discharge coordinators during the inspection. It was evident that the capacity for discharge liaison had increased with coordinators assigned to wards or shared between wards; however, we saw that the oncology ward did not have dedicated support for discharging patients and the nurses reported arranging discharges increased the pressure of workload. 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 post was not yet active at the time of inspection but recruitment was underway.

- Staffing levels were at full complement at the time of the inspection and enabled an SPCT nurse to attend 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.
- We received varied responses from ward staff to questions about their experience of fast track discharge. The minimum length of time achieved to discharge a fast track patient was quoted as three hours; however, ward staff told us their experience was more commonly 24 hours or more. There was no trust definition of a fast track discharge and no audit work had been done to measure performance in this area since the last inspection. We were unable to assess the level of performance in achieving fast track discharges for end of life care due to lack of evidence.

Learning from complaints and concerns

- Very few complaints were received by the service: four complaints were received March 2016 to February 2017 and no trends were identified. Each was dealt with in a timely manner and actions taken where appropriate. Learning from complaints was given to individual staff members and in the monthly team meeting when appropriate.
- Information about how to submit feedback and complaints was available on the wards, on the Mid Yorkshire Hospitals website and displayed on information screens in public areas in the hospital. The Patient Advice and Liaison Service (PALS) team was located in Pinderfields General Hospital, and in addition to providing a telephone service, operated a drop in facility 10am-4pm Monday-Friday. We did not see raising concerns information in alternative languages.
- 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 were 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.
- 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.
- Risk issues such as achieving rapid discharge were escalated to the relevant committees and the board through clear structures and processes.
- The leadership was knowledgeable about quality issues and priorities within end of life care, understood what the challenges were and took action to address them.

However:

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

Leadership of this service

- The end of life care executive lead on the trust board was the director of nursing and quality. The clinical lead for specialist palliative care and the 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 specialist medicine in the directorate of medicine 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 clinical network 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 of the strategy.
- The SPCT 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.
- Staff were aware of the trust values which were 'caring, high standards, improving and respect' and were updated on changes in the trust through the team brief. In addition, 'Big Conversations' led by the chief executive took place in 2016 with an outline of the key priority areas and proposed vision for the trust. Attendees had the opportunity to provide feedback on these as well as sharing their views on the behaviours, which would be expected to deliver the trust's values.

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	
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 387,601 outpatients' appointments at Pinderfields Hospital between December 2015 and November 2016.

We visited the main outpatient departments, ophthalmology outpatients, audiology outpatients, dermatology outpatients, phlebotomy department, diabetes outpatients and physiotherapy outpatients. During our inspection we visited the main radiology department and pathology.

The service had an access, booking and choice directorate. These were responsible for outpatient services managers and were 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. Specialist interventional services included breast clinics five days a week.

Diagnostic imaging services were available for inpatients and trauma patients 24 hours a day, every day of the year. Outpatients and those referred by their GPs could access plain film services from seven days a week between 8am and 8pm and for MRI and CT there were appointments from 8am to 8pm on weekdays. Ultrasound services ran from 8am to 6pm on weekdays for outpatients and 9am to 5pm every day including weekends for inpatients and emergency department patients. Staff provided an ultrasound service for gynaecology and obstetrics patients on weekdays from 8.30 am to 5pm as well as Saturday and Sunday mornings. Out of hours on-call rotas were in place for ultrasound and interventional radiology. 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 at Pinderfields General Hospital, we spoke with three patients, two relatives, and eight 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.

Outpatients and diagnostic imaging

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

During our inspection in outpatients, we spoke with 37 staff, ten patients and visitors and we looked at nine patient records.

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.

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 (RTT) 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 RTT (percentage within 18 weeks). The trust had a trajectory to be achieving the indicators by March 2018.
- Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour.
- 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. Staff were aware of how to report safeguarding concerns.

Outpatients and diagnostic imaging

- Areas we visited were visibly clean and tidy. Medicines checked were found to be stored securely and 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 ensured privacy and dignity was maintained. Diagnostic services were delivered by caring, committed and compassionate staff.
- The Did Not Attend (DNA) rate in outpatients was lower than the England average.
- Managers were able to describe their focus around addressing issues with the referral to treatment indicators and addressing 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.
- Staff we spoke with told us managers and team leaders were available, supportive and visible. Staff we spoke with told us there was good 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.

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 in ophthalmology. However this had not occurred on all waiting lists or backlogs 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.
- Where refrigerator temperature checks showed deviation from the required temperature, the action taken was not always documented on the daily check log. Refrigerator temperature checks processes were changing during our inspection.
- Mandatory training compliance rates for diagnostic imaging staff for medicines management and resuscitation training were low.
- Duty of candour was not well understood across all staff groups; however senior managers could describe the duty of candour.

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.
- Areas we visited were visibly clean and tidy. Hand gel dispensers were in place throughout the outpatient and diagnostic imaging services. We saw staff adhered to 'bare below the elbow' requirements. Radiology departments were clean and hygiene standards were good.
- Staff we spoke with were able to describe how they would report safeguarding concerns and told us they would seek advice from the trust safeguarding team or their manager if required.
- Staff told us records were available for clinics in outpatients. Records were stored securely in electronic format.

Outpatients and diagnostic imaging

- Medicines checked were found to be stored securely and staff told us they stock rotated medicines as they replenish stock. Medicines checked were found to be 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. Managers told us there were no current concerns with nurse staffing levels in outpatients.

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 on 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 would be 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.
- Staff understanding of duty of candour varied across the services, however staff could describe being open and honest.

Diagnostic imaging:

- The services reported no serious incidents (SI's) in radiology 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.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- 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.
- Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care.

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.
- The trust provided surgery division report which included outpatients frontline ownership audit (FLO)

data. The information provided was for February 2017. The eye centre had an overall compliance of 100%, hand hygiene was 98% and bare below the elbows was 100%.

- General outpatients FLO audit for Pinderfields hospital showed general environment at 100%, patients immediate area was 100%, dirty utility and waste disposal was 100%, linen was 100%, storage areas and clean utility/treatment room was 100%. Hand hygiene facilities were at 100% and overall compliance for the FLO audit was 100% at Pinderfields Hospital. Hand Hygiene compliance was 100% and bare below the elbows was at 100%.
- There were carpets in main outpatients. Managers told us these were cleaned when requested by outpatients. Information provided by the trust highlighted carpets were on a schedule for cleaning and included an annual clean, along with a weekly clean. Details provided by the trust stated the carpets had been cleaned in May 2017.
- The trust provided information showing the risk description, controls in place and current risk level. The risk type was environmental compliance. The trust provided information stating this was added to the access, booking and choice risk register in May 2017 and the risk review date was July 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 a domestic staff member and we noted 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 in 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.
- The department quality dashboard showed that the most recent hand hygiene audit had achieved 99% compliance.

Environment and equipment

- The main outpatient departments at Pinderfields Hospital were at the entrance to the hospital and were split into two areas. Electronic check in was available and there were volunteers available to provide support and assistance to people entering the check in area for outpatients. Each outpatient area had a waiting area with a staffed check in desk after the patient had checked in electronically outside main outpatients. There were six electronic check in desks.
- Main outpatients had ten consulting rooms, two treatment rooms and a measurement room.
- Ophthalmology outpatients had a waiting area with seating for patients and televisions showing local bus routes and times along with information about the trust and the ophthalmology unit.
- 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.
- The phlebotomy services areas had limited space with few areas to store equipment, for example mobile trolleys used in the service.
- We looked at equipment, such as resuscitation trolleys and found this to be checked daily.
- Outpatient areas had toilets and disabled toilet access for patient and visitor use at the hospital.
- There had been issues with the chairs used in offices in main outpatients; however managers told us these were being replaced.
- Managers told us booking centre and call centre staff had display screen assessments and that they were up to date with these.

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 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. This 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 replenish stock. Medicines checked were found to be in date.
- Ophthalmology outpatients held a small stock of FP10 (written prescriptions); these were logged as they were used in outpatients. The register used to log the prescriptions had some information in incorrect columns, managers told us they would address this. Managers told us this system was changing in the near future to a regular morning check and evening check.
- During our inspection, there was a trolley in an eye centre clinic room used during clinics and contained ophthalmic medicines. This trolley could not be locked. Staff told us these were there because the clinic had recently finished and the room was still being used. All other medicines cupboards in the room were locked and secure.
- Refrigerator temperatures were found to be checked and documented on a daily log within the services, these were checked when clinics were on. However where the temperature had deviated from the required range, the action taken was not always documented on the daily log. The services were moving from a daily refrigerator temperature check to an electronic recording system where pharmacy would notify the service if the refrigerator was out of the required temperature range.

Diagnostic imaging:

- We found medicines to be managed securely. The medicines refrigerators were locked, temperatures checked and documented correctly, 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 found to be 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 mitigate this by having a standard operating procedure in place.

- Completed patient records were stored securely electronically. There were patient record templates ready for use in clinic outside the clinic rooms on top of a trolley in a patient waiting area. There was a lockable trolley; however this was not always used. Managers told us they had reviewed the storage of records in the department with the governance team.

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. These were stored electronically and were easily accessible to all diagnostic imaging staff.

Safeguarding

- The trust target for completion of safeguarding level 1 training was 95% and 85% for level 2 training.
- 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 required compliance rate for all safeguarding training.
- Staff we spoke with were able to describe how they would report safeguarding concerns and told us they would seek advice from the trust safeguarding team or their manager if required.

Diagnostic imaging:

- Staff had a good 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.
- Radiology training compliance for all staff across the trust was close to the trust target at 92% for Safeguarding adults level 1 and 88% 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 the trust class as core: diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children.
- 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 severe 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 would use 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 had 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. 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 there were no issues with first appointments for the macular unit and for the first 12 months of treatment, however after 12 months there was a six week additional wait for follow up appointments.
- 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.
- Staff told us they would contact the trust crash team where a patient deteriorated within clinic. Outpatients and Ophthalmology outpatients had access to a crash trolley in the departments.
- Ophthalmology outpatients ran an emergency telephone line each day whilst clinic was on. This was managed by a registered nurse who would triage calls as they came through. These staff would provide advice where required and book appointments for patients. The service held up to four appointments each day for emergency appointments.

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 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 Pinderfields Hospital was 23.24 WTE. There were 18.92 WTE in post.
- As at 28 February 2017, the trust reported a vacancy rate of 11% in Outpatients for qualified and unqualified nursing staff. Pinderfields General Hospital had a vacancy rate of 22%.
- Between March 2016 and February 2017, the trust reported a turnover rate of 10% in Outpatients for qualified and unqualified nursing staff. Pinderfields General Hospital had a turnover rate of 9%.
- Between March 2016 and February 2017, the trust reported a sickness rate of 7% in Outpatients. Pinderfields General Hospital had a sickness rate of 10%.
- Managers told us there were five vacancies at Pinderfields outpatient department. These consisted of two healthcare assistants, one registered nurse and there were two healthcare assistants which had been appointed to vacancies.
- 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.
- Information provided by the trust highlighted that staffing allocation was organised to ensure there was a minimum of one registered nurse on duty where clinics were held. Managers would allocate additional registered nurses where workload was expected to be higher. Healthcare assistants were available in clinics. Staff were able to work across all sites at the trust and managers would allocate further staff to departments where this was requested. Managers told us there were no current concerns with staffing levels in outpatients.
- Managers were responsible for staffing rotas across clinics and ensuring appropriate skill mix across the different clinics. Managers told us outpatients always had a registered nurse on duty and healthcare assistants along with administrative staffing.
- Managers in ophthalmology outpatients told us there were no current concerns regarding staffing levels. Main outpatients did not currently have a matron in post due to sickness; however the senior manager in the service had assisted in providing support.
- Dermatology outpatients had recently returned to their planned staffing levels with 24 hours vacancy across the service. Staff were able to work across all sites in dermatology, however generally worked at their base site.
- Phlebotomy staffing levels for Pinderfields showed that there was a planned WTE staffing requirement of five staff with an actual WTE of four staff.
- 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 stating that Audiology outpatients had a planned WTE was 24.84 and the actual WTE was 23.67; however the information provided by the trust stated they had recently recruited and had full establishment as at June 2017.
- The trust provided information on ophthalmology outpatient staffing vacancies. This showed that the trust had one WTE Band six Nurse Practitioner, 43 hours Band five and 1.7 WTE Band three. 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 14 specialist nurses to support interventional radiology procedures. There were four WTE nursing vacancies. However, one new 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.

Outpatients and diagnostic imaging

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.
- 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.
- Managers were planning for new staff to be trained to specialise in modalities including CT.
- 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 within outpatients and diagnostic imaging across the trust.
- Medical staffing in outpatients was organised and managed by individual specialties. The ophthalmology service had a vacancy for one WTE Glaucoma consultant.

Diagnostic imaging:

- The department contracted the reporting of some overnight plain film X-rays to external companies to enable them 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 outsourcing companies.
- There was a national shortage of radiologists. However, this trust experienced no difficulties in recruitment to consultant or specialty training grade posts. There were 28 WTE consultant posts and 27 of these were filled.
- There was consultant cover across the trust out of hours and at weekends.
- At the time of this inspection, the trust had a full establishment of consultant radiologists. The trust employed ten specialist radiology trainees who were completing placements with the trust. There was only one vacant post.
- At the time of this inspection, there were sufficient staff to provide a safe and effective service.

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.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

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

- Staff we spoke with were able to describe the national institute for health and care excellence (NICE) 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 Pinderfields General 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 get consent, for example when they get 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

- Goal setting was in use in services such as diabetes outpatients and physiotherapy service for patients receiving care.
- Staff in diabetes outpatients told us the guidelines used were based on national institute for health and care excellence (NICE) and there had been a multi-disciplinary team (MDT) meeting a year ago to review these. Diabetes outpatients participated in a number of audits, for example a high impact audit and frontline ownership audit.

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 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 they 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

- Staff in the fracture clinic told us they discuss pain management with patients and offer pain relief as required. 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 Pinderfields General 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.

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%, nursing and midwifery staff group was at 82%. Scientific and technical group were at 50% and administrative and clerical were at 71% compliance.
- Staff we spoke with told us they received annual appraisals and that these were an opportunity to discuss objectives.
- 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.
- 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.

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.
- Some staff we spoke with told us they had attended national conferences, training relevant to their practice and they shared information gathered with the team.
- 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

Outpatients and diagnostic imaging

- Staff worked with different professions such as doctors, registered nurses and healthcare assistants.
- Staff in diabetes had access to the community diabetes team. Diabetes outpatients held clinics jointly with paediatrics.

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.
- 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 Accident and 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 between Monday and Friday between 08:30am and 5pm. There were additional clinics during weekends where there was demand for the services.

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 were on site providing overnight cover, with further on-call support available if necessary.
- Outpatients and GP patients could attend for x- rays 7 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 we spoke with told us they received regular communication bulletins. Information was also available on the trust intranet for staff. Dermatology had a communications book in use to share information with staff at the service. Senior physiotherapy staff told us they cascaded the monthly team brief from the executive team to staff.

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 1 training had been completed by 100% of staff within outpatients.

Outpatients and diagnostic imaging

- Staff we spoke with could describe how they get verbal or written consent from patients. Consent given by the patient was recorded and we saw examples of consent recorded in patient records.
- Physiotherapy staff told us they had received mental capacity act training and deprivation of liberty standards training as part of their mandatory training.

Diagnostic imaging:

- Diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. 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.
- 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.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We found staff to provide compassionate care to patients in outpatients and diagnostic imaging and provide 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.

Compassionate care

- We found staff to provide compassionate care to patients and provide additional support to patients where required in clinics. Chaperones were available in clinics and outpatients displayed a sign informing people about asking for chaperones.
- Staff told us they ensure patient privacy and dignity is maintained whilst in clinic through ensuring clinic doors are always closed and clinic curtains are used when required. During our inspection there were some consulting rooms which stated they were vacant outside, however these were in use. This did not contribute to ensuring privacy was maintained.
- Patients we spoke with were positive about the services they had visited. Patients told us staff were supportive, compassionate and friendly.

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 may not always allow for total privacy and confidentiality but staff worked carefully to maintain this as much as possible.
- We spoke with three patients and two people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Outpatients and diagnostic imaging

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.
- Data for the friends and family test in ear, nose and throat showed there was a 6.9% completion rate with a 97.4% positive response.
- Services visited provided patients with contact details of the clinic. Staff in the endocrine clinic discussed choice of treatment, treatment goals and provided details on who to contact if required. Outcome goals were discussed with patients in the plaster clinic.
- The 'One stop skin cancer clinics' carried out a patient satisfaction survey. This showed 100% positive feedback from patients based on 78% response rate to questionnaires.

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 would offer 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. A patient had an appointment on the day of our inspection and had been offered a chance to look around the department and also to take the first appointment so that the department was quiet and there would be a reduced chance of any delays.
- 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) indicators (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 is currently 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.
- The booking centre was responsible for booking outpatient appointments in services such as medicine and surgery. Partial bookings were also made by the booking centre and they took calls from patients regarding outpatient appointments.
- Ophthalmology outpatients partial bookings were completed by the booking centre and all other appointments were booked by ophthalmology reception.
- Outpatients offered appointments between 8.30am and 5pm Monday to Friday and would add clinics on a Saturday where there was demand.
- Ophthalmology outpatients offered a Monday to Friday acute appointment service for patients who were referred from a number of external and internal services for ophthalmology such as general practitioners. This service was available at Pinderfields Hospital.
- Diabetes outpatients had re-designed clinics and introduced practice nurses. The service held a walk in service to help prevent admission at each site. The trust had a separate paediatric diabetes team. There was a clinical nurse lead for diabetes at each of the three sites services were provided.
- Dermatology outpatients held a nurse led "suspected skin cancer clinic" held every Thursday afternoon and Friday morning. This had been a trial from November 2015 and became permanent from September 2016. This was currently held mainly at Dewsbury Hospital and Pinderfields Hospital on a Thursday and Friday.
- The access, booking and choice directorate included a booking and call centre which was based at Pinderfields Hospital. This service carried out partial bookings for the trust and took calls from patients regarding appointments. The service had performance indicators and these were indicated on the call centre electronic boards which highlighted whether they were achieving their performance indicators and the number of calls waiting to be answered.
- Areas visited had cards such as yes and no cards to support patient's where additional support and assistance was required. The services used a VIP card which had information about patients attached and could be shown to staff upon arrival at the services.
- Physiotherapy outpatients provided hydrotherapy pool back classes. Patients received two sessions and then were assessed.

Diagnostic imaging:

- The diagnostic imaging department had good 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 deteriorated 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.

Outpatients and diagnostic imaging

- 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 around 6 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 around 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, putting extra clinics on 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 such as 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.
- Addressing the backlog of outpatients appointments, including follow ups and ensuring clinical deteriorations in a patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments was part of the improvement plan from the previous inspection, however this 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 has been worse than the England overall performance. The latest 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 latest figures for January 2017 showed 80.0% of this group of patients were treated within 18 weeks versus 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 is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- The trust is currently 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

Outpatients and diagnostic imaging

Q1 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 standards 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 6 weeks: annual leave, on call, study leave and under 6 weeks: sickness, non-compliance with process by specialty resulting in late notification. Managers told us clinics were sometimes cancelled within 6 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 would highlight in clinic waiting times on the waiting room information boards and would inform patients as to delays in the service on a daily basis. Staff informed patients of delays after 30 minutes of delay in clinic.
- Managers told us the booking and call centre had a target of 95% to answer calls within 3 minutes. Data from the booking centre between 6 and 10 March 2017 showed that 97% of calls were answered within three minutes.
- Outpatients had an outpatient follow up procedure in place with a review date of February 2019.
- 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 stated time. 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 Pontefract General Infirmary, Dewsbury and District Hospital, and Pinderfields General Hospital was lower than the England average. Information provided by the trust showed an outpatient DNA rate for new appointments was at 7.8% for March 2017 and was at 6.3% for follow up appointments for March 2017. This was below the trust target of less than 8%. The trust had plans to implement a text reminder system in July 2017 to assist in reducing the DNA rate.
- Pathology testing turnaround times were measured on a monthly basis and almost always met national expected timescales. They were rarely rated below trust targets.

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.
- The department had introduced workflow radiographers to continually assess capacity and demand and adjust staffing and reporting availability where necessary.
- Managers told us that they worked closely with staff from other departments and specialties on their performance in providing a good and prompt service to meet targets. These 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 latest figures for January 2017, showed 2.9% of patients waiting more than six weeks versus 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 no less than 99.98% across the department in the last 12 months.
- The percentage of images taken and reported across all modalities for 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. This did not meet Keogh 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

- 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.
- Outpatients had learning disability champions and managers told us they would ensure there were adjustments made to support patients in attending outpatient appointments.
- Staff told us they had access to interpreter services.
- Water was available in main outpatients and staff told us they would provide drinks to patients where required. A bariatric chair was available in main outpatients.
- Staff at 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.
- Ophthalmology outpatients placed an information sheet on waiting room chairs which provided information on how long the appointment will take. Staff told us these were placed on chairs prior to morning clinics and afternoon clinics.
- A number of services visited had patient information leaflets on display for patients, for example ophthalmology had patient information leaflets in waiting areas.
- Diabetes outpatients had bariatric chairs in two consulting rooms and two bariatric chairs in the waiting area. A bariatric hoist was also available to staff for use if needed. Staff in diabetes outpatients were able to describe how they provide further assistance for patients with dementia and learning disabilities. Staff told us dementia patients are accompanied through clinic and support was available. Staff told us they would provide periodic reviews to dementia patients as the condition changes. Care plans were also developed for dementia patients if they were in respite.
- Diabetes outpatients held an ophthalmology clinic once a week for visually impaired patients and diabetes outpatients provided training to respite carers for learning disability patients.
- There was no hoist available in dermatology outpatients for use in the bathroom.

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 provisions were 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 wide range of information. Information was available on notice boards and leaflets. 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.
- Patient information leaflets were plentiful, of good quality and up to date.

Outpatients and diagnostic imaging

- 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).
- Ophthalmology outpatients had a television on display in the waiting area which managers told us displayed information of the trust patient advice and liaison service (PALS).
- Managers in diabetes outpatients told us they did provide feedback from complaints. Reviews of complaints were often completed by team leaders.
- The trust provided seven access, booking and choice complaint action plans. These highlighted the complaint, action and the person responsible 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.
- There were patient information and advice stations located in the main entrance, near to the diagnostic imaging department.
- Volunteers made themselves available to all visitors to the hospital to help them find their way and to access any help they needed.
- 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 around addressing issues with referral to treatment indicators and addressing 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 we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty.
- The services had carried out different engagement with staff and the public through staff surveys and 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

- Services were managed by 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.

Outpatients and diagnostic imaging

- 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 inconsistent and minutes were not always disseminated to staff in main outpatients. Managers told us they were aware team meetings needed to be more consistent and were planning to address this. There were regular meetings in departments such as physiotherapy outpatients and the fracture clinic.

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 feel listened to. We observed good, 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 during the inspection was 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 aims 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.
- Most managers and staff across the services were able to describe the values developed by the trust.

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.

Governance, risk management and quality measurement

- The outpatients department had a risk register which contained a number of identified risks to the services in outpatients. Managers told us the risk register was reviewed monthly. Managers told us the main risks identified in outpatients 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, this 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 around referral to treatment targets and capacity and demand issues across the outpatients at the trust. Each week there was a performance management meeting to discuss waiting times and RTT. Managers told us they were able to escalate 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 through to the surgical directorate which outpatients were part of and risks identified would be escalated to the quality committee. Managers in outpatients told us they attended governance meetings and would enter risks identified onto the services risk register.
- 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 from 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 were part of this meeting.
- The access, booking and choice directorate held a governance meeting and presented quarterly to the surgical meeting. The surgical meeting had presentation 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 survey to gather feedback from staff and managers told us they had increased engagement with staff to assist in improving morale in the service.
- Staff we spoke with told us there was good teamwork within teams and there was a culture of openness and honesty. Most staff we spoke with felt respected and valued by the trust and management.

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 and staffing shortages in the service were also improving.
- Managers told us that they felt well-supported by the organisation.
- Some staff we spoke with told us they had attended national conferences, training relevant to their practice and they shared information gathered with the team.

- Staff were passionate about their work, and in particular their patients, and felt that they did a good job. Staff we spoke to 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 good working relationship between all levels of staff. We saw that there was a very positive, 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.
- 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 to staff.
- The department had a full time research radiographer and three other staff were seconded with external funding to carry out part time research.

Public engagement

- 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 bulletins were provided to staff from the organisation. Services such as dermatology operated a staff awards.
- The outpatient 2016 staff survey showed the positives and areas for improvement in outpatients. For example a highlighted positive was staff having good access to all of the materials and supplies to carry out my role and confidence to approach senior management team. Areas for improvement included training and development needs not discussed in appraisal and not had any training/ development in last 12 months. The survey poster developed by outpatients 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.
- Managers told us they were planning to implement a staff wellbeing group across the access, booking and choice service.
- An access, booking and choice staff bulletin from May 2017 showed the suggestions made and what the service did regarding the suggestion.

Diagnostic imaging:

- 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 to staff. Staff used these meetings to share information and news and to plan for the day ahead.
- 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 or issues identified from the previous day. Staff could discuss concerns they may have or receive and share important information. Staff told us these were good for regular updates about the service and to receive information from other parts 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 teams and specialists from other hospitals within the trust and neighbouring trusts as well as through national groups and panels to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.
- The department funded an annual whole radiology away day to support staff engagement in general, encourage whole team business planning and supported continual professional development of individuals and teams.
- Morale boards had been implemented on each site to enable staff to share issues, encourage staff support, and implement changes

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 in the target date; all other actions were within the target date.

- Phlebotomy services manager's told us they had recently made improvements following negative feedback from staff in other services across the organisation. Negative feedback included being difficult to contact and poor communication. Managers told us they were now fully staffed and had implemented a document to improve communication. Managers told us this had been working well and there had been some positive feedback from wards in the organisation. Phlebotomy services were the 'team of the week' at the organisation in March 2017.
- We spoke with managers in different areas of outpatients and diagnostic imaging and some had attended an improvement workshop at the organisation.

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.
- Staff had developed direct access pathways within interventional radiology for palliative patients to avoid unnecessary admissions.

Outstanding practice and areas for improvement

Outstanding practice

- The facilities on the spinal unit for rehabilitation and therapies were modern, current and progressive.
- The cardiology e-consultation service which provided a prompt and efficient source of contact for primary care referrers who sought guidance on care, treatment and management of patients with cardiology conditions;
- The proactive engagement initiatives used by the dementia team involving the wider community to raise awareness of the needs of people living with dementia. The use of technology to support therapeutic engagement and interaction with patients, stimulating activity and reducing environmental conflict.
- The emergency department had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The facilities on the spinal unit for rehabilitation and therapies were modern, current and progressive.
- The cardiology e-consultation service which provided a prompt and efficient source of contact for primary care referrers who sought guidance on care, treatment and management of patients with cardiology conditions;
- The proactive engagement initiatives used by the dementia team involving the wider community to raise awareness of the needs of people living with dementia. The use of technology to support therapeutic engagement and interaction with patients, stimulating activity and reducing environmental conflict.
- The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience 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. Faster pre-theatre assessment was provided which helped ensure treatment was delivered quicker. The surgical division had reduced pressures on Surgical Assessment Unit (SAU) by taking the bulk of ambulatory plastics patients out of SAU.
- The burns unit play specialist ran a burns club, which provided psychological support to children and their families. This included an annual camp and two family therapy weekends a year.
- The maternity service had implemented the role of 'Flow Midwife', a senior member of staff who had oversight of the service during the day. The aim of this role was to ensure a smooth flow of patients throughout the unit; this included the risk of transfers from the stand-alone birth centres and concerns with the discharging of patients from the postnatal ward and labour suite.

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 that all staff have annual appraisals
- Ensure staff are aware of the duty of candour regulations

Outstanding practice and areas for improvement

- Ensure prescribers detail the indications for antimicrobials and ensure review dates are adhered to
- Ensure it reviews the compliance with Guidelines for the Provision of Intensive Care Services and the plans to meet the standards
- 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 patient bed moves after 10pm are kept to a minimum to avoid unnecessary distress to the patient
- Ensure escalation initiatives and governance processes to support nurse staffing requirements are effective
- Ensure work is undertaken to reduce the number of patients requiring endoscopies being cancelled on the day of their procedure
- Ensure quality and performance is measured effectively
- Ensure it develops and shares with staff a longer term critical care strategy beyond the acute hospital reconfiguration
- Ensure risks are identified and reviewed appropriately
- 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 visible assurance that all electronic equipment has been safety checked and assurance that staff are competent in the use of all medical devices
- Continue to focus on achieving A&E standards and ensure that improved performance against standard is maintained
- Ensure that records are completed fully and that records are stored securely
- Ensure that all appropriate staff have undergone APLS training
- Work with thenon-medical prescribing governance groupto ensure that all non-medical prescribers are supported to prescribe within their competencies
- Ensure that staff triage training is robust and that staff carrying out triage are experienced ED clinicians
- Ensure patients have access to leaflets in alternative formats such as large print, Braille or other languages
- Ensure it completes the outstanding actions remaining from RCEM audits to ensure the quality of care in the department is meeting the RCEM standards
- Ensure that the cross site governance processes introduced in January 2017 become embedded in practice
- Consider an analysis of the increased reporting of clostridium difficile cases across the division
- Ensure all relevant staff are informed of oxygen prescribing standards
- Apply the trust wide pain assessment documentation consistently on wards
- Ensure whiteboards being used at the patient bed head contain the correct information
- Ensure all patients and family members are fully informed and involved in all discharge arrangements and future care discussions at the earliest opportunity
- Consider an analysis of the processes involved in obtaining timely social care assessments for patients on divisional wards
- Consider a review of the current governance processes for the Regional Spinal Unit
- Continue with improvement in staff engagement activity specifically around the acute healthcare reconfiguration and current service demands
- Ensure divisional meetings are quorate and all agenda items are discussed/minuted accordingly
- Improve the proportion of patients having hip fracture surgery on the day or day after admission
- Continue to monitor and improve compliance with the 'Five steps to safer surgery'
- Reduce the management of medical patients on surgical wards
- Reduce the number of patients boarding on PACU and discharging home directly from PACU
- Reduce the usage of extra capacity beds on surgical wards
- Ensure there is evidence of appropriate local induction for agency staff
- Ensure their safeguarding children policy is up to date
- Ensure that staff have regular safeguarding supervision
- Ensure that children have access to child friendly menus
- Consider limiting access to their milk rooms and fridges, to prevent unauthorised access to feeds

Outstanding practice and areas for improvement

- Ensure that staff are following the medicines management policy and that fridge and room temperatures are appropriately recorded
- Ensure that resuscitation equipment is checked daily and appropriately recorded
- Ensure plans for clinical validation across specialties where there are waiting list backlogs are progressed and risks are managed and mitigated
- Audit and report the implementation of the end of life care plan and performance in fast track discharge
- Ensure regular internal performance reporting on End of Life care 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

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)(c) 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— (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%. • Staff attendance at other statutory training such as life support skills were not always meeting the trust standard. • Lack of training across the departments in triage/IAT. This means that potentially less experienced staff were triaging/IAT patients. This occurred in both adults and children.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 53 additional beds at Pinderfields. • 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. • We reviewed 28 patients' records across medical wards at Pinderfields and found five of the 28 patient records (18%) where the capacity assessment documentation was incomplete. • We also reviewed a 'Care Plan for a Vulnerable Patient who requires help with Decision Making and found this to be completed incorrectly.

This section is primarily information for the provider

Enforcement actions

- We identified two patients where deprivation and/or restriction of liberty practices were in force without the necessary documentation being completed
- 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
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 care plan documentation and risk assessments of 28 patients throughout medicine wards at Pinderfields. In seven sets of the 28 records (25%), 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.**

This section is primarily information for the provider

Enforcement actions

- We reviewed care plan documentation and risk assessments of 28 patients throughout medicine wards at Pinderfields. We found 12 out of the 28 records (43%) where fluid, food and/or intentional rounding charts were absent, incomplete or 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
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 Pinderfields 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.