Mid Yorkshire Teaching NHS Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Mid Yorkshire provides care for over half a million people every year, in their homes, in the community and across three hospital sites at Pontefract, Dewsbury and Pinderfields. In addition, the trust provides two specialist regional services: burns and spinal injuries. The trust is made up of a team of 9,200 staff.

The Pinderfields Hospital building was opened in 2011; is the largest of the trust's three hospitals and is the main site for patients requiring acute care. A range of inpatient, outpatient, diagnostic and maternity services are provided. The hospital provides both urgent and emergency care as well as services such as elective surgery. Pinderfields is the busiest hospital within the trust. In any one year there may be over 127,000 attendances to the A&E and over 58,000 emergency admissions.

Dewsbury and District Hospital provides services, usually for patients living in the North Kirklees district. The hospital provides urgent and emergency care, diagnostics, elective care, midwife services and care of the elderly services. The hospital treats over 340,000 patients every year.

Pontefract Hospital opened in 2011 and focuses on urgent care, elective, diagnostics and rehabilitation services.

The trust works in partnership with two local authorities, two integrated care system (ICSs) commissioners and a wide range of other providers, including voluntary and private sector organisations. It also works as a member of the West Yorkshire and Harrogate Partnership, which is the Integrated Care System within which the Trust resides.

We carried out an unannounced inspection of Mid Yorkshire NHS Hospital Trust services provided by this trust over a two-month period as part of our continual checks on the safety and quality of healthcare services. At the 2018 inspection we rated the trust overall as requires improvement. Our inspection was prompted by concerns about the quality and safety of services. We also conducted an inspection of the trust's leadership and governance.

Our findings

From the 29 March to the 30 March 2022 we inspected the Urgent and Emergency Care Centres at Pinderfields Hospital and Dewsbury and District Hospital as part of the urgent and emergency care services review in West Yorkshire. Medical services were also inspected at both hospital sites.

From the 26 April to the 28 April 2022 we inspected maternity and children's services at Pinderfields and Dewsbury and District Hospitals and commenced a well led review of the trust. The Urgent and Emergency Care and Medical teams also returned to the trust to complete the inspections in both areas at Pinderfields and Dewsbury and District Hospitals.

Whilst we inspected during the COVID 19 pandemic the risks and concerns identified by CQC during the inspection were not the result of the immediate pressures faced by the trust as a result of this. The trust had reported the long-lasting impact of the COVID 19 pandemic for the preceding two years. These included the significant impact on staffing, including sickness and the identification and redeployment of clinically vulnerable staff, the prolonged period of command and control arrangements and service remodelling.

At the time of inspection, the trust was responding to the Omicron-wave of the pandemic and was caring for a high number of patients who were COVID-19 positive. The trust had stepped up its strategic oversight and management according to protocol. Immediately prior to the March 2022 inspection.

We did not inspect critical care, end of life care, surgery or outpatients at Pinderfields or end of life care, surgery or outpatients at Dewsbury and District Hospitals. We also did not inspect community health services for adults or community dental services. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

At this inspection we found the core service ratings for maternity at the Pinderfields Hospital had improved from requires improvement in 2018 to good in the inspection of April 2022. Urgent and emergency care and maternity at the Dewsbury and District Hospital remained the same, whilst, the core service ratings for medicine had deteriorated since our previous inspection in 2018.

As part of this inspection, the trust formally notified CQC that it no longer provided medical care at Pontefract Hospital and we have retired the ratings for this core service at this location. This led to a change in the overall rating for effective at Pontefract Hospital which changed from requires improvement to good.

Our rating of services stayed the same. We rated them as requires improvement because:

- Safe and responsive were rated as requires improvement.
- We rated urgent and emergency care and medicine at Pinderfields and Dewsbury and District Hospitals as requires improvement.

However:

- We rated caring as good in all areas except medicine at Dewsbury and District Hospital where caring was rated as requires improvement.
- We rated effective and well-led as good for the trust overall from our inspection of the trust's senior management, leadership and governance.

How we carried out the inspection

Our findings

The team that carried out this inspection comprised of a CQC head of hospital inspection, two inspection managers, one inspector and an inspection planner. In addition, there were two pharmacist specialists, three executive reviewers and two specialist advisers experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection. The core service inspection teams included inspectors and specialist advisers.

Outstanding practice

Pinderfields Hospital

We found the following outstanding practice:

Children and Young People

- Gate 46 had two anti-ligature rooms for young people who were at risk of harm.

Maternity

- Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience.
- One member of staff had been nominated for BAME national midwife of the year.

Dewsbury and District Hospital

We found the following outstanding practice:

Maternity

- Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience.
- One member of staff had been nominated for BAME national midwife of the year.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to six core services and trust wide.

Our findings

Trust wide

- The trust must ensure that an audit schedule is in place and audit data is consistently collected analysed and made available to staff to improve the service. Regulation 17(2)

Pinderfields Hospital

Urgent and Emergency Care Services

- The trust must ensure staff adhere to infection prevention control (IPC) guidance when crossing from red to green areas in Pinderfields Accident and Emergency department. Regulation 12 (2) (h)
- The trust must ensure the streaming nurse at Pinderfields Accident and Emergency department has guidance, an Standard Operating Procedure, or pathways to follow when assessing patients. Regulation 12 (2) (b)
- The trust must ensure patient records are stored securely. Regulation 17 (4) (1) (2)
- The trust must improve patient triage times in Pinderfields Accident and Emergency department. Regulation 12 (2) (a) (b)
- The trust must have a system in place at Pinderfields Accident and Emergency department to identify patients who have left the department prior to being seen or following assessment. Regulation 12 (2) (a) (b)
- The trust must ensure staff adhere to the self-administration of medicines policy used in Pinderfields Accident and Emergency department. Regulation 12 (2) (g)
- The trust must ensure staff record strengths and doses of medicines. Regulation 12 (2) (g)
- The trust must ensure a robust system to record, monitor and mitigate the risk of patients who leave the accident and emergency department before assessment or after assessment. Regulation 12 (2) (a) (b)
- The trust must have robust systems of governance and audit of the Pinderfields Accident and Emergency department. Regulation 17 (1) (2) (a)
- The trust must ensure all electrical equipment is PAT tested and safe for use. Regulation 15 (1) (5)
- The trust must ensure all airflow ports are covered as per national guidance. Regulation 12 (2) (a) (b)
- The trust must improve their NEWS compliance. Regulation 12 (2) (a) (b)

Medicine

- The trust must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b)
- The trust must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. Regulation 12 (2) (b)
- The trust must implement an effective system to ensure all patients receive timely review by a consultant within 14 hours of admission to a medical ward. Regulation 12 (1) (a)
- The trust must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. Regulation 12 (2) (h)

Our findings

- The trust must ensure that time critical and when required medicines are administered at the correctly prescribed times and intervals. Regulation 12 (1) (g)
- The trust must ensure that oxygen is prescribed as required by national guidelines and a record of its administration maintained. Regulation 12(1) (g)
- The trust must ensure there are appropriate numbers suitably qualified, competent, and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1)
- The trust must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b)

Children and Young People

- The trust must ensure that mandatory training compliance, including core specific training such as safeguarding children level three, meets the trust target. Regulation 12 (1)(2) c.

Maternity

- The trust must ensure that mandatory training compliance, including core specific training such as safeguarding children level three, meets the trust target. Regulation 12(1)(2)(c).
- The trust must ensure that all equipment is maintained, service and replaced (especially for cardiotocography (CTG) machines) in line with trust guidance and within a timely manner. They must have oversight of the software license expiry dates required for the cardiotocography (CTG) machines and appropriately manage any associated risks. Regulation 15 (1)(2) (c)(d) (e)

Dewsbury and District Hospital

Urgent and Emergency Care

- The trust must ensure staff adhere to infection prevention control (IPC) guidance when crossing from red to green areas in Dewsbury accident and emergency department. Regulation 12 (2) (h)
- The trust must ensure the streaming nurse at Dewsbury accident and emergency department has guidance, an SOP, or pathways to follow when assessing patients. Regulation 12 (2) (b)
- The trust must improve patient triage times in Dewsbury accident and emergency department. Regulation 12 (2) (a) (b)
- The trust must reduce the time taken to transfer patients from Dewsbury accident and emergency department to Pinderfields. Regulation 12 (2) (i)
- The trust must ensure medical staff maintain up to date patient records in Dewsbury accident and emergency department. Regulation 12 (2) (a) (b)
- The trust must have a robust audit system for patient record forms from Dewsbury accident and emergency department. Regulation 12 (2) (a)
- The trust must ensure medical staff at Dewsbury accident and emergency department accurately record when pain relief is given. Regulation 12 (2) (g)

Our findings

- The trust must record the levels of mandatory training compliance of Medical staff and have a system to monitor when staff need to update their training. Regulation 12 (2) (c)
- The trust must have a system in place at Dewsbury accident and emergency department to identify patients who have left department prior to being seen or following assessment. Regulation 12 (2) (a) (b)
- The trust must ensure staff adhere to the self-administration of medicines policy used in the emergency department. Regulation 12 (2) (g)
- The trust must ensure staff record strengths and doses of medicines. Regulation 12 (2) (g)
- The trust must improve performance in relation to the level of documented evidence of action to mitigate risk of patients at medium or high risk of suicide leaving the accident and emergency department before assessment and treatment are completed. Regulation 12 (2) (a) (b)
- The trust must have a robust system to record, monitor and mitigate the risk to patients who leave the accident and emergency department before assessment or after assessment. Regulation 12 (2) (a) (b)
- The trust must review the out of hours medical support and availability of medical staff in Dewsbury accident and emergency department. Regulation 12 (2) (c)
- The trust must have robust systems of governance and audit of the Dewsbury accident and emergency department. Regulation 17 (1) (2) (a)

Medicine

- The trust must ensure that the care and treatment of service users is appropriate to meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c)
- The trust must ensure patients are treated with dignity and respect. Regulation 10 (1)
- The trust must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b)
- The trust must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. Regulation 12 (2) (b)
- The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. Regulation 12 (2) (c)
- The trust must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. Regulation 12 (2) (h)
- The trust must ensure that they follow national guidance to ensure there is an accurate list of the patient's medicines within 24 hours on admission. Regulation 12 (2) (g)
- The trust must ensure that medicines are stored securely. Regulation 12 (2) (g)
- The trust must ensure that the nutritional and hydration needs of service users are met. Regulation 14 (1)
- The trust must ensure the storage of equipment is appropriately located for the purpose for which they are being used. Regulation 15 (1) (f)

Our findings

- The trust must maintain securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation (17) (2) (c)
- The trust must ensure there are appropriate numbers of suitably qualified, competent, and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1)
- The trust must ensure that persons employed receive appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications. Regulation 18 (1), (2) (a) (b)

Children and Young People

- The trust must ensure that mandatory training compliance, including core specific training such as safeguarding children level three, meets the trust target. Regulation 12 (1)(2) c.

Maternity

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- The trust must ensure that all equipment is maintained, serviced and replaced (especially for cardiotocography (CTG) machines) in line with trust guidance and within a timely manner. They must have oversight of the software license expiry dates required for the cardiotocography (CTG) machines and appropriately manage any associated risks. Regulation 15 (1)(2) (c)(d) (e)

Action to trust SHOULD take to improve:

Pinderfields Hospital

Urgent and Emergency Care Services

- The trust should consider redesigning the public reception front desk at Pinderfields Accident and Emergency department reception area to ensure effective oversight of patients waiting to be seen.
- The trust should provide information in Pinderfields Accident and Emergency department for patients in multiple languages taking account of the demographic of the area.
- The trust should ensure sharps boxes are stored safely.
- The trust should ensure all call bells are within reach of patients.
- The trust should implement an effective system to ensure staff complete risk assessments for trolley rails for patient who will be in the department a long time.
- The trust should implement an effective system to ensure staff consistently complete body maps where appropriate.

Medicine

- The trust should ensure that patients have a record of placement of their medicine administered through a patch.
- The service should ensure that all medicines dispensed to patients are labelled according to the MHRA guidelines and includes a patient information leaflet.

Our findings

- The trust should ensure that patients requiring a meal that suites their cultural and religious preferences are offered an appropriate choice of meals.
- The trust should ensure that patients living with mental health problems, learning disabilities and dementia, have personalised plans of care that considers individual needs and preferences.

Children and Young Peoples Services

- The trust should ensure that they have data which accurately reflects they have sufficient staff with right qualifications, skills, and training to meet minimum staffing levels to keep people safe.
- The trust should ensure that they provide written information leaflets that are available in a range of languages spoken by the children, young people, their families, and local community.
- The trust should ensure all staff receive an annual appraisal.

Maternity

- The trust should ensure they have enough staff with the right qualifications, skills and training to meet minimum staffing levels and keep people safe from harm.
- The trust should ensure all staff receive an annual appraisal.
- The trust should ensure there is enough suitable equipment for staff to safely care for women and babies.
- The trust should improve the effectiveness of engagement and communication with staff. They should ensure staff understand the staffing and redeployment decisions being made as part of the planning and management of the service. In addition, they should ensure staff are confident and skilled to work on higher acuity areas.

Dewsbury and District Hospital

Urgent and Emergency Care

- The trust should consider redesigning the public reception front desk at Dewsbury accident and emergency department public reception area.
- The trust should ensure they have a separate room for private consultations at Dewsbury accident and emergency department public reception area.
- The trust should ensure they extend the Band 6 streaming role at Dewsbury accident and emergency department to cover 24 hours
- The trust should ensure the NHS Ambulance provider is made aware of the patient eligibility criteria for patients at Dewsbury accident and emergency department.
- The trust should ensure they devise a plan to improve the level of patient feedback responses.
- The trust should provide information in Dewsbury accident and emergency department for patients in multiple languages taking account of the demographic of the area.
- The trust should ensure they have a dedicated crash team to deal with cardiac arrests/resuscitation in Dewsbury accident and emergency department.
- The trust should ensure they review the clinical pathway document called ‘What Patient Where - Pinderfields, Dewsbury and Pontefract Hospitals’ with the local NHS Ambulance provider.

Our findings

Medicine

- The trust should ensure that safety guards are used when hot drinks dispensers are not in use on all ward/patient areas.

Children and Young People

- The trust should ensure all staff receive an annual appraisal.

Maternity

- The trust should ensure they have enough staff with the right qualifications, skills and training to meet minimum staffing levels and keep people safe from harm.
- The trust should ensure all staff receive an annual appraisal.
- The trust should ensure there is enough suitable equipment for staff to safely care for women and babies.
- The trust should improve the effectiveness of engagement and communication with staff. They should ensure staff understand the staffing and redeployment decisions being made as part of the planning and management of the service. In addition, they should ensure staff are confident and skilled to work on higher acuity areas.

Is this organisation well-led?

Our rating of well led improved. We rated it as good.

Leadership

Senior leaders demonstrated the necessary experience, knowledge and capacity to lead effectively. They had identified their priorities and developed plans to manage these in an effective, sustainable and timely way. Executives were visible and approachable. The executive and non-executive team worked as a unitary board and there was a common understanding and agreement about areas of concern They worked well as both an executive team and with leadership teams/team across the trust.

The new Trust Chair joined the trust June 2019 and the Chief Executive (CEO) joined the trust in October 2021.Though relatively new they worked well together with common aims, looking to improve the outcomes for patients. New Non-Executive Directors (NEDs) to the Trust told us they had been well supported and received a through induction to their role and that they worked well together as one board. The Chief Executive (CEO) joined the trust in October 2021. The role involved working with the trust as well as working in partnership with the integrated care system (ICS) in the region. The Chief Operating Officer (COO) had held the post since March 2016. In January 2022, the COO took on the role of Deputy Chief Executive.

The Medical Director joined the trust board in May 2015, prior to which she had worked in other leadership roles in the organisation, including Deputy Medical Director and as a Consultant Paediatrician at the trust.

The Chief Nurse joined the trust in July 2016, the Director of Workforce was appointed in September 2018 and the Finance Director was appointed in January 2016. The Director of Community Services joined the Trust in April 2022.

Our findings

Though several members of the leadership team had been with the trust for some time, the CEO and DCEO were relatively recent appointments. The DCEO role was newly aligned to the COO portfolio in a strategic recognition of the changing system landscape. The COO had been a member of the Executive Team for six years. At the inspection during interviews with staff and managers we explored what the changes in senior leadership had meant to them. Staff were positive overall about the changes and felt enabled, supported, listened to, to undertake their roles. This particularly included how clinical information was managed and how digital information supported better more efficient working. A decision was made to try to connect community services with social care services with the appointment of a joint director to start to create a unified vision of what out of hospital care would look like and this was seen as a positive move towards better integration.

However, whilst positive changes were seen at board level and Senior Leadership Team (SLT), there was more work for the trust to undertake to ensure leaders in divisions and core services demonstrated these values consistently and this impacted positively on the care patients received within the trust. SLT did recognise these challenges and the need to ensure these values were embedded. Work was ongoing to address identified shortfalls, but this was not completed at the time of the inspection.

A new clinical operating division, the Acute Care Division was created from 01 April 2022. There was investment in a Senior Leadership Team for the newly created Division. This was in recognition of the scope of the Division of Medicine and the challenges this posed. As a result, following consultation in winter 2021, approval was given by the Trust Board to split the Division of Medicine into two separate divisions: the Acute Care Division, which encompassed the Emergency Departments and urgent care, and the Division of Medicine, which retained the inpatient and outpatient medical specialities.

During our inspections we found that the effectiveness of local leadership of the core services varied. There was a lack of progress since the last inspection in relation to the leadership of the medicine care group. The Trust said challenges in the Division of Medicine were recognised prior to the inspection and actions were being taken, which included the separation of the division into two operating divisions with an increase in leadership through a designated senior leadership team for each division.

Progress was impacted by the effects of the COVID-19 pandemic.

Finance

Trust Financial Governance (Trust Financial Governance report; 25 April 2022)

There were no concerns about the Board's capacity and capability regarding finance. The board worked well together and had a shared view of the financial requirements of the Trust and where resources needed to be focused. All Executive Director members were substantive appointments and had many years NHS experience.

A new CEO was appointed seven months ago, bringing substantial experience and leadership capability.

The Director of Finance was experienced and had been in post since 2016. They were due to leave the organisation in June 2022 and backfill agreements were in place whilst the trust substantively recruited to the position.

Our findings

The trust delivered its financial control total in 2019/20 and had delivered its financial plans with agreed resource allocations throughout the duration of the pandemic. During the pandemic and under the temporary financial regime the trust delivered a breakeven position in 2020/21 and again in 2021/22. However, during the inspection the board identified that delivering this year's financial control targets would be more challenging.

The trust was system oversight framework (SOF) at SOF level 3 due to its underlying financial sustainability, which will be reassessed as the trust developed the medium to long term plan which was expected in 2022/23.

Prior to the Pandemic in 2019/20 efficiency levels of 3.1%(£18.7m) were delivered at the trust. Levels of efficiency were lower throughout the pandemic, but the trust planned for higher levels of efficiency to be restored in 2022/23 consistent with the national requirement.

The trust had worked on the financial plan for 2022/23, in conjunction with the Integrated Care System.

The trust had not reported to NHSEI any financial regulatory issues or adverse external audit reports and NHSE/I had not had any reason to need to test financial governance due to the trust's current financial position.

NHSEI had not tested the trust's response to system working, and the information received by the board, however, the ICS had equally delivered on key financial targets of the previous 2 financial years.

Fit and Proper Persons Requirement (FPPR)

We found the trust had a Fit and Proper Person Procedure and the files we checked were predominantly in line with the requirements of the regulation.

There was a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed 11 executive and non-executive director files in total. Our review included checks for the newest executive and non-executive appointments. All but one file included references and signatures and documentation stating copies of the original documents such as degree certificates had been seen.

One file of an employee who had been with the trust for a number of years did not contain original documents such as qualification certificates. This was raised at the time of inspection and we received assurance that these documents had been seen and verified.

We also looked at the trust's Fit and Proper Person Procedure and spoke to the company secretary who was responsible for oversight and compliance with the FPPR procedure.

We reviewed the six-monthly self-declarations, made by the directors, to confirm that they remained fit and proper. We found these were completed consistently and in line with the trust's procedure.

Our findings

Vision and Strategy

The current vision and strategy for the trust was in place from 2017-2022 this had been extended for 12 months while a new vision and strategy was developed. The current vision was based around striving for excellence and ensuring a great patient experience every time. The trust was engaging in the development of the new strategy with both internal and external partners However, in the core services we inspected staff were not always able to articulate their divisions vision and strategy.

The Striving for Excellence corporate strategy, initially for 2017-2022, was refreshed and extended until 31 March 2023. The trust told us that the strategy was extended for the following reasons:

The changing system landscape, the appointment of a new Chief Executive, and the COVID-19 pandemic.

Plans to develop a new Quality Strategy were included within the scope of the Strategy Development Programme for delivery in 2022/23, which had commenced in February 2022. This was a planned programme that would deliver a new Trust corporate strategy and align with the existing supporting strategies, including MY Quality Strategy. This was led by the Chair of the Quality Committee, the Director of Nursing & Quality, and the Medical Director.

The trust had values to support their vision. These were caring, high standards, improving and respect. Staff that we spoke with during the inspection knew what these values were and were able to articulate how they demonstrate them in the care and treatment they delivered.

The view of the board was these values would provide the basis for future development, but work was needed to develop a sustainable vision and strategy going forward.

The board were working to incorporate a place-based strategy for Wakefield into the trusts new vision and strategy.

A consultation session involving 120 people, mostly front line clinicians including divisional directors and heads of services had been held to listen to people's views and ideas about how services could be accessed and delivered local to them.

Primary care was also supportive and involved in the development of the Vision and strategy going forward

The plan was that the trust new strategy would link with the place-based strategy for Wakefield and the wider integrated care system (ICS). The trust had appointed a new director of community services who had joint roles within the local authority and clinical commissioning group with the aim of transforming out of hospital care and improving outcomes for the people of Wakefield. This was still in the early stages of developing the role, developing ways of working and transforming and embedding into practice.

The CEO had previously worked with other systems nationally who had built this model but was clear that any vision and strategy had to be right for people using services in the Mid Yorkshire Trust, Wakefield and the West Yorkshire System

The CEO told us the unified vision and strategy would be in place by the beginning of June 2022 with another consultation session to be held in early May. This would include a demonstration of the vision and strategy, giving mainstream staff a forum to discuss the strategy with SLT.

Our findings

A shadow board committee for strategy was in place and was to be responsible to ensure that the operational plan linked to the vision and strategy was implemented.

The service had a clear vision for what it wanted to achieve, as part of the wider Division of Medicine, and a strategy to put this into action developed with all relevant stakeholders.

The trust provided data to evidence that the vision and strategy were focused on promoting patient safety, ongoing improvement and development and sustainability of services which aligned to local plans within the wider health economy.

We were also provided with data to evidence leaders and staff within the wider Division of Medicine understood the vision and strategy and how to monitor them.

The medicine division followed the trusts current 2017-2022 overall vision and strategy. This was complimented with the Mid Yorkshire (MY) quality strategy. At ward level, leaders shared with us ward improvement plans that identified targets and visions for improvements.

In maternity although leaders had shared the plans for the vision and strategy in various team meetings not all staff understood the work being done to improve staff experience. The service was working extensively with the maternity voice partnership (MVP) and the safety recommendations from the Ockenden report to develop the next strategy due for release in 2023.

However, we heard many examples from staff who did not know the future for the Bronte birth centre and what this meant for the birth centre staff, community and continuity midwives.

The Children's and Young Peoples Service (CYP) always had a vision and a quality strategy which focused on keeping patients safe and providing excellent patient experiences. The service had clear priorities and an operational plan which focused on staffing, safety and costs.

Culture

Overall staff felt respected, supported and valued. Staff spoke about the improvements in morale. Staff were focused on the needs of patients receiving care despite the challenges in services. The trust was working towards a more open culture where patients, their families and staff could raise concerns without fear.

During interviews with the board we were told about strong relationships between members of the senior team who had adapted the way they worked during the pandemic including virtual board to ward visits to ensure SLT visibility across the trust and promoting the shared aim of improving patient care and experience.

The trust had a number of mechanisms to monitor culture these included board to ward visits where members of the board and executive team would visit clinical areas and meet with frontline staff on a regular basis.

The staff survey results and people pulse survey was shared department and at board level. There was also a monthly report to the executive team targeting particular themes, for example, bullying in the organisation.

The trust encouraged staff to report concern's and promoted the role of the Freedom to speak up Guardian (FTSUG) to support this approach. Specific staff webinars had been set up to support staff, including BAME staff to use the FTSUG.

Our findings

The Executive Lead for FTSUG at Trust Board was the Director of Nursing & Quality

In addition, there was a Non-Executive Director with lead for FTSUG. The FTSUG produced a paper for each meeting of the Trust Board that was submitted via the Company Secretary

The FTSUG was invited to attend the Trust Board as required, and as a minimum annually for a Q&A session.

Whistleblowing internally to the FTSUG, staff side and externally to the Care Quality Commission (CQC) were well-established mechanisms in the trust to raise concerns. Staff were supported by Human Resources or the FTSUG person during the whistle blowing event.

We were told there was still anxiety about raising concerns because of possible negative consequences and the initial response from managers could cause more anxiety rather than the issue itself.

There were operational tools in place to improve the culture faster, for example the sickness and disciplinary policies and line management training support to ensure staff were managed in a consistent way.

In recognition of the national workforce challenge in the NHS the trust was looking to improve flexible working over the next 12 months.

We found staff morale to be generally good in the core services we inspected with the exception of urgent and emergency care core service, where some staff told us that there was a culture of support for some but not all staff. The internal staff survey results for the emergency department showed that team working was beneath the trust average, with the majority of staff supported each other well and there was good teamwork. We observed good rapport between staff across the trust of different professions, and teams we spoke with were proud of the services they provided and the work they had done during the COVID-19 pandemic to care for patients.

The guardian for safe working (GFSW) team supported junior doctors in their role and facilitated meetings to discuss support and concerns with good representation from all relevant areas in the hospital. The pandemic had meant that more meetings were able to be attended via a virtual platform rather than needing to take time out of work schedules to travel to face to face meetings.

Quarterly reports were discussed at the board meetings and then sent to the regional guardians. An action plan was used to support learning and monitor progress. Senior management looked at the implications of any gaps in the medical rota to ensure staff were not working in excess of their hours. The Medical Director was aware of all Rota issues to have oversight and ensure the appropriateness of decision making

The FTSUG attended every induction of junior doctors along with the Guardian of Safe Working Hours. The Medical Education Team support raising of concerns to the FTSUG, the investigation and triangulation of concerns, and provided support to junior doctors involved once consent was obtained. All junior doctors were encouraged to contact the FTSUG with any concerns and have an honest and open discussion.

During the pandemic, the trust recognised that they needed to ensure the wellbeing and safety of their staff and developed a range of initiatives. Wobble room/ areas were set up; these safe spaces were set up for staff to go to for time out, recuperate and reflect. These had remained available to staff if needed.

Our findings

The trust appointed a clinical psychologist to work with staff. The trust also had the MY Wellbeing Matters Service in place which allowed staff to access the rapid intervention of trained psychologists. Recently a Staff Wellbeing Hub has been set up through the ICS which was centrally funded to allow staff to access training packages as well as support.

The trust had a comprehensive Bullying and Harassment Policy which was up to date and accessible to all staff on the trust Intranet. The policy sets out a clear commitment to eliminate all forms of bullying and harassment.

The trust rewarded and recognised staff with two additional rewards during the pandemic. In 2021 this included £100, an extra half day holiday and a medal in response to the pandemic, and in 2022, a further £50 in shopping vouchers and an additional day of annual leave. Staff told us this had made them feel very much appreciated and was very much a well-received boost to morale.

Governance

Systems and processes were in place to support governance processes; however, we were not assured staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There was a lack of assurance that performance from audit was accurately measured and we found examples where processes were not undertaken in line with guidance.

Trust Governance Arrangements

The Mid Yorkshire Hospitals NHS Trust Board and Committee Structure (April 2022) membership comprised of assurance/statutory groups with executive, non- executives and external parties as members.

The trusts governance structure identified the trust executive group as the primary forum for operational accountability, assurance and for reporting and escalation to sub-committees of the board. Confirmation of individual accountability was described, for example, the trust secretary reported to the chief executive officer. Discussions seen in meeting minutes with the non-executive team confirmed that the executive team were appropriately challenged around governance and performance.

The trusts board assurance and reporting arrangements confirmed working group accountability to the executive team.

Assurance that governance and committee structures worked effectively was confirmed by the implementation of a biannual review of committee chairs who met to see how the committees were functioning.

Chairs of tier one committees met twice yearly; led by the audit committee chair to ensure no duplication and effectiveness of the committees.

Committee Structure

The Charitable Funds Committee reported directly into the trust board. The Trust Chair and Chief Executive Officer attend the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common, an externally established Committee which is responsible for leading the development of the WYAAT Collaborative Programme and workstreams, and report to the trust board.

There were six sub-committees of the board:

Our findings

- Executive risk committee
- (Shadow) Strategy and transformation committee
- Quality committee
- Resource and performance committee
- Audit and governance committee
- Remuneration and terms of service committee

Governance accountability and Assurance

A non-executive chairperson led each board committee. The chief operating officer chaired the executive risk committee. Biannual meetings took place with the committee chairs and trust secretary. Bi-monthly shadow strategy and transformation committee meetings took place.

Tier one committees completed a chairs report included as part of the trust board agenda. Each tier 1 committee included a section on COVID as part of the agenda.

The reportable issues log contained incidents which were discussed at board level.

The audit committee provided assurance that internal processes and controls were effective and received individual Chairs committee reports, for example, quality committee minutes went to the audit committee for assurance before going to the trust board.

The June 2022 board development session had planned to develop the workforce committee whose remit included looking at the trust culture. The governance lead had stressed the importance of whole board involvement and recognition of organisational culture in these future discussions.

The trust had a devolved system of governance where committees, teams and other working groups focused on specific areas including, infection, prevention and control, equality and diversity, patient safety and clinical experience. Divisions submitted in advance a governance review report to the quality committee on a bimonthly basis.

We saw evidence of information presented at committees for assurance and could see how assurance worked within committee structures. Different sub-committees fed into the quality committee and then up to the Trust Board. The assurance flow involved the reporting of individual sub-committee minutes and Chair's reports into the quality committee.

For example, patient safety and clinical effectiveness and patient experience sub committees reported into the quality committee. The patient experience committee reported into the patient safety and clinical effectiveness committee before presentation at the quality committee. Monthly, two divisions reported to the quality committee, then progressed to the trust board.

The infection prevention and control team (IPCT) provided an overview of infection rates.

Board Assurance Framework

Our findings

The board assurance framework (BAF) identified 11 principle risks agreed through trust board development sessions. All but two principals were aligned to the executive directors. The two not aligned related to COVID and partnership working which were aligned directly to the trust board. Quarterly discussions of the BAF took place at the trust board. In-between, these quarterly discussions two principal risks from the BAF, dependant on priority, were discussed at the trust board.

Board seminars took place in October 2021 and February 2022 where the BAF was discussed. Live topics were discussed, and the trust was now focused on risk appetite and this had been included within the BAF from May 2022. A session on 'Planned care and Strategy' was planned for the end of May 2022.

The corporate governance team and trust secretary were working with the executive leads to align these risks against the controls and assurances approach. The initial revised BAF was due for submission to the tier one committees in June; which would then feed into the July report and then onto the trust board.

Quality Governance Committee

Recognition of clinical risk by the quality governance committee resulted in the establishment of 30-minute quality committee seminars where individual issues were discussed in more detail. All members of the committee could attend. The quality seminars were designed to focus on outcomes. Examples of the topics discussed included:

- Health Care Acquired Infection, as the dashboard had shown an increase in these areas.
- Data on timely administration of antibiotics after diagnosing sepsis.

There was also a focus on the quality aspects which were discussed at more than one committee, for example, staffing. The clinical consequences of staffing shortfalls were discussed and what sat behind the statistics This was then discussed and if any shortfalls were identified and action plans put in place and monitored at committee and at divisional level.

Ward to Board Governance and Assurance

We had concerns with the governance processes in the medicine and urgent and emergency care (U&EC) specialities, how concerns were escalated within the trust and the timeliness of actions taken. We were particularly concerned that some of the patient safety risks we had identified on our first inspection of urgent and emergency care and medicine had not been identified sooner within the trust and actions taken to mitigate risks. When we returned for our second visit, we found some actions had been taken but not all of the areas had improved. In medicine at Pinderfields Hospital the ward health check audits highlighted low compliance for example storage of equipment in unlocked storerooms, resuscitation trolley daily checks and skin assessments. Senior leaders were aware of audits, but they could not explain the actions to address areas of low compliance and the trust did not share any action plans despite them being requested after the inspection.

Gaps existed in audit data and there was a consistent failure to meet targets in some audit areas for example the urgent and emergency care areas. One example related to the sepsis audit for antibiotics given within one hour showed a lack of compliance over several months.

Our findings

Also, during our inspection visit of the urgent and emergency care areas at Pinderfields in March 2022, we found the air ports that must have be covered to prevent air being delivered to the patient rather than oxygen were not. This had not been identified in safety audits by the department. We found differences between the Pinderfields and Dewsbury site in how the leadership teams assessed quality and safety.

The trust had recognised these issues and had recently divided the divisions of U&EC and medicine including their governance and escalation structures. Their view was with a reduction in size of the divisions and an increase in clinical audit staff, who had now stepped down from direct clinical work because of the reduced COVID work, they would be able to support clinical managers to embed governance processes.

Throughout and after the inspection we made requests for further information from the trust despite this the trust failed to provide evidence showing compliance with regulations and/or good practice or provide an explanation as to why they could not provide this evidence. For example, we requested information for the medical division about individual ward action plans for hand hygiene following low compliance and vacancies rates for medical staff, registered nurses, healthcare staff and trainee nursing associates.

A shortfall in registered nurses and healthcare staff was a feature across the medical division.

Management of risk, issues and performance

Leaders and teams used systems to manage performance and risk effectively. They identified and escalated relevant risks and issues through established channels both in the Trust and system wide. Actions were then put in place to reduced risk and their potential impact. Plans were in place to cope with never events through business continuity planning. Staff contributed to decision-making to help avoid clinical and financial pressures compromising the quality of care.

The trust met, as often as daily when required, with other members of the local health and social care system which included the CCG, Local Authority and NHSEI when pressures in the trust escalated. The trust identified pressures within the trust in line with the national tool known as OPEL (Operational Pressures Escalation Level). These levels were graded one to four. One being the normal level of activity with little risk to the service the trust could provide. Four was where pressure in the local health and social care system continued to escalate leaving organisations unable to deliver comprehensive care and where there was increased potential for patient care and safety to be compromised.

During the inspection the trust was at OPEL three/four. We observed the OPEL meeting, system partners worked closely together to mitigate risk to patients using a number of different actions including redeploying staff including those not in a clinical facing role , instigating additional signposting to out of hospital services and increasing social care provision.

The trust risk registers, both corporate and divisional described risks on the register with clear mitigation's and actions next to each one. Monthly risk committee meetings took place. Divisions if unsure bought their proposed risk to the committee for discussion on the risk level. Principle risks were identified on the trust level risk register. Conversations took place at the risk committee prior to the risk being added to the trust level risk register. The trust risk register and BAF were presented quarterly to the trust board.

Since March 2022 the trust board were sent a monthly summary of the risk register which informed them about changes in that month.

Our findings

Risks were escalated through the two-weekly patient safety panel and the executive and head of department groups discussed issues and patient safety alerts. Each division linked to the trust level risk register, for example violence and aggression. The division then identified what they had in place to manage this.

Divisional governance meetings minutes and individual risks were discussed at the risk committee. Where there were common themes, for example staffing, which was also included on the trust level risk register, timely administration of medicines, i/c the administration of insulin and antibiotics for sepsis and patient flow.

Infection Prevention and Control (IPC)

The trust had polices and processes to control infection risk well. However, we found that staff did not always put these polices and processes into practise well and staff did not always use equipment and control measures to protect patients, themselves or others from infection. They kept equipment and the premises visibly clean.

Infection Prevention and Control (IPC) inspection findings:

IPC shortfalls were noted in the medicine and urgent and emergency care services we visited on both the Pinderfields Hospital and Dewsbury and District Hospital sites.

In both services we observed staff not always following infection control principles including the use of personal protective equipment (PPE). We observed staff moving between the red and green zones not donning and doffing uniforms or changing their PPE.

The Director of Nursing and Quality was the Director of Infection Prevention and Control (DIPC). The DIPC had completed the DIPC program and described a good relationship with clinical experts and frequent communication. The DIPC attended the two-weekly regional DIPC meeting.

The DIPC was supported by a robust infection prevention and control reporting structure.

Investment over the last two years has ensured growth of the IPC clinical team members, including the appointment of a Matron for IPC and additional Band 6 IPC nurse specialists and there would be access to three substantive microbiologists by the end of April 2022. The trust was also developing an IPC specialist Nursing Associate role.

The Infection Prevention and Control (IPC) strategy focused on safety and providing a safe service for patients The IPC Work Programme 2022/23 detailed the strategy in place to ensure appropriate arrangements and management systems for infection prevention and control.

The trust was identified as an outlier in relation to *Clostridium Difficile* Infection cases in Yorkshire and Humber Acute Trusts data for the period October - December 2021. The Trust had delivered an action plan which included Hydrogen Peroxide Vapour cleaning of five wards, education to clinical staff and increased antimicrobial stewardship activities which staff could articulate. In January to March 2022 the Trust was below the England mean for *Clostridium Difficile* infection.

The IPC strategy was aligned with national priorities and the wider health and social care economy. An action plan was in place to meet the national ambitions to reduce gram negative infections.

The IPC strategy had been shared with the community of teams to ensure alignment.

Our findings

The trusts principle current infection control and decontamination risks related to the conflicting issues of Covid and C Diff as some estates were not suitable or consistent. Dewsbury District Hospital (DDH) was identified as having more estate and patient group IPC risks. The strategies for managing risks involved bed management and the IPC team presence on the DDH site.

IPC issues and lessons learnt were discussed at the trust safety panels; divisional IPC groups were working to refresh IPC action plans.

Infection Prevention and Control (IPC) Board to Ward Assurance Processes clearly defined IPC governance framework was in place which identified the committee, accountability and reporting structures.

The annual infection prevention and control report was reviewed quarterly and discussed at the trust board. The report was shared publicly through the trust quality accounts, trust website and was shared and discussed with the Local Authority, Overview and Scrutiny Committee and Health Watch.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust digital strategy, MY Digital Future,2019-2025, included how the trust would manage both patient and staff information safely. The strategy's aim was to transform patient care by the application and advancement of information technology at the Trust.

The trust was digitally mature and had worked across departments and organisations across the system to improve, while keeping information secure. For example, the trust had worked with the local Clinical Commissioning Group (CCG) during the COVID pandemic to ensure information being used by community and hospital-based clinicians was based on the same data to ensure continuity and validity

Also, community teams had access to System One to aid the sharing of information between the hospital and community with GP's and other health professionals.

The strategy of the trust was to look past good information management and move to information for improvement enabling early diagnosis and better clinical decisions.

This had enabled 25% of outpatient appointments to be conducted remotely, telemedicine in dermatology clinics, safeguarding alert automation and the roll out of the virtual ward nursing observations being achieved through the implementation of this strategy.

The EPR (PPM+ is the system used by the trust) has been implemented across all three sites since 2019. Observations went live in November 2019, medical notes/clerking June 2020 and nursing notes April 2021. Paediatrics went live in April 2022.

In the core services we inspected we saw that important information such as policies and minutes of meetings were easily accessible to staff. Data management systems were integrated and secure.

Our findings

Notifications were submitted to external organisations as required. For example, the service submitted staffing positions for the previous 24 hours to the Local Maternity System (LMS) and NHS England and Improvement (NHSE/I).

Staff across all sites could easily access the electronic patient record systems and care records. The EPR (not ESR as stated in the report) has been live across all three hospital sites since 2019.

Information governance was included in mandatory training, however we found patient information was not always secured appropriately on the wards, with patients records not been securely locked.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public, national and local organisations to plan and manage services.

A consultation session involving 120 people, mostly frontline clinicians including divisional directors and heads of services had been held to listen to people's views and ideas regarding the new vision and strategy . A further consultation exercise was planned for early June 2022 with an audience that included system wide partners.

The CEO had engaged with other systems nationally to develop the new strategy but was clear this had to be right for people using services in the Mid Yorkshire Trust and the West Yorkshire System.

The new patient, carer and family experience and engagement framework was in draft and being reviewed by the quality committee virtually, who provided constructive challenges on the framework. Engagement with patients, carers and families now took place through this framework.

Over the last five-years the trust board had wanted to know about patients' feedback and what the feedback included rather than just the numbers of complaints; the trust board wanted to know what patients were telling them so they could address themes and trends. For example, maternity feedback had included a theme the about consistency of seeing the same midwife this was feedback to NED with the maternity lead to take forward.

The patient experience committee was attended by Healthwatch, a patient representative and the complex needs' patients experience group to ensure a range of views were listened to.

Links existed to Carers Wakefield in the trust, two Carers Wakefield volunteers would hold conversations with patients, to gather feedback about their experience, this would then be shared with the patient advisory liaison (PAL) team.

Feedback about patient experience was sent to the trust from a number of organisations including: Healthwatch, NHS UK and Care Opinion which was fed back into the patient experience committee. Three monthly quality and safety walks conducted by the Clinical Commissioning Group and the trust monthly ward health checks also contributed to patient feedback.

Bereavement services engaged with different faith groups to ensure good relationships across the community for example the early release of Muslim bodies within 24 hours of death process.

The bereavement service contacted relatives following their family members passing and arranged the paperwork. The trust sent out forget-me-not seeds to relatives a few weeks after the patients' death.

Our findings

Staff described one priority over the next 12 months was to contact the travelling community in Wakefield and engage to understand their information requirements and access to services.

Staff described how they responded to staff groups concerns throughout the Covid-19 pandemic when issues were raised about personal protective equipment. Two examples related to staff concerns about the wearing of long-sleeved fluid repellent gowns and the standard of some items of PPE, particularly in relation to eye protection. We saw through multi-disciplinary problem solving and joint working that solutions were identified and agreed with staff groups so that the PPE used was appropriate for the use intended.

The trust had a dedicated equality and diversity policy. Leaders and staffed talked about the diversity of staff and being inclusive.

Staff said they had seen a difference in how people talked, challenged others which demonstrated the values, for example, such as caring and respect values.

Learning, continuous improvement and innovation

The trust had systems in place to identify learning from the majority of incidents and the mortality and complaints review process, these systems were effective, and outcomes delivered in a timely way which meant any required improvements to patient care was timely. We did see examples when this was not the case. Staff were committed to continually learning and improving services. Quality improvement methods had been introduced and staff understood the skills needed to use them, but these improvements were not fully embedded. Leaders encouraged innovation and participation in research.

During the Serious Incident Review process a summary of learning was shared across the trust and WYAAT, themes were identified and included in the quarterly report around learning from deaths. Lower scoring reviews graded a 1 or 2 (poorer care) were looked at to ascertain whether there were opportunities for cross divisional learning to be shared. The trust were able to share examples of how shared learning across WYAAT from serious incidents.

Incidents were presented at the Quality Governance Committee by the divisions and the patient safety and clinical excellence committee group. Six never events were reported in the financial year 2020/21. In 2021 there was a total of three never events reported for surgery.

In the latest financial year 2021/22, the number of never events reported was three; one surgical and two retained swabs post procedure in maternity in February 2022.

Compliance with the WHO checklist was one identified shortfall during the reviews. Additional audit and training had been put in place and compliance from December 2021 to March 2022 was at over 95%. Human factors training had been commissioned following the recognition of human factors themes in incidents.

The executive team confirmed the areas they were proud of. These areas included:

- Incidents had seen an improved culture of staff around raising incidents and feeling supported when doing this.
- Action plans following serious incidents had improved in how they were written. The Trust was currently looking at how actions from these action plans had been embedded.
- People had greater confidence when speaking up.

Our findings

Mortality

Mortality performance continued to be any area of focus during 2020/2021 and the trust had seen an improvement, though still below the national average, in both its HSMR and SHIMI figures rates throughout 2020/21. Oversight was maintained and led by the medical director (MD) at the trust.

HSMR performance per 100,000

- 2019/20 - 110.7
- 2020/2021 - 101.2

SHMI performance per 100,000

- 2019/20 - 1.07
- 2020/2021 - 1.06

The Mortality Improvement Group was chaired by the MD being the senior responsible officer. The group had its own analytical support and used the outputs from the trusts safety data. The group had a grasp of where the trust was at and what was needed to be done to ensure this was effective.

Complaints

During the inspection we reviewed six complaints. Of the six the majority were supportive, assessed any ongoing risk, included a thorough investigation and identified any learning. However, one of the complaints we reviewed was defensive and did not deal with the issues raised clearly and with a full investigation or sympathetically. There was no evidence of learning.

We brought this to the attention of the SLT who acknowledged further work needed to be undertaken to ensure all complaints were appropriately dealt with

We were told of improvements made following patient complaints received by the trust. The improvements all related to communication:

- During Covid-19 waves 1 and 2 two staff per ward were redeployed to become patient liaison officers, then became family liaison officers.
- On the elderly care wards staff agreed with their families how often they would ring them which resulted in a reduction in concerns.
- Visitors who required support because they were visiting a patient with complex needs and / or end of life received additional help which was personalised to the individual with visiting arrangements.

Improvement and innovation

The trust was ambitious to become a university hospital and had established an On-site nursing degree program, which was also supported nurse recruitment also the CEO was also planning to develop vocational training for 16 to 18 year olds in collaboration with the ICS.

Staff felt confident to suggest improvements in divisions for example the combination of weekly outpatient clinics in the maternity division into fortnightly clinics for women under the continuity service.

Our findings

We saw posters displaying achievements including recognition across the trust in each division.

My Digital Future the strategy to support information management in the trust was ambitious with an aim to improve patient outcomes by 'going digital'. Significant progress had been made since the introduction of the strategy in 2019. SystmOne is in place across all services including community services, and the PPM+ EPR has been successfully implemented across all three hospital sites since 2019.

The maternity division collaborated with regional universities and charities to support research studies. They had participated in the obstetric anal sphincter injuries 2 (OASI2) research and helped with a 'big babies' trial for when babies were bigger than expected. They also contribute towards 'Tommy's national rainbow clinic study; which is a specialist service for women and families following stillbirth, pregnancy loss and neonatal death.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Requires Improvement ➔➔ Nov 2022	Good ↑ Nov 2022	Requires Improvement ➔➔ Nov 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Pontefract Hospital	Requires Improvement → ← Nov 2022	Good ↑ Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Requires Improvement → ← Nov 2022	Requires Improvement → ← Nov 2022
Pinderfields Hospital	Requires Improvement → ← Nov 2022	Requires Improvement ↓ Nov 2022	Good → ← Nov 2022	Requires Improvement → ← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement → ← Nov 2022
Dewsbury and District Hospital	Requires Improvement → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Requires Improvement → ← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement → ← Nov 2022
Overall trust	Requires Improvement → ← Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Requires Improvement → ← Nov 2022	Good ↑ Nov 2022	Requires Improvement → ← Nov 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Pontefract Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Urgent and emergency services	Requires improvement Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Requires improvement Dec 2018
Maternity	Good Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018
Outpatients	Requires improvement Dec 2018	Not rated	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Requires improvement Dec 2018
Overall	Requires Improvement → ← Nov 2022	Good ↑ Nov 2022	Good → ← Nov 2022	Good → ← Nov 2022	Requires Improvement → ← Nov 2022	Requires Improvement → ← Nov 2022

Rating for Pinderfields Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Good →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022
Services for children and young people	Good ↑ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022
Critical care	Good Dec 2018	Good Dec 2018	Outstanding Dec 2018	Good Dec 2018	Good Dec 2018	Good Dec 2018
End of life care	Good Oct 2017	Good Oct 2017	Good Oct 2017	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017
Surgery	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Urgent and emergency services	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement →← Nov 2022
Maternity	Requires Improvement ↓ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good ↑ Nov 2022	Good ↑ Nov 2022	Good ↑ Nov 2022
Outpatients	Requires improvement Dec 2018	Not rated	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Requires improvement Dec 2018
Overall	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement →← Nov 2022

Rating for Dewsbury and District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement ↓ Nov 2022
Services for children and young people	Good ↑ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022
End of life care	Good Oct 2017	Good Oct 2017	Good Oct 2017	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017
Surgery	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Urgent and emergency services	Requires Improvement →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement →← Nov 2022
Maternity	Requires Improvement ↓ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good ↑ Nov 2022	Good →← Nov 2022
Outpatients	Requires improvement Dec 2018	Not rated	Good Dec 2018	Requires improvement Dec 2018	Good Dec 2018	Requires improvement Dec 2018
Overall	Requires Improvement →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement ↓ Nov 2022	Requires Improvement →← Nov 2022

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Community dental services	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017
Community health services for adults	Requires improvement Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017	Good Oct 2017

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Dewsbury and District Hospital

Halifax Road
Dewsbury
WF13 4HS
Tel: 08448118110
www.midyorks.nhs.uk

Description of this hospital

Dewsbury and District Hospital provides services, usually for patients living in the North Kirklees district. The hospital provides urgent and emergency care , diagnostics, elective care, midwife services and care of the elderly services. The hospital treats over 340,000 patients every year.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training.

Nursing managers monitored mandatory training and alerted staff when they needed to update their training. This was done through staff being sent e mail alerts in their work diaries as to when the training needed to be completed by.

Staff told us they were given time at work to complete their mandatory training either online or through face to face teaching.

At the time of the inspection nursing staff had achieved 100% compliance regarding their mandatory training and medical staff training compliance was 88% against a trust target of 90%.

Training refresher dates were based on the dates the staff member joined the department which meant the mandatory training was spread over the financial year and there would never by a time when there wasn't a member of staff who was not trained in a particular discipline.

The mandatory training for nursing staff was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse.

All band six and seven nursing staff were trained to safeguarding level three.

Medical staff received training specific for their role on how to recognise and report abuse.

Data showed Medical staff training compliance was 93.1% for Safeguarding level one training and 88.2% for Safeguarding level three training, both of which were above trust targets.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff we spoke with were able to explain the safeguarding reporting procedures and tell us about examples of safeguarding referrals they had made.

Staff followed safe procedures for children visiting the department.

There was an area set aside in the department, away from the treatment bays, dedicated to safeguarding, where staff could speak to patients privately and make referrals. There were wall charts and documents displayed which staff told us they used for reference purposes.

Staff we spoke with were able to explain what arrangements would be put in place to enable the patients identified as being an increased risk to themselves to remain safe, which included use of a dedicated room, use of bays in view of the nurses station, increased nursing support and supervision of patients by security staff prior to the patient being assessed or treated.

The trust had an Adults Safeguarding policy which followed intercollegiate guidance due for review in August 2024 and a Children's Safeguarding policy which followed intercollegiate guidance and due for review December 2023.

We randomly checked staff records which evidenced suitable recruitment checks had been completed prior to employment which complied with schedule three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also saw evidence of appropriate enhanced disclosure and barring service (DBS) checks completed for all active staff members.

Within the trust Urgent and Emergency Care departments there was oversight of vulnerable patients provided by mental health ambassadors who were the deputy director of operations and matron for urgent and emergency care had trust responsibility and a sister at Dewsbury Emergency Department supported by a Staff Nurse had local responsibility for this.

Cleanliness, infection control and hygiene

The service did not consistently manage infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw the correct storage of cleaning materials and mop heads in-line with control of substances hazardous to health (COSHH) guidelines.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

We inspected three treatment rooms with en-suite bathrooms. All appeared visibly clean.

Disposable labelled curtains were used around the bays. The mattresses were clean and free from breaks.

All sharps bins were dated, signed and less than ¾ full.

The department had a process whereby a Band six nurse had responsibility for overseeing IPC audits and reported the findings to the Band seven nurse department manager. This responsibility was on a yearly rotational basis with other Band six nurses.

Infection prevention and control (IPC) audits were carried out daily. Examples in the full department cleaning schedule, included both the rooms and equipment used within the emergency department, staff hand hygiene and bare below the elbow audit and the commode cleaning records.

On inspection the most recent IPC audits showed 100% compliance.

The IPC audit results were displayed in staff room. The results were discussed at the quarterly clinical governance meeting.

There were numerous sinks in the department with hand gel and handwashing instructions on posters displayed near the sinks. Staff were observed washing their hands before and after patient contact.

The department had a temporary wall erected which split the department in to two parts. The wall was erected at the start of the COVID-19 pandemic. The wall enabled the department to be spilt into designed red and green zones. There was different entrance for suspected COVID-19 patients who entered the red zone. There was external signage for patients with suspected COVID-19 to follow.

None COVID-19 positive patients entered through the main department reception waiting room.

The department had their own COVID-19 swabbing area with results provided within the hour. The red zone was for the treatment of COVID-19 positive patients.

Four patients had been swabbed which were COVID-19 positive and were being treated in the red zone bays.

There were three designated Health Care Assistants who were trained to carry out the COVID-19 swabbing.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). During inspection we did observe staff moving between the red and green zones not donning and doffing uniforms or changing their PPE. This meant there was a potential infection risk to patients and staff.

There were notices displayed in the department reminding the public to wear face coverings. While on inspection we did observe security staff challenging members of the public who were not wearing face coverings.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Since the last inspection, the main check-in area had been made secure to promote staff safety. There were screens in place at the front desk and access to the main seated waiting area was through a locked door which was controlled by the reception staff. CCTV was present within the waiting area and all staff had access to a personal safety alarm. The department had security staff deployed 24 hours a day.

Urgent and emergency services

The departmental public reception area was small. The desk was closed off by two clear windows with a central grill which people could speak into. On both days of the inspection we observed at different times, with the reception area being so small, people waiting in the queue outside the building.

The public waiting area had fixed metal seats with some labelled not to sit on to maintain social distancing.

There was a vending machine in the public waiting area but no toilet facilities. There was not a messaging system to explain to patients what the average waiting time was.

At the time of the inspection there were no notices in different languages displayed to provide patients or families information. However, managers told us that the department would be introducing electronic leaflets using QR codes which would allow information to be accessed in different languages and various formats for patients with communication difficulties.

Although there was a hearing loop system in the public reception area staff told us because of the height of the ceiling and volume of people often waiting; patients or carers who were hearing impaired found no benefit from the loop.

The front reception desk was at height whereby patients in wheelchairs could speak to reception staff face to face.

Medical equipment was managed through an equipment computerised management system. The full maintenance and service history for all medical devices were held within the database. The service was audited to ISO9001 which was the internationally recognised Quality Management System (QMS) standard. No issues were identified with the system used.

There were 20 treatment bays in the department.

Staff carried out daily safety checks of specialist equipment.

The recent reorganisation of the stock cupboard, using the Mid-Yorkshire Quality Improvement System framework, had optimised storage and enabled staff ease of access to consumable items and helped prevent unnecessary stock wastage.

On inspection we checked 12 consumable items from the stock cupboard, and all were in date.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. Arrangements were in place for the segregation, storage and disposal of waste.

At the last inspection conducted in March 2018 the trust was told it had breached Regulation 12: Safe care and treatment. The trust was told it must review the designated mental health room and complete regular risk assessments of the room.

Dewsbury emergency department had a designated mental health room and completed regular risk assessments of the room.

There was a separate room in the emergency department for conducting assessments of adults with mental health conditions.

The trust had a standardised tool to risk assess the environment of designated MY Safe Space rooms.

A MY Safe Space room or cubicle was an area identified to provide a safe and suitable environment for the assessment of patients requiring urgent and emergency mental health care assessment in accordance with Psychiatric Liaison Accreditation Network (PLAN) standards.

The room we inspected complied with this guidance.

The department had direct access to diagnostic services and an independent health provider who managed primary care patient appointments.

The resuscitation trolley was kept in the resuscitation area of the department. The trolley held a defibrillator machine (AED) and equipment. There was evidence the equipment had been checked each day and was fit for purpose.

We inspected the major incident storeroom. We randomly reviewed nine consumable items which were in date. The room was well organised, and all equipment was accessible. There were copies of major incident plans available for staff to use in the event of them being involved in a major incident.

There were back-up generators in the emergency department which would be used in the case of failure of essential electrical services being regularly tested.

There was evidence of a departmental fire evacuation plan accompanied by evidence of recent testing of the plan conducted in November 2021.

The trust also had a fire safety policy which was in date and provided staff with clear guidance to follow.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. The did not always remove or minimise risks and updated the assessments. Staff could not always identify and quickly act upon patients at risk of deterioration.

Patients who walked into the department provided their details to reception staff. If the reception staff had any concerns, they sought advice from a band six nurse who worked in reception between 9 am and 7.30 pm in the streaming nurse role to identify the most appropriate care pathway. Two staff members advised us the service had previously not had an initial assessment and streaming clinical role in place at initial contact and the streaming role was introduced in 2021 as part of the trust's response to monitoring patient risk and optimising access and flow within the department.

Following the inspection, managers provided evidence that guidance and processes were in place for the streaming role within reception. However, Staff told us there was no formal guidance, a standard operating procedure (SOP), job role or designated pathways in place for the streaming role at Dewsbury and District Hospital. Staff who performed the streaming role told us they used their professional judgement to risk assess patients and prioritise treatment.

Outside of the streaming nurse working hours there was a list of minor injuries and illnesses the receptionists could refer to in order to determine whether a patient could to be sent through to triage within the department. Two of the reception staff we spoke with advised they would send patients experiencing chest pain, shortness of breath, per vaginum bleeding or severe abdominal pain through to be triaged.

Urgent and emergency services

Staff did voice concerns there was no access to a private triage room to complete observations or speak further with the patient upon initial access to the department. During inspection the streaming nurse was only able to speak with patients through the window at the front desk of the department. We were advised when the department was particularly busy, patients could wait for over an hour to be triaged.

During the inspection we spoke with 28 patients in the public waiting area. They had been waiting between 45 minutes and up to two hours to be triaged which presented potential risks for example, to complete sepsis screening, manage pain and carry out timely observations for possible deteriorating patients.

We observed four ambulance crews arrive at the department and handover patients in a timely manner. All four patients were triaged within 15 minutes using a nationally recognised triage system.

We were informed by staff patients sometimes left the public waiting area prior to treatment due to extended waiting times.

Although the trust had a process for staff to follow for patients who had chosen to leave the department prior to assessment by a clinician, or patients who have left after assessment by a clinician, staff we spoke with told us the patients who left the department were not reviewed or followed up. This meant patients at risk may not have received the treatment they required before leaving and would remain at risk. However, after the inspection, the service provided us with an audit of patients who had left the department in the six-month period November 2021 to April 2022. This evidenced risk-based follow up of patients in the audit sample and escalation to other agencies, including the police where appropriate. The audit also showed that 98% of patients in the cohort categorised as “left before assessment” had a full triage completed.

Staff told us they were made aware, in advance, of an ambulance attending and to the acuity of the patient so their treatment could be prioritised.

Patients brought in by ambulance did wait in non-treatment areas and were supervised by ambulance staff.

During inspection we reviewed the trust’s Observations Standard Policy for all in-hospital Adult Patient Care Environments policy which was in date.

The policy set out the standards for the provision of observations for all adult patients who were either at risk of, or who were acutely ill, in all patient care environments within the Mid Yorkshire Hospital Trust, excluding obstetric, paediatric and critical care areas.

There was evidence in the patient records we checked nursing staff followed the policy by completing risk assessments for each patient on admission in the department, using a recognised tool, and reviewed this was reviewed, including after any incident.

However, medical staff did not follow this policy as some records we checked did not have up to date medical notes in them.

There was evidence in the records we checked there was a screening tool for patients with suspected sepsis which was accompanied by an escalation plan.

Urgent and emergency services

We reviewed eight records of patients who had come into the department overnight. Two of the records showed it had taken two hours 23 minutes to hand the patient over from the ambulance and another had taken three hours ten minutes to hand over the patient.

Three of the records showed excessive time periods from the patient being triaged to being assessed by a doctor. One record showed it took three hours 48 minutes, another seven hours 34 minutes and a third five hours 39 minutes.

One record showed a patient had been in the department seven hours 56 minutes. There was no medical assessment recorded.

Five of the records showed having been assessed by the doctor when they took over in the morning, but we were unable to locate notes recorded of the handover.

In the eight records we checked, four showed a decision had been made to admit the patient. At the time we checked the records' s one patient had been waiting eight hours 38 minutes for admission, another 11 hours six minutes, a third four hours 41 minutes and a fourth 35 minutes. All were still in the department when we checked the records.

Two patients had been admitted into the department with chest pain. There were no updated medical notes, no treatment plans and no discharge plans.

This was brought to the attention of the nurse department manager who was not aware doctors were not completing records.

Staff we spoke with told us when the department was often busy overnight and sometimes doctors forget to type their notes into the computer and some doctors saw multiple patients one after the other. They would try to type up the medical notes all up at the same time. This added an element of patient risk because information could be forgotten or added to the wrong patient record.

The hospital had a dedicated crash team to respond to cardiac arrests. There was 24 hour medical cover on-site at registrar level, and 24-hour consultant cover for the Emergency Department. Paediatric medical cover including a consultant was provided up to 10 pm when the children's assessment unit closed. After this time, paediatric medical support was available from the Pinderfields site or via the paediatric consultant on-call, all of whom had appropriate experience in paediatric life support and trauma care.

There was 11 hours of on-site consultant presence within the department and a dedicated on-call consultant available 24 hours a day.

Due to only limited services on-site at Dewsbury and District hospital, the trust had developed a care pathway with the ambulance providers to ensure that patients accessed the correct emergency department in order to receive the most appropriate care and treatment. This ensured that critically ill or injured patients were transported to Pindefields in the first instance, as well as ensuring processes were in place to support with intra-hospital transfers for patients requiring in-patient care. Data provided by the trust for the year 2021/2022 highlighted that of 93,023 patients who attended the department, only 6755 required transfer to an inpatient bed at another hospital.

Staff knew about and dealt with any specific risk issues including sepsis, VTE, falls and pressure ulcers. Departmental audits in relation to these which showed high levels of compliance.

Urgent and emergency services

At the time of the inspection the department there had been no recorded falls for 158 days and no hospital acquired pressure sores for 128 days.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff access mental health support for patients in a timely manner. We observed two patients were seen within one hour of the initial referral to liaison psychiatry.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

During inspection patients undertook psychosocial assessments.

Nursing staff shared key information to keep patients safe when handing over their care to others.

Nursing shift changes and handovers included all necessary key information to keep patients safe. An example was the daily nursing handover documentation which was made available to all staff on-shift and contained relevant information to promote the delivery of care.

Data supplied by the trust showed in the three weeks prior to the inspection the percentage ambulance handovers within 15 mins were 97.9%, 97.6% and 100%. There were no ambulance handovers exceeding 60 minutes.

The department had a standing operating procedure (SOP) with the local NHS ambulance provider as to the acuity of patient to be admitted.

The consultant in Emergency Medicine and Head of Clinical Service had led a bespoke review with the local NHS ambulance service to produce a clinical pathway document called 'What Patient Where - Pinderfields, Dewsbury and Pontefract Hospitals' which provided a criteria-led guide for ambulance crews to refer/convey patients to the most appropriate emergency department within the Trust.

The aim of the document was to ensure patients were referred to the most appropriate emergency department or urgent care service across the Trust according to the patients acute care needs, and aligned to the medical, surgical, paediatric, and obstetric service provision and in-patient bed profile.

The criteria for Dewsbury highlighted, no resuscitation (resus) cases and no cardiac arrests.

Prior to the COVID-19 pandemic, the criteria document would be formally reviewed jointly with the local NHS ambulance trust as part of the Emergency Medicine's governance process, and as required if any speciality reconfigurations required a change in the ambulance criteria for any site. The criteria would also be reviewed, for example, if learning from incidents indicated this was required.

Due to challenges arising from the pandemic, it had not been possible to jointly review the criteria; however, an internal review of the document has been completed within the Trust to ensure the criteria remained fit for purpose considering the changes in service provision necessitated by the COVID-19 pandemic. Amendments made to the criteria since the start of the pandemic included those for patients with potential COVID-19 infection, were reflected in the document. This was last reviewed in November 2020.

Urgent and emergency services

We observed a patient in the department who had arrived by independent ambulance working on behalf of the local NHS ambulance provider. The staff challenged the crew as to why they had brought in a patient who was of a higher acuity than agreed. The crew stated they were unaware of the criteria. The discussion took ten minutes during which time the patient received no treatment placing them at risk.

On average between 10 to 15 ambulances attended the department each day. There was evidence 98% of the ambulance handover times had been achieved.

Staff took part in scenario training as part of the deteriorating patient group work activity. The service had developed a tailored programme to support multi-disciplinary teaching and learning across the department. All scenarios undertaken were based on previous incidents which had taken place, in order to aid learning. Staff undertaking the training were always provided with feedback and learning points.

During inspection we reviewed the Emergency Department quality and safety dashboard. The dashboard contained monthly audit information which was aligned with clinical indicators specific to clinical areas.

There was evidence in patients records that there was a screening tool used for patients with suspected sepsis which was accompanied by an escalation plan.

Although we saw examples in nine out of 10 patient records that sepsis screening had been completed in-line with national guidance, the audit results for antibiotics given to patients with sepsis within 1 hour showed in December compliance was 70%, January 85% and February 70%.

The audit for Sepsis (Proforma completed) had not achieved target since May 2021. In October compliance was 70%, November 70%, December 60%, January 80% and February 75%.

We reviewed the sepsis audit data for April 2021 to February 2022. The audit recorded that 537 out of 548 patients had been screened for sepsis. Of those patients screened for sepsis, 76% were screened using the latest screening tool.

However, the audit also looked at when patients received intravenous antibiotics after being diagnosed with sepsis. Almost 25% (133) did not receive this within the recommended one hour timeframe.

There was a strategic sepsis action plan which had last been updated on 3 March 2022. Most of the actions were completed. There were three actions RAG rated red and incomplete which were; to develop and build a new electronic screening tool as a joint collaboration with another NHS hospital, develop an alert system for stat dose antibiotics through the E-Meds system, development of 24/7 business case. All the actions had owners and comments regarding progress to completion.

In the February 2022 Deteriorating Patient Group Meeting minutes there were attendees from urgent and emergency care department.

We reviewed the notes of the meeting of the patient safety and clinical effectiveness (PSCE) sub-committee held 16 March 2022. The meeting highlighted current audits which showed the requirement for improvement in both the use of the screening tool and in early administration of antibiotics.

There was evidence in the minutes of the meeting of the actions to be taken to improve performance including, a 5TOP quality improvement initiative to ensure timeliness of escalation and sepsis screening for patients who trigger high NEWS scores and a quality improvement plan which was split into three phases: education, performance monitoring/ data collection and self-monitoring.

Although there were short- and long-term actions in place, the audits in relation to sepsis indicated they were not bringing the improvements required and patients remained at risk.

Following the 2018 inspection the trust were given a should do action to ensure consistency in the care of patients with sepsis. The trust had appropriate guidance in place and introduced new initiatives to ensure suitable care of patients with suspected sepsis. Although the trust had taken relevant steps to address these concerns, further embedding of processes was required.

The trust had a standard operating procedure (SOP) which outlined the procedures to be followed when transferring a patient from Mid Yorkshire Hospitals Trust (MYHT) to a mental health placement.

The SOP provide staff with clear guidance to follow to reduce the risk to the patient and staff.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers. On inspection it was noted the nurse staffing allocation board highlighted at points throughout the day, there had been one less nurse and health care assistant (HCA) than planned.

We reviewed the registered nurse and health care assistant staff rota records for March 2022. These showed that whilst the department occasionally worked below planned levels, it had not operated with fewer than one member of staff below what was planned.

The service had low vacancy rates. There was one band seven vacancy, 1.3% down on band five staffing, 1.7% over on band six due to maternity cover.

The service had low turnover rates.

The service had low sickness rates. The nurse staffing sickness rates at the time of the inspection were 3.78%.

In February 2022 there were the following whole time equivalent (WTE) vacancies in Dewsbury Urgent and Emergency Care department; 1.06 registered nurses. 3.36 Health Care Assistants.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the department did not provide 16 hours on-site consultant cover each day, seven days a week as recommended by the Royal College of Emergency Medicine (RCEM).

The trust provided data to evidence the service had enough medical staff to keep patients safe. Medical workforce rosters were computer based which identified additional demand before the commencement of each rotation of shifts. Any known rota gaps which had not been filled translated into shift gaps. Shift gaps were advertised through the Trust's Internal Medical Bank and the agency locum market. Bank and agency locums were then put forward to fill shifts.

The service had low vacancy and turnover rates for medical staff.

In the financial year 2021/22, the trust had two new staff added to the substantive medical workforce who worked across both urgent emergency care departments. In the same period two staff from the medical workforce left the Trust; one due to retirement and one to work abroad.

At the time of the inspection the trust had recently appointed three new Consultants who were awaiting confirmed start dates.

Data provided by the trust evidenced low sickness rates for medical staff on the department, with short term absences for the department of medicine at 3.07% and no long term absences documented for March 2022.

Data provided by the trust highlighted reducing rates of bank and locum staff since January 2022.

Managers could access locums when they needed additional medical staff and ensured a full induction was provided before they started work.

Although the service had a good skill mix of medical staff on each shift, it was highlighted that there were gaps in registrar staffing on occasions. The trust were able to review any potential gaps in staffing and could move staff between hospital sites if required.

The department had 11 hours of consultant presence within the department 8 am to 11 pm on weekdays and 9 am to 10 pm on weekends and always had on-call consultant cover available 24 hours a day. The Consultant staffing model for the department was risk-assessed, based on the function and acuity of the department.

Two Registrars worked 8 am to 4 pm, one Registrar worked 9 am to 5 pm, one Registrar worked 1 pm to 9 pm and one worked 3 pm to midnight. On one day during inspection we found the 1 pm Registrar post had not been filled due to short term sickness. One registrar worked overnight 10 pm to 8:15 am.

There was one senior house officer started work at 8 am, one started at 10 am, one started at 1 pm and two worked 4 pm to midnight.

Some staff we spoke with told us they felt the staffing levels after 11 pm were not safe due to the high volume of patients. They told us that there was no paediatric consultant on duty after 10 pm, with appropriate paediatric medical

cover provided via the on-call system. Staff also described that during this time accident and emergency staff were required to treat children as well. The knock-on effect was delays in treating patients in the department. The trust provided assurances that the paediatric emergency department was staffed by a minimum of two registered nurses qualified in children's nursing, in-line with national guidance, to ensure patient safety.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear, but not always up to date, stored securely and easily available to all staff providing care.

All patient records were a mix of paper and computer based. We reviewed 18 sets of notes, all of which were legible, however, not all contained relevant patient information.

During the last inspection conducted in March 2018 the trust were given a should do action to ensure that patient records were completed consistently, particularly in relation to pain scores, NEWS, nutrition and hydration of patients. However, audit information received after the inspection evidenced improvements and consistency in the completion of documentation, particularly in relation to NEWS, pain scores and nutrition and hydration. The department Quality and Safety Dashboard evidenced 96% compliance with the completion of NEWS and 97% for pain assessment and management over the last 11 months.

During this inspection we found not all patient notes were comprehensive. We identified some patient records had not been updated up by the duty doctor in the morning of the inspection following a verbal handover.

Medical staff we spoke we told us use of the patient record computer system was not popular as it did not have the ability to add drawings/ body maps to show injuries and on occasions medical staff were simply too busy to write up the notes.

The lack of updated patient notes resulted in delays in patients being moved to medical wards from Dewsbury to Pinderfields as patients would not be accepted without their records being up to date.

Nursing records were comprehensive and legible. There was evidence in the records we checked risk assessments had been completed.

All staff could access them easily. Records were stored securely.

Mental health assessments, care plans and risk assessments were accessible to staff in the department.

The trust provided an audit of documentation which included records kept in the emergency department at Dewsbury. The audit had been completed in November 2021, December 2021 and March 2022. The audit showed records were consistently stored securely, however the results for whether records were complete and signed appropriately were mostly below compliance targets. The Trust told us the November 2021 audit of the adults' emergency department records at Dewsbury did not take place due to auditor sickness.

Additional evidence provided by the trust highlighted that a key improvement project had been put in place in the adult's emergency department to improve documentation standards and to support the department as part of the organisation's digital transformation. The aim of the project is to support improvement in documentation standards and ensure safe storage of records.

Urgent and emergency services

Medicines

The service used systems and processes to safely prescribe, administer, and store medicines. However, staff did not ensure records of administered medication were complete and contemporaneous.

Staff followed systems and processes to prescribe and administer medicines safely.

Medicines were stored securely with only appropriate staff having access. Controlled drugs required a double signature with one signature having to be a senior member of staff.

Fridge temperatures were monitored centrally, and alerts given to the department if they went above recommended fridge temperatures.

We looked at three medicine records in the emergency department at Dewsbury. In one of the records we were told the patients relative administered their medicines, however we found no medicines prescribed or this self -administration recorded in the notes.

However, policies provided to us by the trust post inspection stated self-administration was not to be used in the emergency department.

Allergies were recorded in all the records we looked at.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Specific advice was given to patients when take home medicines were given from the department.

Staff stored and managed all medicines and prescribing documents safely.

Specific advice was given to patients when take home medicines were given from the department.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Medicine reconciliation by the pharmacy team did not take place in the emergency department. This fell under the scope of the clinicians at the first point of information gathering by a clinician about a patient's condition before hospital admission.

Staff did not complete medicines records accurately and kept them up to date.

In two of the records there were medicines listed however this was not comprehensive as this did not record strengths or doses.

Staff learned from safety alerts and incidents to improve practice and we saw evidence of lessons learned on display in staffing areas and also available within the designated safeguarding area.

We found no evidence in patient records and through observations to suggest that people's behaviour was controlled by excessive and inappropriate use of medicines.

The trust confirmed at the time of the inspection they did not conduct any audits of medical staff prescribing medicines.

The department had achieved 100% compliance in the most recent controlled drugs audit completed in March 2022, which highlighted 100% compliance with both daily and monthly controlled drugs checks.

Overall staff compliance with medicines management training was 88.8%.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Managers shared learning with their staff about never events that happened elsewhere. The department nurse manager told us they shared learning with staff in relation to incidents that had occurred elsewhere in the trust.

Staff reported serious incidents clearly and in line with trust policy using the internal reporting procedures.

Two serious incidents which had been reviewed. Both had findings and areas of learning which was shared in the department.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff we spoke with gave us examples of when the principles of when the principles of the duty of candour had been applied.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Root cause analysis was used in investigations of incidents with findings and arrangements for shared learning.

The trust had previously completed a nine-point serious incident action plan for an incident which took place in November 2021, with all action points being approved by commissioners.

Managers debriefed and supported staff after any serious incident.

The trust confirmed that there had been no never events reported in the department over the previous 12 months.

Urgent and emergency services

Arrangements were in place to respond to relevant external safety alerts, recalls, investigations and reviews. This was done during handover meetings, sharing the information on staff notice boards and e mails to staff.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw two patients had been referred to Liaison Psychiatry and receiving an assessment with one hour of being referred by the department.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

In nine of the ten records we checked sepsis screening and management was done effectively. However, in one of the records antibiotics had not been prescribed with the hour as per NICE guidance.

The trust employed security staff to assist staff in dealing with violent or aggressive patients or family members. Security staff could be present in the department while mental health assessments were being carried out, if required.

The trust had carried out a review of patients with mental ill health who had attended Dewsbury emergency department comparing the findings to three national standards. The audit showed good compliance with standards requiring patients to have a mental health triage assessment and further risk assessment of their mental health. The audit showed low compliance with recording observations or intermittent checks and managers had implemented an action plan to improve performance.

The trust had established a governance process for the dissemination, implementation and monitoring of national institute of clinical excellence (NICE) guidance.

The trust had a policy “An Organisation-wide Document for the Dissemination, Implementation and Monitoring of NICE guidance, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and other National Inquiries”, issued December 2021 and approved January 2022, which covered the processes.

Newly received NICE Guidance was discussed at the Speciality Governance Meetings, Divisional Governance Meetings and the NICE Internal Panel.

Urgent and emergency services

The trust used a NICE tracker to record any new guidance which required action. The tracker recorded if the Trust were compliant with the guidance or if not, what progress was made toward compliance.

Nutrition and hydration

Data obtained from the trust indicated that staff provided patients with enough food and drink to meet their needs and improve their health.

There was a trust wide emergency department health check of nutrition and hydration management through a monthly audit.

The trust provided audit results for nutrition and hydration management from November 2021 until March 2022. Audit activity was paused during January 2022 and February 2022. Staff consistently achieved 100% in all areas for November, December and March.

We saw evidence that the trust could meet the nutritional needs of patients with special dietary requirements if required.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way. Following admission in the department they supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We could not be assured staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. This was due to the department not having a separate area at the front desk to complete initial observations, there was no facility to administer pain relief to patients who may have needed this whilst after an initial assessment in the records we checked some patients received pain relief soon after it was identified they needed it, or they requested it. However, in two of the records we checked there were no updated patient records so it could not be established if pain relief had been given.

Staff prescribed, administered and recorded pain relief accurately. In ten of the patients records we checked there was evidence pain relief medication being given in a timely way.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements, however, they did not always evidence that good outcomes were achieved for patients.

Audit data provided by the trust highlighted consistent levels of quality within the department to promote patient care. However, the trust acknowledged that ongoing improvement was required in regards to management of sepsis in patients attending the department.

The trusts unplanned re-attendance rate at Dewsbury urgent care department was; December 8% against a Trust target of 7.8%, January 7% against a Trust target of 7.9% and February 7% against a Trust target of 8.1%.

This data showed the departmental unplanned re-attendance rate at Dewsbury urgent care department mirrored the trust's rates.

Urgent and emergency services

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Nurse managers supported staff to develop through yearly, constructive appraisals of their work.Staff had recorded quarterly one to one meetings with nurse managers to discuss progress of any objectives or training needs identified in the annual appraisal.

The completion rates for medical staff appraisals rates were 100%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Band six nurses were given additional responsibilities to improve performance and develop their skills, which included IPC audit, mandatory training oversight and management of consumable items.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

There was a processes to allow staff to have continuous professional development (CPD), which included; the process for study leave for non-medical staff, the process for accessing CPD funding streams, different pathways through nursing and which training programmes were available internally to support development, and organisational development pages on the trust intranet site which highlighted the courses and support available to enhance staff learning

The clinical educators supported the learning and development needs of staff.

Nursing staff were allocated into a mentoring team, which was under the leadership of a Band six nurse. As part of the mentorship team, all staff had an annual appraisal, where learning needs were identified.

The emergency department Clinical Educator maintained and displayed an education calendar of planned education sessions/study days in the staff room. Staff who had not had opportunity to attend training were rostered to attend or would attend in their own time and be given the time back.

All nursing staff were provided with the Royal College of Nursing, Emergency Nurse competency booklets (Level one or two) and Band six or Band seven mentors supported staff to complete these. The unit manager held a three-monthly review with the Band six staff to review their staff teams and identify any learning needs and opportunities.

Band six staff had been allocated focused and link roles which were supported with additional education where it was required.

Courses that became available throughout the year were advertised for staff to attend and those expressing an interest were given the opportunity to attend either through time back or via allocation on the roster.

Doctors in training grades were placed at the trust as part of their developmental pathway and accessed both formal and informal internal CPD opportunities through activities including bed side teaching, clinics and theatre lists as well as formalised training including the revised STR1DE Foundation Year one training programme delivered in the Trust.

There was formalised training through college tutors in the divisions/specialities and formalised training through the relevant schools and training programmes. Doctors in training grades could apply for study leave to support external CPD opportunities and each request was considered individually prior to approval.

Consultants and doctors which were speciality doctors and specialist grade doctors (SAS) with at least four years of postgraduate training, two of which are in a relevant speciality, had access to internal and external CPD opportunities.

Internally this included; speciality governance held monthly, mandatory training for which time was allocated, new consultant programme and aspiring clinical leaders programme. Externally Consultant and SAS grades were eligible to apply for study leave which was governed by the Trust study leave policy.

The trust had a Performance Management and Capability Policy which clearly outlined the objectives to ensure employees were supported to perform in their role and to contribute to the core values of the Trust. The policy provided guidance to managers in helping performance manage employees to work towards achieving the strategic aims of the Trust as described in the Striving for Excellence programme.

The trust had an effective process for managing under performing staff. Two staff were being managed through the informal performance management procedure. Both had ongoing support plans.

One member of staff was being managed through the formal performance management procedure with an ongoing support plans. One member of staff had been involved in informal performance management but had met the required standards**.**

Two staff had been involved in formal performance management one had resigned and was referred to the nursing and midwifery council (NMC) and the other re-deployed

The trust planned simulation training each Wednesday morning at 9 am.

Nurse managers made sure staff attended team meetings or had access to full notes when they could not attend. All relevant information from team meetings were displayed on the staff notice board. Staff had access to paper copies of key points discussed within team meetings, as well as electronic copies of meeting minutes.

Nurse managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff were provided with an office-based day every fortnight to enable them to complete any outstanding training. At the time of the inspection the overall training compliance rates for nursing staff was 100%.

Nursing staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with gave us evidence of courses they had been on including those above their banding to allow them to develop their career.

Nursing managers made sure staff received any specialist training for their role.

Some medical staff we spoke with expressed views an experienced Registrar was required to be on duty overnight. Concern was raised about the lack of paediatric support overnight. This meant the department medical staff, on occasions, had to treat children, which were outside their level of expertise. It was also highlighted the departmental consultant sometimes had to work alone as no registrar was available.

Urgent and emergency services

Despite the individual views of some medical staff, the trust indicated that there was adequate medical cover available and that any shortfalls in staffing were risk-assessed, and staff could be moved across hospital sites to mitigate risk if required.

The trust had a Restraint and Restrictive Practices Adult policy. The policy was to support a consistent and positive approach to the management of patient behaviour such as aggression, violence and resistance to care by patients who lacked capacity and acted against own best interests within the Mid Yorkshire Hospitals NHS Trust.

The policy provided clear guidance for staff to follow to reduce the risk to themselves and patients.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We saw one patient waiting to be transferred to a psychiatric hospital for further care and support, following a referral to the Crisis Team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff had access to diagnostic services and mental health services 24 hours a day.

Support from doctors was available 24 hours a day, however, due to clinical pressures during night shifts, staff told us it was not always possible to seek and obtain medical advice in a timely manner.

The trust adopted the clinical standard set by the Royal College of Physicians and the Seven Day Services Clinical Standards, which was for consultant review of emergency admissions within 14 hours of admission. In line with the clinical standards, the Trust had some pathways which did not require 14 hours consultant review.

Although national submissions against the Seven Day Services clinical standards had been suspended during COVID-19, the trust had continued to monitor performance internally.

An audit sample of 71 patients admitted as emergencies via the Emergency Department to the Acute Assessment Unit (AAU) between Monday 21 March to Monday 28 March 2022, shows 89% (63) of patients received a consultant review within 14 hours.

Of the eight patients that did not receive a consultant review within 14 hours of admission, one was due to the patient absconding from the ward, and one patient was known to the medical team and was seen by the specialist in-reach respiratory team. No harm was identified in any of the eight cases.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The trust had relevant information promoting healthy lifestyles and support on the department. There were multiple information leaflets and posters within the department for both physical and mental health needs.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. In three patient records (PRF's) we checked in nursing notes staff formally assessing patients' capacity and taking appropriate actions to ensure safe care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. In five of the PRF`s we checked consent had been sought appropriately to enable safe care and treatment.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

When a patient entered the emergency department at the point of triage an assessment was completed, which included a functional mental capacity test which consisted of four questions which were asked to establish if the patient had capacity.

The outcome of the initial triage assessment determined if the patients care could be delivered with informed consent, or if care would be delivered after considering acting in the patient's best interests.

The trust had three assessment tools to assist in establishing if the patient had capacity.

The trust recognised staff in the emergency department often worked in life saving situations and it could be necessary to use the Mental Capacity Act 2005 to take necessary action to prevent serious deterioration in the persons condition without their consent.

Staff clearly recorded consent in the patients' records.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data submitted by the Trust showed the compliance rate at the time of the inspection for MCA and DoLS training was 100%.

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data submitted by the Trust showed training level compliance for was 89.7% for Mental Capacity Act Level one and 88.9% Mental Capacity Act Level three.

Urgent and emergency services

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. We saw two examples where staff had completed relevant MCA documentation and followed appropriate guidance to request a Mental Health Act assessment for a patient. The information documented was appropriate and legible.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Within the department there was a designated safeguarding area for staff containing all relevant guidance for MCA and DoLS.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

In the emergency department staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed consultations being carried out behind closed curtains.

Patients we spoke with told us staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported the family of a patient, as well as treating the patient, staff relocated the family members to a room within the department to ensure privacy was upheld.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff we spoke with understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Urgent and emergency services

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Due to COVID19 restrictions, the department followed national guidance to ensure that only patients who required support from a loved one or carer were allowed into the department accompanied. Staff ensured that patients were supported by a carer when requiring support with communication or making complex decisions about their treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department there were patient and families feedback forms available which could be submitted at the nurses' station. The staff room also contained the survey results from each month of the previous year. The last survey result was from December 2021 which had a 12.5% response rate from patients where 81.5% of patients had provided positive feedback.

We reviewed the February 2022 friends and family test results. There were 3515 patients through the department of which 416 or 11.8% submitted a response, of these 77.4% were positive and 16.1% were negative.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in coordination with services across the trust to meet the needs of local people and the communities served.

In the records we checked the individual needs of patients with complex needs, learning difficulties and dementia were recorded.

Not all facilities and premises at Dewsbury were appropriate for the services being delivered. Patients checked in at the front desk which was often observed as crowded and noisy. One patient advised that they had difficulty communicating with the staff member on the front-desk due to the noise, making it difficult to discreetly share private information.

We observed the public reception area to the department was always busy with multiple members of the public in the foyer waiting to be seen by reception staff. Due to the fact there were two reception areas on the same desk where the public engaged with reception staff sharing personal information there was no privacy or dignity as what was being said could be overheard by other members of the public.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the prompt response and support from the emergency mental health support teams.

Urgent and emergency services

The trust had systems to help care for patients in need of additional support or specialist intervention.

The trust relieved pressure on other departments where they could by referring patients into care pathways which did not require patient hospitalisation.

The department had the ability to stream appropriate patients to a primary care centre which was on the site of the hospital.

All areas of the department were well lit, in good physical condition and in good order.

The waiting area had reading material in relation to the services provided but not in multiple languages reflective of the population demographic of the area. There was WIFI and television access. There were no notices or a message relay system to provide updated waiting times. There were no toilet facilities within the seated public waiting area.

There was a dedicated psychiatric assessment room which met Psychiatric Liaison Accreditation Network (PLAN) standards.

There was signage on the walls and different coloured directional footprints on the floor with the department name for patients to follow which were to assist patients to navigate through the emergency department.

There was evidence of discharge planning in the records taking account of social and welfare concerns.

Dewsbury hospital site provided a limited range of specialist services and often more acutely unwell patients would need to be transferred off-site. We observed delays in transferring patients to the neighbouring hospital site at Pinderfields due to lack ambulance availability.

We were advised by staff it was difficult to contact patients who left the department prior to being seen, particularly if they had not yet been triaged. We spoke to one patient who had left the department and re-attended on two previous occasions due to extended waiting times.

We reviewed the trust's, "How to achieve safe, sustainable care in our Emergency Departments report". The report was informed by the 2021 Royal College of Emergency Medicine (RCEM) Cares document and was used to inform the operating plan for 2022.

The document contained five domains and outlined the (RCEM) system wide plan to improve patient care. There were five areas considered, which were; crowding, access, retention, experience, and safety. The senior management team reviewed the document and then triangulated this with workforce, activity and performance/standards as part of the operating planning process.

Several actions to bring about improvement were still ongoing at the time of the inspection.

The trust's emergency department had been working alongside the system wide transformation programme to reflect the needs of the population. This included being part of the long-term strategic work as well as developing short term actions such as more integrated working with the walk-in centre though piloting a new model of staffing.

Urgent and emergency services

The Trust was represented on the multi-agency forum established and embedded for the collaborative review and management of frequent users of urgent and acute care services locally to determine individual patient management plans and alternative pathways.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was evidence of this in the records we checked.

The department used forget me not stickers to ensure patients with cognitive difficulties were easily identifiable for both nursing staff and porters. The trust also used hospital passports to support patients with learning disabilities.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Staff told us they used translation services to communicate with patients when English was not their first language. They told us of occasions when staff were used to interpret for patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Reasonable adjustments had been made so people with a physical disability could access the service. These included a ramp to the public access, lowered reception desk, wide enough spaces in the department for wheelchair access and disabled toilet facilities.

The departmental nursing manager explained frailty assessments of patients were done on arrival. The assessments included a pressure sore assessment. If any pressures sores which were community acquired were identified they were recorded in the records and through the trusts internal reporting system.

The department complied with the Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of people with a disability or sensory loss.

Nurse training in dementia was mandatory and at the time of the inspection the compliance rate was 100%.

Due the fact Dewsbury Hospital only had care of the elderly wards, if patients required further medical treatment, they were transferred to medical wards at Pinderfields hospital or to other specialist NHS hospitals.

The trust has an Enhanced Care of Children and Adults Policy which was due for review in April 2025. It was recognised patients may have changing clinical, mental health, psychological and social needs and may require varying degrees of support including observation to be offered during these phases.

The policy aimed to safeguard both staff and people who used services by helping to prevent and manage situations where patients may present with behaviours that were challenging or were at risk to self or others, providing guidance for safe management.

Urgent and emergency services

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to, however, they did not always achieve this.

Although the trust had robust systems in place to monitor patient waiting times and the time taken to be seen by a doctor, during the inspection we spoke to 28 patients in the department public waiting area. All had been waiting in excess of 45 mins and some over 2 ½ hours to be seen by a doctor.

We found on inspection patients often left the department prior to being seem as they no longer wished to wait due to extended waiting times. On inspection we were told 30 patients had left the department overnight prior to treatment. Staff told us there was no system in place to identify if any of these patients were at risk or required to be followed up/ traced. However, the trust provided us with evidence following the inspection that there were processes in place to monitor patients leaving the department prior to receiving treatment.

Staff supported patients when they were referred or transferred between services.

Due to ongoing pressures within the integrated care system, patients could not all access the department in a timely way and the trust faced known challenges with access and flow. Difficulties accessing resources within the community and limited bed capacity across hospital sites continued to impact upon waiting times for patients. During inspection we reviewed eight records. Seven patients had breached the four-hour admission time. Five of the eight patients had been waiting in the department between four and 12 hours. In addition, one patient had been in the department 15 hours 39 minutes and another 12 hours 15 minutes.

We reviewed the trust`s performance against the following indicators for a 6-month period September 2021 to February 2022; percentage of patients are in the department for over 6 hours, percentage of admissions achieving 4 hours wait target, percentage of admissions waiting 4-12 hours from decision to admit to admission and percentage of patients leaving before being seen. The percentage of patients leaving before being seen was higher at Dewsbury than in the trust's other services.

The performance data showed patients were more likely to wait for more than four hours but less than six hours to receive care at Dewsbury emergency department than in the trust's other urgent and emergency services.

The ambulance handover times against performance target for the months December 2021 to February 2022 had been validated and submitted nationally which showed Dewsbury met the 98% target of under 30 minutes handover and had no reportable 60 minutes ambulance breaches.

The trust had an ambulance handover flow chart with actions for staff to take to attempt to prevent ambulance handover breaches.

Urgent and emergency services

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

The nurse manager told us they had autonomy to deal with complaints and conclude them if they could. The nurse manager could differentiate between complaints which would require a formal investigation and those which could be immediately resolved.

We reviewed the trusts Management of Complaints and Concerns Policy Incorporating Patient Advice and Liaison Service (PALS) policy, which was due for review in June 2022.The document clearly outlined the staff roles and responsibilities in the investigation of complaints.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

There were 24 complaints made between 1 April 2021 to 31 March 2022. Six were still under investigation, two were upheld, eight partly upheld and eight not upheld.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The nursing management leaders had the skills, knowledge, experience and integrity.

Urgent and emergency services

The Head of Clinical Service for Emergency Medicine had responsibility and accountability for Emergency Medicine and the Emergency Departments in the Trust.

They were supported by the Assistant Director of Nursing and Deputy Director of Operations.

Nurse managers we spoke with understood the challenges to quality and sustainability. This was evidenced by the departmental training compliance levels, high levels of audit compliance and low staff vacancy levels.

The departmental action plan was RAG rated. There was progress recorded against most of the actions.

Senior leaders told us they had obtained clinical commissioning group (CCG) funding to fund a trust wide urgent and emergency care lead. The role was to produce a strategic plan regarding accessibility to urgent care.

Vision and Strategy

The service had a clear vision for what it wanted to achieve, as part of the wider Division of Medicine, and a strategy to put this into action developed with all relevant stakeholders.

The trust provided data to evidence that the vision and strategy were focused on promoting patient safety, ongoing improvement and development and sustainability of services which aligned to local plans within the wider health economy.

We were also provided with data to evidence leaders and staff within the wider Division of Medicine understood the vision and strategy and how to monitor them.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Nursing staff we spoke with told us they felt supported, respected and valued by their managers.

All nursing staff we spoke with expressed positive views of working in the department and felt proud to be working at the hospital.

Following the 2018 inspection the Trust were given a should do action to review security within the department.

Managers told us of the improvements made to improve staff safety, which included the locking of access doors into the department, staff being issued with personal panic alarms and the presence of security staff.

All staff we spoke with told us they felt safe particularly at weekends and out of hours.

Staff received training in duty of candour. The training compliance was 100%. Staff could explain what the principles of duty of candour were and gave examples of when they had been applied them.

Managers gave us examples of the action taken in relation to staff to address behaviour and performance issues which was inconsistent with the vision and values of the department.

Staff we spoke with told us the department had an open and honest culture.

There were annual nursing staff appraisals supported by quarterly one to one meeting which contributed toward staff development and career progression.

Managers and staff told us of there was a cooperative and supportive relationship between staff. Staff worked collaboratively, sharing responsibility to resolve conflict quickly.

The trust has a Prevention and Management of Violence and Aggression Policy. The aim and purpose of the policy was to ensure, so far as is reasonably practicable, that Mid Yorkshire NHS Trust employees and persons working for Mid Yorkshire NHS Trust were not exposed to significant risk to their health and safety and outlined the steps to assess risk of harm from violence at work.

The staff wellbeing internal audit conducted in February 2022 reported an overall significant level of assurance of working in the department and feeling safe.

Governance

We saw evidence that leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

During inspection we reviewed the minutes of the Division of Medicine DOM Divisional Clinical Governance Meeting 24 February 2022. There were no key risks identified at Dewsbury urgent and emergency care department.

The trust had an Urgent and Emergency Care governance meeting which was to ensure there were systems and processes in place across Pinderfields and Dewsbury emergency departments to have robust scrutiny relating to quality and safety.

Under quality and safety assurance the areas of clinical quality and safety and planning and driving continuous improvement were listed as areas the meeting would cover.

In the Minutes of Emergency and Diagnostic Clinical Governance Meeting that serious incidents, morbidity and mortality information were agenda items.

There were gaps in audit data and consistent failure to meet targets in some audit areas.

Staff told us this had been caused by winter pressures, the Omicron variant and high attendances at A&E at both this site and the Pinderfields site.

The morbidity and mortality information between 1 September and 30 November 2021 had been discussed. It showed there had been 37 deaths within an age range 39-97 (mean 73.3yrs), in 27 of the 37 cases imminent death anticipated within the emergency department, one of 10 unexpected deaths occurred in the intensive care unit (ITU) and the mean age of unexpected deaths was 66.5yrs.

Each of the unexpected deaths had been reviewed and learning points identified which had been shared within the department.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to manage performance. We were not assured they identified and escalated all relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust had a process to manage risk, however, we did not see evidence areas of risk were effectively mitigated against.

The senior Emergency Medicine team met quarterly to review the services' ongoing risks that were recorded and to consider any new or emerging risks requiring adding to the risk register. The risks were aligned to operating plans and featured as an agenda item in speciality governance meetings, which occurred monthly, where staff could escalate risks outside of the quarterly review cycle. This was completed for each Trust site.

The most recent review of risk took place on the 29th March 2022 and discussed the current risks recorded for the Pinderfields site, and a further 12 risks recorded as whole service risks.

Once a risk review had been undertaken, any changes were shared with the Assistant Director of Nursing and Head of Governance for the Division.

In accordance with the divisional risk process, any new risks or changes to risk scores scored at 12 or above, were discussed at the Divisional Management Team meeting. All risk changes and risks scored greater than 12 were presented at both Divisional Management Team meeting and Divisional Governance Group Meeting.

All risks scored 12 were presented to the Risk Committee on a bi-monthly basis.

Risk scores ranged from nine (possible occurrence with a moderate consequence) to a score of 20 (almost certain occurrence with major consequence).

During inspection we reviewed the minutes of the Division of Medicine DOM Divisional Clinical Governance Meeting 24 February 2022. There were no key risks identified at the Dewsbury urgent and emergency care department.

We reviewed the Urgent and Emergency Care risk register created April 2022. All the risks had action owners, updates on progress, mitigation and review dates.

There were three risks specific to Dewsbury Urgent and Emergency Care department which were nurse staffing numbers, security in the department, and the risk of a negative CQC inspection due to not meeting RCEM guidance resulting in potential poor patient outcomes.

The trust was sighted on the risks and had the right mitigation in place

Following the last inspection in March 2018 the Trust was given a should do action to continue to review consultant presence in the department, in line with RCEM guidance.

The evidence obtained during this inspection showed the Trust was not meeting RCEM guidance.

Information Management

The service collected reliable data and analysed it.

Urgent and emergency services

Following the inspection, the trust provided us with additional data to assist with analysis of performance and compliance within national standards. We have included the findings from the additional data requests throughout the body of the report. However, of the additional information which is referenced within this report, only two sets were received within the set deadline of 08 April 2022. Twelve sets of data were received after the 08 April 2022 and a further 19 were either not received or returned to us with the incorrect standard naming convention which did not enable the inspection team to easily access this information.

Although we saw evidence of development in multiple areas of performance such as NEWS scores, documentation of mental capacity and recording of pain scores. Ongoing improvement was required in the management of sepsis, overall standards of patient records and improvement in the time taken to triage patients.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All staff had enough access to information through e mail and information displayed on posters in staff rooms and on the walls in the department. Staff we spoke with told us they did it appropriately through their managers.

There were clear and robust service performance measures, which were reported and monitored, however, we did not see evidence some areas of repeated under-performance were identified, and improvement actions implemented.

We saw evidence of the departmental key performance indicators and current performance against them.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Between 1 April 2021 to 31 March 2022 staff in the department received 15 compliments.

Patient engagement had driven improvement in urgent and emergency care.

The department use carers lanyards. The aim of this was to improve communication and patient experience and was be supported by reception team leaders. Carers/relatives were identified at reception and given a pink lanyard. This signified their carer or relative should remain with their relative during their time in the department.

During the booking in process the receptionist asked if the if they required any reasonable adjustments in relation to; learning disabilities, autism, or dementia. If the patient answered yes, the receptionist would ask if they have a MY passport.

Situation, background, assessment, recommendation (SBAR) stickers had been created to ensure staff were communicating patient care using a structured approach with the accepting ward/unit. Included in the SBAR stickers were key safety and quality measures such as skin assessments/pressure damage/falls risks/DNAR status, communication needs and recent NEWS score and actions/escalations.

Patients who were medically fit to be discharged from the department to their home address but may have required additional help with activities of daily living, could be referred to the AGE UK service directly. This ensured timely discharge for patients' home (generally less than an hour from referral) and ensured the patient was safely back in their home environment. Additionally, if required, AGE UK would complete follow up visits for up six weeks to assist patients with everyday activities, including, shopping and making meals.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust used Simulation teachings (SIM). These were an experiential learning technique where nursing and medical staff were presented with a situation that replicated an event or real-life scenario that had occurred within the Emergency Department. Sometimes the training occurred within the department environment.

The Emergency Department consultant in charge had the final decision regarding whether the simulation training should proceed.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff; however not all staff had completed training in line with trust guidance.

The trust set a target of 90% for completion of core mandatory training and 80% for completion of role specific mandatory training. Not all staff had completed their mandatory training. We requested trust data to reflect training split into nursing and medical staff training compliance at site level. We did not receive this information at the time of writing this report. Leaders told us that medical staff worked across sites, so it was not possible to allocate them to one site or another in relation to training compliance. Due to timescales to provide data the trust was unable to provide a breakdown of compliance by staff in nursing and medical groups. However, managers outlined the processes in place to manage compliance with core and role-specific training for both staff groups.

The trust sent evidence to support trust wide training compliance within the medicine division for both core and role specific training. Core training showed a compliance rate of 89.2% which did not meet the trust target of 90%. Role specific training compliance rate of 79.5% which did not meet the trust target of 80%.

The service and wider trust recognised that it was in a recovery phase for mandatory training compliance, after a risk-based decision was agreed by the executive team to pause mandatory training in 2020/21 to prioritise patient safety as part of the pandemic response. Compliance in medical care was further impacted by operational pressures over the winter period and arising from the Omicron variant of COVID-19. Managers monitored compliance rates at service and individual level. Since the last inspection, the trust had implemented the electronic staff record (ESR) which automatically notified staff and managers when an individual was required to undertake training.

Resuscitation training was part of the core specific training for both nursing and medical staff. Leaders told us that face to face training had been difficult to facilitate due to operational pressures, however they had tried to make training accessible to staff by adding in drop in sessions that staff could attend at short notice if they had availability.

The trust instigated training for all nursing staff with regard National Early warning Score 2 (NEWS2). Training compliance (trust wide) for nursing staff showed a compliance rate of 65% overall, evidencing 533 nursing staff as compliant with 280 staff non complaint. The trust told us training compliance was impacted by high staff turnover (leavers/recruitment) and staff sickness.

The service and wider trust recognised that it was in a recovery phase for mandatory training compliance, after a risk-based decision was agreed by the executive team to pause mandatory training where safe to do so in 2020/21, to prioritise patient safety as part of the pandemic response. Following inspection, the trust informed us that compliance had increased to 73% for NEWS2 training.

Medical care (including older people's care)

Medical staff receive NEWS2 training during the F1 teaching programme. A Foundation doctor (FY1 or FY2 also known as a house officer) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. The trust had recently instigated NEWS2 training onto the junior doctor's induction programme.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw examples of how managers on individual wards monitored mandatory training. Staff told us that protected training time was rostered on the safer care planning tool. Face to face training had re commenced for basic life support and moving and handling. Staff had been allocated dates for face to face training moving forward as spaces were limited due to additional risk factors surrounding social distancing. The resuscitation team had instigated additional training sessions and drop-in sessions where staff could attend at short notice when available. Staff told us they were given time at work to complete their mandatory training either online or through face to face teaching.

The training refresher dates were based on the dates the staff member joined the department which meant the training was spread over the financial year and there would never by a time when no one was trained in a particular discipline.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust set a target of 90% for completion of core safeguard training and 80% for completion of role specific safeguard training.

We requested trust data to reflect training split into nursing and medical staff training compliance at site level. We did not receive this information at the time of writing this report. The trust sent evidence to support trust wide training compliance within the medicine division for both core and role specific. Leaders told us that medical staff worked across sites, so it was not possible to allocate them to one site or another in relation to training compliance. Core safeguarding training showed an overall compliance rate of 93.4% which exceeded the trust target of 90%. Role specific safeguarding training showed an overall compliance rate of 85% which met the trust target of 85%.

Training on mental health awareness and dementia awareness was incorporated in the trust's safeguarding training package, in line with the approach set out in the trust's mental health strategy. At the time of inspection, the trust provided training on complex needs (including mental health, learning disabilities, and autism) completed as part of the safeguarding Level 3 (adults and children) training. 85% of eligible staff at the trust were compliant with this training requirement. Following our inspection, the trust informed us that the next phase of the roll out of complex needs training (within safeguarding Level 2 - adults and children) was to be instigated in May 2022.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Ward staff knew where safeguarding policies were and how to access them. They used online forms to refer safeguarding notifications or queries to the local authority multi-agency safeguarding hub.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.We saw examples in patient records where safeguarding concerns had been escalated in line with local procedures. Staff we spoke with were able to explain the safeguarding reporting procedures and they were able to tell us about numerous examples of safeguarding referrals they had made.

The trust had a trust wide adult safeguarding policy which followed intercollegiate guidance and was due for review August 2024 and a children's safeguarding policy which followed intercollegiate guidance and was due for review December 2023.

Senior leaders told us the complex needs team provided support at ward level for safeguarding concerns. This included the daily presence of a team member on site, to help review the need for enhanced care, support risk assessment processes and facilitate escalation if required. The safeguarding team also provided weekly "walk about Wednesdays" at Dewsbury and District Hospital (DDH) and offered a base for staff to drop in and discuss concerns as well as proactively visiting the wards.

Divisionally, key metrics were included as part of information discussed at monthly meetings.

Speciality performance meetings and weekly head of nursing meetings also reviewed mandatory training. 1-1 proformas also included a point of discussion around training compliance.

Leaders told us more patients were being admitted with or requiring on admission Deprivation of Liberty Safeguards (DoLs) and mental health needs. This was reflective of the increasing complexity of admissions and also systems and processes embedded since the last inspection to improve the identification of patients requiring DoLs or input for mental health needs. Leaders completed snapshots audits across the division to ensure that the documentation was up to date and discussed this at the daily patient flow meeting.

The safeguarding team had regular interactions with clinical teams in relation to education and support regarding DoLs identification and request for authorisation. This support, alongside with an ongoing campaign to embed Mental Capacity Act / Deprivation of Liberty Safeguards was resulting in a higher awareness and therefore a larger number of patients with Deprivation of Liberty Safeguards (DoLs) needs being identified. There was a robust governance process for making and monitoring of DoLS authorisation requests, to ensure compliance. This was an improvement since the last inspection.

The clinical teams received daily information regarding the current DoLS position, via the daily bed report, to enable them to meet needs and manage daily risks.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles, however we had concerns that on one ward where personal protective equipment (PPE) storage location was not optimal. At the time of the inspection, on the Dewsbury acute care of the elderly (DACE) staff told us that a patient bay was closed to visitors due to COVID 19 contact patients. The unit also had two COVID 19 positive patients. There was no IPC equipment stored at the entrance to the COVID 19 contact bay, however we did see IPC equipment within the bay.

We escalated this to the trust on the day of inspection. The trust explained that a risk based decision had been made and that due to a shortage of space, one trolley of PPE was being shared between the contact bay (bay 2) and side room 11 (positive patient). This was because the area around bay 2 and room 11 was small and could become cluttered and additional trolley placement would create a clutter and falls risk. PPE was available at locations throughout the ward in line with national guidance. However, upon receiving our concerns the trust completed an immediate review of the area and a reassessment of the IPC hierarchy of controls risk assessment for ward 9 considering the CQC feedback with regards to the provision and location of PPE.

We observed a COVID 19 contact patient mobilising outside the protected area. The patient had dementia and was challenging staff regarding being restricted in the bay. The patient was challenged a number of times by staff and requested to return to the bay; however due to staffing pressures on the ward the patient continuously left the area. The patient was sat outside the area next to the nurse's station and offered lunch. This was a risk to other patients and staff due to the breach in IPC practice and trust guidance. The bay did not have a dedicated nurse to respond and manage the patient to prevent recurrence.

The assistant director of nursing (ADN) within the division of medicine requested the trusts infection control (IPC) team and the matron for estates to review longer term solutions to support the ward team. Staff told us that ward 9 was part of the Dewsbury hospital refurbishment programme and the observations and feedback provided would be considered into the planning of the refurbishment.

The service generally performed well for cleanliness. We reviewed environmental cleaning audits (March 2022) for the wards inspected which showed good compliance overall. Where compliance (overall score) was below target the area was reviewed by the service manager to identify the shortfall. For example, ward 8 result scored 93.93% against a target score of 94%, the shortfall was identified against high level dusting. This minor shortfall had been brought to the attention of the member of staff concerned and training was instigated.

The trust acknowledged that some wards had lower than expected completion rates for cleaning audits. The completion rate reflected how much of the ward area was audited with a lower rate indicating some areas were not checked. The trust informed us that this was because certain areas of wards were closed (such as bays with COVID infection) and therefore it was not always possible nor safe for staff to enter these areas for the purpose of undertaking an audit.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). NICE guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified.

Sepsis is a common condition where the body's immune system goes into overdrive in response to an infection. Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities which are associated with a greater risk of mortality than sepsis alone.

The most common sites of infection leading to sepsis are the respiratory, gastrointestinal, renal, and genitourinary tracts.

We reviewed the trusts audit scores for sepsis screening Q4 (January to March 2021) for inpatients which showed 100% compliance for the screening of patients as requiring a sepsis screen. With 56.2% of patients (41 out of 73) receiving antibiotics in line with guidance, within one hour, with 32 patients receiving antibiotics out of this timeframe.

However, the trust explained that the audit data captured a wider group of patients than those highlighted in national guidance as needing antibiotics within one hour. Percentage compliance against national guidance was established in a subset of the sepsis audit which showed a 77% compliance with national guidance (17 of the 73 patients not receiving antibiotics within an hour).

Having extracted learning from the audit, the trust had identified key contributing factors to antibiotic delays and was working with clinical staff to improve these, for example, working with the critical care outreach team, who had been successful in applying for Patient Group Directions (PGD's) for two first line antibiotics (penicillin and non- penicillin allergy options) and were awaiting training on these.

Each month a retrospective audit, led by the trust clinical audit department captured up to 50 patients who had been given a sepsis diagnosis code on discharge, and critiqued whether or not sepsis screening had been undertaken, whether or not a screening tool had been utilised and whether antibiotics had been administered within an hour. The trust had seen a steady improvement in the timeliness of antibiotic administration since the monthly audit had commenced.

The process for screening had been changed from a paper based to an electronic tool which the nurses are able to access and complete in response to elevated NEWS scores. The trusts latest local audit results show sustained improvements (April 2021 to January 2022) in the rate of screening on the electronic sepsis screening tool. Whilst the Trust is trying to promote the use of the screening tool (and in some cases the use of the screening tool remained poor) where the tool is not used, screening is undertaken in the form of medical documentation in the patients notes, of which we saw good evidence.

The trust had been complimented by the Chief Executive Officer (CEO) of the UK sepsis trust, for their approach to the sepsis audit.

Since the last report, the team has continued to scrutinise and audit the referrals to the critical care outreach team (CCOT) which favourably showed that, of all patients triggering on NEWS and referred, up to 90% of patients had a sepsis screen completed electronically.

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The trusts latest local audit results showed sustained improvements (April 2021 to January 2022) in the rate of screening on the electronic sepsis screening tool. Since the last report, the team has continued to scrutinise and audit the referrals to the critical care outreach team (CCOT) which favourably shows that, of all patients triggering on NEWS and referred, up to 90% of patients had a sepsis screen completed electronically.

We reviewed the trusts training compliance figures for sepsis training which evidenced trust wide training compliance of 91.5% for nurse staffing against a target rate of 85%. Registered nurses and midwives (whose roles require this knowledge) must complete the trust sepsis e-learning package every three years. Medical staff receive sepsis training as part of induction and as part of the F1 teaching programme.

Medical care (including older people's care)

There was a quality improvement programme being delivered across the trust, led by the quality and patient safety team. This was a standardised five-week programme delivered across all ward areas, identifying sepsis champions to help deliver the improvements. Where the programme had been completed, the trust was seeing sustained improvements and ward areas were auditing themselves at local level on a monthly basis and benchmarking against each other.

The national annual programme for patient led audit of the care environment (PLACE) audit had been suspended due to the COVID-19 pandemic and had not re-commenced nationally. However, the trust had opted to undertake the PLACE-Lite programme (a 12-month programme) until the formal PLACE audit was re-commenced in 2023. Although not a mandatory requirement, the trust told us that it had opted to undertake the PLACE-Lite programme as an opportunity to review performance against key measures, highlight current challenges and identify areas of improvement. Although the PLACE-Lite programme does not require a minimum number of areas to be audited, the trust had a programme of PLACE-lite audits planned to take place during April and May 2022.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

We reviewed the trusts infection rates from April 2021 to February 2022. The trust provided trust wide figures within this timeframe which evidenced reported infection rates as MRSA bacteraemia (11) and clostridium difficile (101).

Cleaning records were up-to-date and demonstrated that most areas were cleaned regularly.

There were adequate supplies of hand gel and PPE in most areas we visited but we did not see prompts at some ward entrances to remind or encourage staff and visitors of hand hygiene. This put staff and patients at risk of potential harm from cross infection.

However, in line with infection prevention and control guidance and advice, the focus of hand hygiene was at the point of patient care/contact; this being the critical infection prevention control moment. The trust focused on ensuring that hand hygiene posters were in place on all wards/clinical areas with a poster displaying the correct hand washing process at all clinical hand wash basins, rather than at the point of entry to the ward. This has been evidenced to be more effective than prompts at ward doors.

There was alcohol hand gel at all ward entrances for staff, visitors to clean their hands on entrance to the ward. All entrances to the hospitals had hand hygiene stations and the national 'Hands Face Space' posters reminding visitors to clean their hands.

We asked the trust to provide hand hygiene audits where they had checked the compliance score of hand hygiene completion. We reviewed trust data which showed 99% compliance over the last eleven months. We also reviewed the trust's health check audit data for March 2022. This evidenced good compliance with average hand hygiene score across the medical wards at DDH above the trust target, at 92.7%. There were however two wards with lower compliance with ward 9 scoring 84% and ward 10 scoring 80.6%, both falling below the target of 85%.

Staff also had access to isolation rooms on the wards to help control the spread of infection amongst patients.

Medical care (including older people's care)

There were designated wards for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which wards were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The Dewsbury & District site had a closed a number of medical wards to visitors due to increased levels of COVID 19 infections. Some wards remained open; however, some side bays and single rooms were closed due to some patients being potential COVID 19 contacts. These patients were nursed in dedicated side bays and tested for COVID 19 to ascertain positive or negative results.

Patients deemed to be a high risk due to exposure of infectious disease or potential to infectious transmission were isolated (barrier nursed) appropriately for example C Difficile infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing the correct PPE including surgical face masks in accordance with national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands.

Patients told us and we saw that staff cleaned their hands regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw a number of examples where domestic staff and nursing staff had cleaned equipment and clinical areas.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well, however hazardous substances were not always stored safely.

Wards we visited had boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance. However, this were not always visible due to the storage of linen trolleys and beds on the corridors in front of them. We observed linen trolleys outside each ward entrance, including a number of spare patient beds. This was a risk as corridor width was reduced. We were therefore not assured of the safe evacuation of patients in the event of a fire or resuscitation emergency.

We escalated this to senior leaders on the day of inspection. The trust completed an immediate

review with the general manager for facilities supported by the infection control lead. The outcome

of this review was that the trust procedures in relation to the placement of these trolleys and beds required updating to prevent the risk that this placement caused.

A local operating procedure (LOP) was drafted for both beds and linen trolleys to outline safe storage practices and monitoring. The LOPs were immediately implemented and communicated to the facilities supervisor team to disseminate and implement.

When we revisited the service four weeks following the original inspection, we noted no equipment storage on any of the corridors leading to all wards inspected.

We observed a number of patients on wards 8, 9, 10 and 11 who did not have access to their nurse call bell including frail elderly patients and patients whose care included the use of bed rails. Most of the patient call bells were left in the holder positioned behind patient beds, out of reach of patients. We also noted a number of situations where nurse call bells were left unanswered for differing lengths of time. This posed a risk to patients as it meant some patients who were vulnerable were unable to attract the attention of staff if they needed to access care or support.

We asked the trust to provide audit compliance where they had checked the compliance score of bed rails assessment completion on the trust's IT platform. We reviewed the trust's health check audit data for March 2022 which evidenced good compliance across the medical wards at DDH, with overall compliance of 97% achieved against the 85% target. Five of the six wards audited achieved 100% compliance and the trust target of 85%. One ward did not achieve the 85% target, Ward 10, which achieved 80% compliance with four out of five bed rails assessments completed in the audit. This did not reflect what we found on inspection.

We observed a patient call for assistance on ward 10, on one of the bay areas with no HCA in the bay. The patient needed to use the bathroom. It took a total of seven minutes for a nurse to arrive and support this patient. Due to this delay the patient was unable to prevent urinary incontinence and was visibly upset by this.

The senior team on receipt of the concerns raised completed walk arounds of all the wards and emergency departments at both sites, to assess patient's access to nurse call bells, and ensure immediate safety concerns were addressed. Overall, compliance was good.

The trust recognised that at times of peak operational pressures and at times of staff shortages, (both issues present at this time of the inspection), that call bells were not always answered in a timely way. The learning was being shared with matrons and ward managers for daily ward support and oversight.

In addition, questions had been added to the ward/ED weekly health check, to include a section that the ward and ED demonstrate patients have access to nurse call bells and call bells are answered timely. The ward/ED health check was completed the week of the 01 April 2022, with no significant concerns identified. In addition, the senior corporate team went to do to an 'eyes on' review for further assurance. They visited nine wards and an emergency department, randomly selecting five patients in each area, and identified 90% compliance with patient's access to nurse call bells. These questions will continue to remain part of the audits in the nursing and midwifery quality governance framework.

When we revisited the service four weeks following the original inspection, we observed all patients had call bells within reach.

We observed a storage door left open on ward 9 which was the Dewsbury acute care of the elderly ward (DACE), the door had a digital lock in place; however, the door was left ajar. The room contained consumables for the ward including, sharps, venflons, intravenous fluids (IV), meal replacements drinks etc. Consumables were stored on the floor, stacked high and not securely. Staff told us storage was an issue in this area.

We escalated this to senior leaders on the day of inspection. The senior team on receipt of the concern completed a same day walk around of all medicine wards and urgent and emergency care (UEC) to assess the safe storage of sharps and IV equipment and medicines safety, to ensure immediate safety concerns were addressed on the day.

In addition, questions had been added to the ward/UEC health check, to include a section that the ward and UEC demonstrate safe storage of sharps and intra venous equipment and medicines safety. The ward/UEC health check was completed the week of the 01 April 2022, with no significant concerns were identified. This question will remain part of the monthly quality and safety monitoring and supportive actions.

We also found sluice rooms and storage rooms on other wards inspected that stored substances such as alcohol solution and cleaning products were left unlocked. This was a security risk given the types of consumable stored in this area. Some patients on the wards were vulnerable frail elderly with the potential of confusion, delirium, and substance misuse. This was a risk as patients had access to unlocked storerooms where alcohol solution and cleaning products were stored. This was highlighted as a should do action at the last inspection. We escalated this to senior leaders on the day of inspection.

We asked the trust to provide audits where they had checked the compliance scores of ward environment checks to clarify that storeroom doors were locked and secure. We reviewed the trusts health check audit data for March 2022 which evidenced good compliance except for

ward 2. The data evidenced that wards 5/6, 8, 9, 10 and 15 were compliant; however, this was not reflected in what we found whilst on inspection on. Ward health check audits were undertaken by members of the corporate nursing and quality team. We lacked assurance that senior leaders were sighted on risks surrounding non-compliance.

The trust responded to this concern to explain that sluice room doors are required to have hand free access to facilitate safe healthcare worker access whilst disposing of human excrement and fluids. An IPC risk-based decision was made to maintain unlocked sluice room doors. This was based on the risk that the digital locks would become a source of cross infection of staff as it would be a frequent touch point.

Whilst the rooms themselves should be unlocked, there are cupboards within the rooms to store hazardous chemicals and it was acknowledged that some substances were not in these cupboards.

The senior team on receipt of the concern completed a same day walk around of all the wards and urgent and emergency departments (UEC) to assess the risk of cleaning products being stored within the sluice areas and cleaning rooms being unlocked. The senior walk around did not find any unlocked cleaning cupboards. Cleaning products which should have been locked away were removed from sluices and stored within the cleaning rooms behind locked doors.

A question was also added to the ward health check to review that ward cleaning cupboards were locked at the time of the ward health check being completed and that no cleaning products were in the sluice rooms. The ward health check was completed the week of the 01 April 2022 and no concerns were identified. This question will remain part of the monthly quality and safety monitoring and supportive actions.

The health and safety team also visited each ward to speak with the ward managers regarding the safe storage of hazardous substances and the importance to patient safety, they also mounted posters in sluice rooms to remind clinical staff of the importance of cleaning product safe storage.

When we revisited the service four weeks following the original inspection, we observed storeroom doors were locked on all wards inspected.

All wards that we visited had unattended hot drink stations, which had a spout that could be pulled to release boiling water. The spouts had a safety guard that could be put in place; however, this was not in use on any of the trolleys that we observed. This posed a risk, especially to confused patients that were observed mobilising around the wards and to visitors.

We noted that resuscitation trolleys were shared between two wards on the day of inspection. We escalated this at senior level on the day. Staff told us this was standard practice across the two wards at local level. We noted that ward 11 had to share a resuscitation trolley with ward 10. We had concerns that this was a risk given the number of frail elderly patients on both wards. Ward 10 (34 beds) ward 11 (28 beds) which were full to capacity.

The trust reviewed the highlighted concern. Although no incidents or concerns had been identified and the risk remained tolerable, a recommendation by the resuscitation training team from the 2022 audit was to substantively provide a dedicated resuscitation trolley to ward 10, as this would be deemed best practice and facilitated as part of a defibrillator replacement programme. When we revisited the service four weeks following the original inspection, we noted that the resuscitation trolley had been replaced on ward 10.

All resuscitation trolleys stored drug boxes/containers containing resuscitation drugs, all of which had tamper evident seals. This was compliant with current Resuscitation Council (UK) guidance.

We reviewed the trusts resuscitation policy which had an issue date (May 2021) and a review date (May 2024).

There were gaps in the daily checks of the resuscitation trolleys on all wards we inspected. This posed a risk given the number of frail elderly patients on individual wards. We were not assured that the risk had been assessed or that senior leaders had oversight of the ongoing risk. The lack of consistent daily checks increased the risk as we were not assured that stock consumables would be readily available in the event of an emergency.

We asked the trust to provide audits where they had checked the compliance scores of daily checks on resuscitation trolleys. We reviewed the trusts health check audit data for March 2022 which evidenced overall good compliance except for wards 2 and 5/6. The data evidenced the remainder of the wards inspected were compliant; however, this was not reflective of what we found whilst on inspection.

The trust acknowledged there were gaps in the resuscitation trolley checks. However, the service and organisation maintained oversight of the risk and monitoring was in place to continuously assess it. Ward managers also completed checks of the check log, and if an omission was noted a check would be carried out immediately.

On inspection we observed a number of oxygen cylinders (CD, 460 litres) stored on the wards for general use were low or empty. One cylinder on the resuscitation trolley on the DACE unit was empty. We escalated this to the trust on the day of inspection who immediately reviewed the situation and found all cylinders at the DDH site were full or partially full (at a safe level) and available for use. The clinical site manager found the oxygen cylinder on the crash trolley to be full, it had not been turned on using the dedicated key to do so, and as such would not register that there was oxygen in the cylinder.

Senior leaders told us that the checking of oxygen cylinders was embedded in the daily checks of resuscitation equipment which was monitored and audited by the resuscitation training team and in the ward health checks. Additional checks had been implemented in the weekly matron assurance checklist to ensure this standard is maintained.

When we revisited the service four weeks following the original inspection, we observed oxygen cylinders were full or partially full on all wards inspected.

We observed a table on ward 9 displaying friends & family leaflets, a returns box and a large number of patient information leaflets stored underneath. The table was a safety risk to patients, staff, and visitors as it was not stable. Following the inspection, the table was removed and replaced.

On ward 9 we observed a patient toilet which did not have an emergency pull cord located by the toilet. The pull cord was located next to the door which was not within reach of the toilet. This was a risk to patients in the event of a slip/trip or fall. Following the inspection, the cord was repositioned and replaced.

The service had enough suitable equipment to help staff safely care for patients and staff we spoke with did not report any shortages of equipment. Equipment was used to safely lift patients and had dates of the last and next service displayed and these were in date. Servicing of equipment was up to date for most items that we checked. However, a defibrillator on one resuscitation trolley had an expired servicing date of February 2022.

Post inspection the trust provided information to clarify the servicing of equipment. The monitoring of medical equipment servicing compliance was managed through an equipment management system. The full maintenance and service history for all medical devices was held within the database. At the end of February 2022, 98% of high-risk (which included defibrillators) equipment maintenance was completed within the required timeframes, against the institute of physics and engineering (IPEM) standard of 80% and the trust's aspirational local target of 95%. The database shows as of August 2022, all defibrillators across the DDH site were within their service dates.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff did not always undertake appropriate assessment or provide support to meet patient's nutrition and hydration needs. Patient risk assessments were not always completed contemporaneously, and the care provided to mitigate risk was not always in line with the assessment.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff completed risk assessments for each patient on admission / arrival, using the NEWS2 tool; however, patient notes were not always comprehensive. We reviewed 10 full sets of patient notes and several sections of patients records when looking at examples of care we had observed across the medical wards inspected. We saw gaps in recording in patient's records including skin and wound management, lying and standing blood pressures, height and weight, venous thromboembolism (VTE), malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making.

We reviewed one patient record on ward 9 (DACE) for a patient admitted with a history of falls and diabetes. The patient also had a moisture lesion of the natal cleft; however, the record evidenced only one daily check in the risk assessment to evidence fundamental care delivery in the skin and wound management record. The patient's MUST record was not completed in line with guidance. Patient weight should be recorded on admission and then at a minimum, weekly thereafter. The patient's weight was recorded once on admission, we saw no evidence to support that the patient's weight had been re checked. We also saw no evidence of pain scores or lying and standing blood pressure recorded. This

was a risk as the patient had been admitted with a fall and there was no baseline to evidence lying and standing blood pressure at point of admission. The patients notes stated that the patient had been observed hourly overnight; however, there were no records to evidence this. Patient records evidenced that observations had been completed on admission at 17.58 and then not repeated until 06.02 the following morning and then again at 18.34 in the evening.

Intentional rounding (skin and wound management, SSKIN) is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect. There were gaps in recording in patient's records including the skin and wound management record to evidence the repositioning of patient interactions about the care and support that staff provided. For example, during patient turns for pressure care, there were gaps in records of which side patients were moved to and what time it was last completed. This meant staff could not be sure what the next turn should be, which could impact on patient skin integrity.

We asked the trust to provide audits where they had checked the compliance scores of patient pressure area care completion. We reviewed the trusts health check audit data for March 2022 which evidenced low compliance and or not meeting trust the trust target rate of 85% on some wards with regard a registered professional completing a full skin inspection on each shift and recorded in the SSKIN record. For example, ward 2 scored 60%, ward 5/6 scored 20% and ward 8 scored 20% which did not meet the trust target of 85%.

When we revisited the service four weeks following the original inspection, we observed gaps in the recording of completion of SSKIN records on wards 2, 8, 9 and 10.

The trust provided the number of reported grade three and four pressure sores. Data from December 2021 to February 2022 showed the trust reported one grade four pressure sore which remains under investigation to determine lapses in care and learning.

We observed meal services throughout the inspection which included lunch and dinner. Patients who were able to eat independently did so, however we saw that for those needing assistance either with positioning or feeding, this was not always offered, or offered too late, which meant staff were not able to meet individual patient needs. This increased the potential risk to patients being unable to eat meals or drinks.

Staff did not always adjust patients sitting position whilst in bed to be fully upright to assist with their comfort and swallowing at mealtimes. We observed poor handling techniques when two staff re-positioned a patient at meal service. The staff used a drag technique in one instance and did not communicate with either the patient or one another to communicate the timing of the movement.

On another occasion a patient’s position was readjusted by changing the bed position using the head control; however, the patient was not informed of the interaction. Patients were at a higher risk of choking as they were not always observed or assisted at mealtimes, this was not always recognised by staff on the wards.

We also noted not all patient beds had bedside chairs for patients to have the ability to sit out of bed at mealtimes and during visiting times.

We checked the records of a patient on ward 10 who had been admitted with a new onset of confusion. Concerns had been documented in their notes following a specialist nurse assessment about eating and drinking, and to encourage oral intake, however the patient’s fluid balance chart was not consistently completed. There was no evidence of completion of weight or MUST scores.

Medical care (including older people's care)

We asked the trust to provide audits where they had checked the compliance score of nutrition and hydration with regard completion of patient food charts and identification of patients at nutritional risk on the electronic IT system. We reviewed the trusts health check audit data for March 2022 which evidenced low compliance and or not meeting trust the trust target rate of 85% on some wards. For example, ward 2 scored 40% and ward 9 scored 80% compliance with regard the completion of patient food charts. Ward 8 scored 40%, ward 10 scored 33% and ward 15 scored 50% with regard identifications of patients at nutritional risk.

Staff knew about and dealt with specific risk issues. On all wards inspected we observed information boards which displayed the number of pressure sores and fall reported the previous month.

On ward 10 we observed a patient in a cohorted bay mobilise to the toilet unassisted. The patient had dressings on both lower legs & feet and wore slippers that did not fit correctly due to the bulky dressings in place. The patient mobilised with a zimmer frame with one hand whilst holding their pyjama bottoms with the other. This was a risk as the patient was already identified at being a risk of falls and left unassisted to mobilise to the toilet alone which increased their risk.

On ward 10 staff told us they had reported four falls in the month of March 2022 two of which were reported with harm. For example, in both cases the fall had resulted in fractured bones. Both falls were under investigation and had been reported on the online incident reporting system.

We reviewed the number of patient falls reported within the medicine division at DDH which showed on wards 2, 4, 5/6, 8, 9 and 10 that 53 falls were reported overall in March 2022. Out of the 53 falls reported 12 of these were reported as falls with harm.

Most patients we observed on inspection were cared for in bed with bed rails sides in place. We noted physiotherapist and occupational therapists were not prominent on the wards we inspected. We discussed therapy provision with a band six physiotherapist. Therapy staff told us that patient interaction time was limited as two physiotherapists were expected to cover one 34 bedded ward. They told us that nurses on admission assessed then referred patients to physiotherapists who would then assess and add mobility status to patient records which was reflected on ward IT information boards. A large amount of time was spent completing the differing pathways for example discharge to assess (D2A) or transfer of care referrals to external partners. Therapy staff told us they tried to review a maximum of 10 patients in any one day on individual wards.

We asked the trust to provide audit compliance surrounding Venous Thromboembolism (VTE). The VTE risk assessment tool was used to assess patients (aged 16 or over) admitted to a hospital provider, for the risk of VTE. The trust reported in the last six months the reported position relating to VTE assessments showed fluctuating performance. VTE assessments evidenced levels below the expected target of 95%. The trust had instigated a number of actions to improve performance. Under reporting of VTE assessments meant the level of patient risk could not be fully established.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We reviewed the hand over sheets on all wards we inspected. We observed that key risks were discussed, and information disseminated to reduce risks. Staff told us that individual wards instigated safety huddles as part of the daily handover process where patient risks were discussed including: staffing, number of patients, risk of falls, enhanced care patients, high NEWS, end of life, cannula care, pressure ulcers, infections, IPC and COVID 19 swab status and do not attempt cardiopulmonary resuscitation orders (DNACPR) DNACPR.

We reviewed DNACPR, on all wards inspected. For example, on ward 11 we observed 20 out of 26 patients had DNACPR orders in place. We looked at six DNACPR documents which evidenced that these were appropriately completed, showing sufficient information to provide assurances that decisions had been discussed with the patient or their family.

We observed patients waiting in the discharge lounge on the day of inspection. We spoke with four patients who were waiting to be discharged. Patients were seated in a small lounge area where both male and female patients awaited collection from relatives and or ambulance transfer. Patients told us they had waited a long time for transport some as long as four hours and they were tired and uncomfortable as they had been seated for differing lengths of time. Staff told us patients were observed by the nursing team and were offered food and drink.

We reviewed the meeting minutes from the deteriorating patient group (February 2022) which showed an agenda, update from differing specialities, sepsis performance and an action log.

We requested data to evidence the audit of NEWS, it was agreed to postpone the 20/21 audit as the trust was in the middle of the COVID waves and the corporate staff who would usually undertake the audits had been moved to work clinically. The 2021/22 audit had been undertaken; however, the report was not yet completed.

Staffing

Nurse staffing

It was recognised by senior management that the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established safe levels of staffing.

Due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. There were continuous advertisements for nursing and healthcare assistant vacancies. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible. However, staff in the areas we inspected told us they were often short of qualified nursing staff.

During the inspection three out of the five wards we visited did not meet planned verses actual staffing numbers which included registered nurses and healthcare assistants. Ward leaders were not always supernumerary due to low staffing numbers. Ward managers told us they were allocated fifteen managerial hours per week; however, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care due to frailty.

Medical care (including older people's care)

The trust provided data for the wards inspected in the medicine directorate at DDH site. This identified some shortages in registered nursing and healthcare staff, for example on ward 9 the average day time nursing fill rate for February 2022 was 72.5% with healthcare staff showing a fill rate of 73.9%. The planned verses actual staffing numbers for day shifts was not met on approximately half of the wards.

For example, on the day of inspection the nurse staffing on ward 9 (DACE) planned verses actual was not met. The ward had 19 beds and was full to capacity and had highlighted four patients requiring 1:1 nursing care. Ideal planned staffing should include two registered nurses, three health care assistants and a third registered nurse for the twilight shift and a nursing associate.

Actual staffing was one trained nurse and a ward manager, one other supernumerary nurse in training and one nursing associate. There were two health care assistants and a safety support worker. We discussed this with the site matron who acknowledged the staffing did not meet planned verses actual. This was escalated and reported, the senior team were sighted on this.

The average day time fill rate for medical wards at Dewsbury Hospital was 93.1% for registered staff and 93.6% for non-registered care staff and night-time was 109.8% for registered staff and 106.8% for care staff, against a target of 85%. The data also evidenced that staffing on some wards exceeded the planned verses actual staffing, allowing for staff movement where needed.

Senior leaders told us they used the electronic staff record (ESR) when redeploying clinical staff to other wards to assess skill and competency. Ward managers and matrons told us risk assessments were completed, based on ward requirements and staffs competency and skill set. Leaders looked across the whole division and moved staff across site when needed based on the skills available.

Senior leaders told us they used SafeCare software to compare staff numbers and skill mix alongside actual patient demand in real-time, to base informed decisions. The trust had a clear escalation process for making staff moves and recorded this on the roster to ensure oversight of staff moves.

Some ward managers told us they found it challenging to support students requiring mentorship due to staff shortages.

The ward manager could adjust staffing levels daily according to the needs of patients. However, staff shortages were not always met. Staff told us they reported staffing shortages on the incident reporting system identifying themes and trends.

The service had vacancies for registered nurses, healthcare staff and trainee nursing associates.

All wards we inspected on the day of inspection had staff sickness, some staff were absent with COVID 19 symptoms or were self-isolating.

All vacant shifts were put out to bank and agency, but wherever possible managers, requested staff familiar with the service. Ward managers could request additional staffing levels daily according to the needs of patients. However, they explained that staff were not always provided.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical care (including older people's care)

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites.

On inspection we observed staff working hard to complete tasks for patients; however, we were not assured that staff had the time to always provide person centred care that met individual patient needs.

Senior leaders told us safe staffing reviews had been completed recently as part of the twice-yearly review. The last comprehensive review was undertaken in June 2021 which informed the inpatient staffing levels for the business case that has been approved at corporate level. The approval supported an increase in inpatient staffing levels. Senior leaders within the directorate planned to undertake a comprehensive annual review as well as a six-monthly check and challenge. Leaders had engaged in conversation as to how this can be embedded in the business planning process.

Successful international recruitment for specific specialities had been completed a few years ago with the trust looking to undertake similar recruitment again. Recruitment has been undertaken over the last 18 months with significant investment in international recruitment with over 200 internationally educated nurses arriving in trust and a further 40 expected before the end of the year. The trust was committed to ongoing international recruitment and has a successful pipeline commissioned which will continue into the next financial year. In addition, the trust has been a site of choice as an early adopter with Health Education England (HEE) for the displaced talent programme for recruiting refugee nurses. The trust supported five refugee nurses in addition the trust was a pilot site for the stay and strive work to support the retention of the international workforce.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe.

The medical staff did not match the planned numbers. For example, on the day of inspection on ward 9 planned medical staffing was two consultants and three junior doctors for wards rounds. A post-admission ward round, also referred to as a post-take ward round (PTWR), was a key component of daily hospital activity and provided an opportunity for the multidisciplinary team (MDT) to meet and review a patient's condition.

Actual staffing was one consultant and one senior house officer/trust grade from Pinderfields hospital site to cover and an FY1 doctor. A foundation doctor (FY1 or FY2 also known as a house officer) was a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme – a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training. Medical staff told us there was 24/7 medical cover.

On ward 10 we spoke with two FY2/trust grade doctors who were unaware who their educational or clinical supervisor was. They told us they were often moved from one ward to the next to fill in gaps in the rota or move from one hospital site to another to do the same.

The trust instigated a weekly medical rota meeting, if an area was considered to be light then medical staff were moved to accommodate gaps. Senior leaders told us there was an escalation process in place to ensure this did not impact on trainees.

Medical care (including older people's care)

The trust had instigated new blended workforce models using physician associated and doctors assistants to increase the clinical input into the wards and improve the timeliness and responsiveness of patient care. Medical staff told us the site had two doctors assistants to assist with to take out medications (TTOs), bloods, arterial blood gases etc. medical staff told us that this assisted to reduce daily tasks. One was based on ward 9 and the other covered the entire hospital site.

Medical staffing was included in the division of medicines (DOM) risk register which listed a high risk surrounding reduced medical staffing availability across the DOM due to COVID and non COVID related reasons, with vacancies to medical staffing impacting on clinical service delivery and the quality and safety of care to patients and their experience. It was also noted that staffing availability affected morale and health and wellbeing of the workforce. The risk was listed for review in June 2022.

The trust provided data to evidence consultant and doctor fill rates from March 2021 to March 2022; however, this was not site specific. In elderly medicine the consultant fill rates in March 2022 did not match actual verses planned with a substantive fill rate of 91.72%.

The trust provided data to evidence medical staff sickness rates from February 2021 to January 2022; however, this was not site specific. The trust advised that as the medical staffing for the medicine division was planned across the hospital sites, it was not possible to split the sickness absence by site. Sickness rates for medical staff showed a sickness rate of 8.3% in January 2022. We did not receive a summary to provide the reasoning behind the increase for example the sickness rate in December 2021 showed a sickness rate of 4.71%. Post inspection the trust confirmed that the increase was due to the local prevalence of COVID-19 at the time which led to the service experiencing some of its highest rates of COVID related absence.

We requested vacancy rates for medical staff; however, did not receive information at the time of writing this report. Post inspection the trust advised that they monitor the fill rate for medical staff rather than the vacancy rate, as vacancy in the substantive workforce was very low and not always reflective of the fill rate.

Managers made sure locums had a full induction to the service before they started work.

Leaders within the directorate told us the main issue that had changed since last inspection were the Royal College of Physicians (RCP) definitions with tier 1 and tier 2 staff. The RCP provides a formal process that reviews the evidence presented by the trainee and their educational supervisor, relating to their progress in the training programme. It enables the trainee, the postgraduate dean and employers to document that the competences required were being gained at an appropriate rate and through appropriate experience.

The General Medical Council (GMC) survey had triggered a review and investment to lead to a more blended workforce, physician associates have been expanded within the division. The division has addressed the impact of internal medicine training with recruitment to backfill when trainees rotate through intensive care units (ICU). Trainee induction training was continuously under review. Senior leaders told us they are aware of the specialities that are fragile for example oncology and haematology.

Records

Staff did not always keep detailed records of patient's care and treatment. Not all records were clear, contemporaneous, up-to-date, or stored securely, however they were easily available to all staff providing care.

Staff used an electronic patient record supported by paper records for each patient.

Medical care (including older people's care)

Patient notes were not always comprehensive; however, staff could access them easily. We reviewed 10 full sets of patient notes and sections of patients records when looking at examples of care we had observed across the medical wards inspected. We saw gaps in recording in patient's records including skin and wound management, lying and standing blood pressures, malnutrition universal screening tool (MUST) scores, fluid balance charts, pain scores, venous thromboembolism (VTE) and best interest decision making. This was a risk to patients ongoing care as records were not contemporaneous to evidence complete ongoing assessment with a view to possible deterioration of frail elderly sick patients. Records were not completed in line with trust policy.

We reviewed the records of a patient on ward 8 (medical step down) with a length of stay of 58 days admitted with dementia. The record evidenced patient care was compromised due to staff shortages and that this had been escalated to the site manager. The patient had not been reviewed by a medic from the 25 to the 29 March 2022. The last medic review was recorded on the 24 March 2022. The patient had been assessed by the medical team as medically optimised for discharge (MOFD) and therefore was categorised as no reason to reside. The patient was awaiting a discharge to assess bed in the community.

Post inspection the trust provided information to support the reason to reside process. Reason to reside' (R2R) is a national policy to help identify patients and ensure that their care is delivered in the most appropriate place. As the patient had been identified as MOFD with no reason to reside in the acute hospital, on-going medical input was not required, unless a deterioration or condition was identified. The patient notes highlighted that the patient was agitated, and confusion was increasing. Handwritten behaviour management plans were in place; however, we found no summary to evidence decision making and next steps.

Monthly ward health check audits are completed in accordance with the nursing midwifery quality governance framework (MQGF). The audit covers, record keeping & documentation standards Due to system pressures the audit was suspended for two months in January and February 2022 and recommenced in March 2022.

We asked the trust to provide records audits where they had checked the completion of care records and the implementation of care plans and risk assessments. We reviewed the trusts health check audit data for March 2022 which evidenced an average of 94% compliance against standards for record keeping and documentation standards across the DDH medical wards, therefore meeting the trust target of 85%.

One question showed lower compliance, not meeting the trust target rate of 85% on three wards with regard the marking or records with a name, signature, and designation. For example, ward 9 scored 60% and ward 15 scored 80% on this question.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. On all wards we visited notes trolleys were mostly left unlocked and unattended with patient notes stored underneath trolleys, easily accessible to visitors. Skin and wound management records on wards we visited were stored in folders outside of each bay, or in folders not stored securely in the bay. We also saw a number of staff identification cards left in computer keyboards allowing easy access into confidential patient records. This was in breach of trust policy and General Data Protection Regulation (GDPR).

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations. However, we did see gaps where patient information had changed and had not been updated on the whiteboards.

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However, we found that access to medicine storage areas was not always secure and the process of checking patients medicines on admission was not completed in a timely manner.

Staff followed some systems and processes to prescribe and administer medicines safely. We found that all prescription records examined had allergy status recorded. However, the checks on medicines prescribed to the patient on admission to hospital were not always carried out in a timely manner. This could have resulted in patients missing critical medicine doses. National guidance recommends undertaking medicine reconciliation within 24 hours of admission. This allows early action to be taken in relation to discrepancies and a complete and accurate list of medicines available.

We reviewed the trusts medicines reconciliation policy which was issued in February 2020 and had a review date of August 2022. The aim of performing medicines reconciliation on admission to hospital, was to minimise the risk of any unintentional drug changes and as a result, also minimise the risk of any subsequent harm or confusion caused to the patient by these changes.

The trust provided data which showed the current figure at MHYT for medicines reconciliation performed within 24 hours of admission to hospital is 52% (December 2021) compared to 65% in December 2020. The target was 65% of patients have medicines reconciliation performed within 24 hours. The mitigation actions include clinical pharmacy teams trying to perform medicines reconciliation at the point of discharge if not already done, Medicines Information dealing with queries related to patients' medications when they are discharged from MYHT and finding different ways of working to try to improve capacity within the team so that teams can spend more time performing medicines reconciliation especially for higher risk patients.

We reviewed the divisional governance group meeting minutes for February 2022 which highlighted the trust audit of oxygen prescribing showed 61% of patient's met the British Thoracic Society standard guidance against a target of 95%.

We reviewed the trust medicines management policy. The medicine charter was an intranet-based policy and procedures document published using the trust IT platform.

We reviewed trust data which showed nursing staff medicines competency compliance. When all new nursing and midwifery staff start at the trust, they attend clinical orientation. The medicines optimisation nurses (part of the medicines optimisation and pharmacy services team) teach for two whole days on the scheme.

Nursing staff were not permitted to administer medicines independently without attending the medicines sessions and without completing the medicines administration competencies in their workbook. The medicines optimisation group receive monthly updates on staff compliance with mandatory training on medicines. Level 2 mandatory training on medicines was for all staff who administer medicines. At 25th March 2022, 665 out of 778 staff (86%) in the division of medicine were compliant with their Level 2 mandatory training on medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were visible on the wards we visited and reviewed patients' medicines, for example where patients were at an increased risk of falls and monitoring appropriate antibiotic prescribing.

Staff completed medicines records accurately and kept them up to date. The Trust used an electronic system to prescribe and record the administration of the patients' medicines.

Staff stored and managed some medicines safely. However, we found access to medicine storage areas was not secure on two different wards.

During the inspection it was also, found that there were a number of oxygen cylinders that were available for administration to patients that were quarter full. This was of concern on wards which did not have access to piped oxygen at each bedside. However, the trust informed us of the daily process for checking oxygen supply on the wards as well as considerations that would be made to ensure patient safety.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. However, it was evident from the electronic records that the process was not always being completed in a timely manner. On ward 9 nine patients were waiting for medicine reconciliation process to be completed at 24 hours and two were not completed at 48 hours post admission. Data from the trust for March 2022, showed the medicine reconciliation rate was 70% on ward 9. However, taking the data across all four wards inspected, there was an average medicine reconciliation rate of 37.5% and a total across the Dewsbury Hospital site of 48%. The trust target was greater or equal to 65%.

The pharmacy team provided an on the ward discharge service which helped improve the speed of providing medicines to patients. The staff on the wards were knowledgeable about obtaining advice and medicines outside of pharmacy opening hours. This was used alongside a centrally managed service, which provided electronic tracking data

Incidents

The trust managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them. For example, staff were able to recall a recent fall with harm incident on ward 9 January 2022. The falls investigation had highlighted no lapses in care other than staffing shortages and skill mix. Staff told us that incident feedback was discussed at safety huddles and staff meetings.

Ward leaders could give some examples of recent incidents that had resulted in shared learning for the ward.

The ward manager on ward 11 demonstrated good shared learning from incidents. There was a file stored on the ward that showed incidents that had been investigated with outcomes and evidence of learning shared, staff had signed to say they had read the file.

Feedback and learning from incidents were cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

Medical care (including older people's care)

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service reported no never events within the medicine division from April 2021 to March 2022.

Staff reported serious incidents clearly and in line with trust policy. The trust reported 12 serious incidents (SIs) in medicine at the DDH site which met the reporting criteria set by NHS England from May 2021 to March 2022. Five investigations were reported as falls with harm on wards 5/6, 8, 9, 10 and 12.

Newly reported serious incidents are discussed at the trust patient safety panel as a standing agenda item. Key messages from patient safety panel are shared in the trust patient safety bulletin which is circulated via the communications team.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Newly reported incidents that relate to sub-optimal care of the deteriorating patient or sepsis were discussed at the trust deteriorating patient group. Learning from completed serious incidents and near miss incidents that relate to sub-optimal care of the deteriorating patient or sepsis were shared at this meeting. We reviewed the minutes from the deteriorating patient group (January 2022) which evidenced discussion, learning and action taken to prevent recurrence.

The resuscitation team attend the patient safety panel and share learning through the resuscitation training provided by the trust. This included information on escalation of the deteriorating patient, personal protective equipment (PPE) requirements and adrenaline use in anaphylaxis.

The practice development and education unit (PDEU) and continuing practice development (CPD) teams had requested copies of completed serious incident reports to inform education. With a key focus on falls, pressure ulcers and sub-optimal care of deteriorating patient cases.

There was evidence that changes had been made as a result of feedback. We reviewed a reported serious incident which had occurred on ward 2 at DDH within the medicine division. An investigation was instigated, the learning, root cause and outcome was shared with staff and reported via the patient safety and clinical effectiveness (PSCE) subcommittee.

Lessons learnt from pressure ulcer and falls multi-disciplinary team (MDT) meeting are shared at the patient safety panel and are included in the patient safety bulletin. We reviewed an example of learning which evidenced a review of lessons learnt following falls. Learning from the MDT meeting is shared at the trust improvement group.

Serious incidents submitted to the clinical commissioning group (CCG) the previous month are shared. This includes the SHARE learning on a page document and the action plan. This review encouraged cross divisional questioning of action plans to ensure they had the required outcome and are achievable.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Ward managers and most of the staff we spoke to knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families.

Medical care (including older people's care)

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The trust provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies, and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Teams had access to a psychiatric liaison team on site which was provided by an external stakeholder.

Nutrition and hydration

Staff did not always provide patients with enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary; however, we were not assured that all patients requiring assistance were always assisted to eat and drink. The service made adjustments for patients religious, cultural, and other needs.

We observed a significant number of patients who were being nursed in bed, not repositioned including during mealtimes. We did not see patients receiving therapy which would have supported safe self-management of risk whilst eating & mobilising.

We escalated this with the trust on the day of inspection. The senior nursing team on the site completed a walk around of all areas identifying the ambulatory status of all patients. These visits identified several reasons as to why patients were in bed at the time of the visit. We were told this would be explored as part of a working group.

The working group was commenced led by the inpatient therapy service lead, comprising of divisional nursing, therapy, manual handling, and corporate nursing teams. This group met and discussed the concerns raised by the CQC visit and reviewed a recent audit conducted by the therapy service lead which identified several factors for consideration. These included

1. There was a lack of confidence from nursing staff with regards to ambulating patients. Staff fear patients were at an increased risk of falls; this fear reduced prompting of ambulation or sitting the patient out.

2. The last two years focus had been on caring for unwell patients and supporting patient discharges and therefore the culture had shifted away from rehabilitation.

Following this feedback and reflecting on previous successful 'End PJ Paralysis' campaign strategies, the group also identified areas for improvement.

When we revisited the service four weeks following the original inspection, we observed an improvement in the number of patients nursed in beds. However, this was inconsistent on all the wards we inspected. For example, on ward 8 we observed 18 patients out of 25 were nursed in bed and served breakfast whilst in bed. Seven out of the 25 patients were sat out for breakfast. We noted 18 patients were highlighted as being medically optimised fit for discharge at the time of inspection.

On ward 10, 16 out of 29 patients were nursed in bed; however, all patients had access to fluids with water jugs and beakers accessible.

Staff did not always complete appropriate assessment and support to meet service user's nutrition and hydration. During inspection we noted that clinical staff on all wards routinely served patient food. Whilst staff were serving food, they could not assist patients with positioning or feeding. This meant that food was often cold before staff could then support a patient to eat it. We did not see consistent levels of eating support provided to patients who required assistance. Most patients were not encouraged to sit in chairs at mealtimes, which increased the risk to patients of choking or scalding with hot drinks.

We observed patients at breakfast and lunch service during the inspection across all wards we visited and did not see consistent support from staff when it was required. Staff did not always adjust patient beds to be fully upright to help with their swallowing.

The majority of patients on the wards were elderly often with complex care needs with associated risk factors. As the trust had visiting restrictions in place during our inspection only a few patients had one short-term visitor to help them if needed. This was a risk as patients were not always able to ensure they maintained their own nutrition and hydration.

We observed one elderly patient requiring assistance given a beaker of hot soup without the lid in place. The patient was nursed in bed with bed rails in place and was not repositioned into a sitting position. The support worker told the patient the soup was hot, and she would come back to assist with eating it. The patient was at risk of scalding as the beaker did not have a lid in place.

We saw other examples of lunch being left on side tables where patients were in bed with bed rails and required assistance. We observed a number of meals left untouched by patients who were asleep and not encouraged to eat by staff.

Patients told us food was mostly warm, tasty and there were differing choices to choose from.

We observed nutrition boards near the main nursing station which listed patients requiring red trays, assistance with eating and drinking required, nil by mouth and patients who were diabetic requiring dietary support.

Staff did not always fully and accurately complete patient's fluid and nutrition charts where needed. We observed several charts which were incomplete or had no information recorded.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, it was not always completed fully or in a timely way and weights were not regularly recorded.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and give pain relief in a timely way. They did not always support those unable to communicate or use suitable assessment tools or give additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool.

Staff used a pain-scoring tool, from one to 10, to assess a patient's level of pain. All staff we spoke with knew about pain assessments and how to score patients level of pain.

Staff prescribed and administered pain relief. Pain relief was prescribed, and staff would request additional pain relief from medical staff, if required. Some staff told us that some pain medications were often given late due to medic requests for prescribing being delayed due to system pressures.

Patients we spoke with told us staff did not always manage their pain in a timely way. For example, one patient we spoke with told us they had waited for an extended period of time for their call bell to be answered. The patient told us that they were in a considerable amount of pain. The patient records evidenced no associated details in relation to pain scores. We escalated this at the time of inspection. The patient was re assessed by medics and prescribed additional pain medication.

We asked the trust to provide pain management audits where they had checked the compliance score of pain management. We reviewed the trusts health check audit data for March 2022, there was limited data to support site level compliance. The trust provided trust wide compliance from November 2021 to March 2022 which evidenced low compliance rates for all key questions surrounding pain management. The data results in March 2022 evidenced overall compliance of 50% against a trust target of 85%.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

Audits were carried out in 2020/21 despite the COVID-19 pandemic, outcomes of the audits that were completed showed mostly good compliance. Audits that had outcomes that were not compliant had action plans in place or had the audit re-done.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Performance dashboards were used to measure performance and improvement.

Managers and staff used the results to improve patients' outcomes. The regular monitoring of falls and pressure ulcer documentation was undertaken through the monthly ward health check tool, this included risk assessments and care plans.

Publishing of local, divisional and trust wide falls and pressure ulcer incident data is published through the falls and pressure ulcer dashboard via the trust intranet. Monitoring was via the patient safety and clinical effectiveness subcommittee and was actioned through the divisional improvement plans.

Managers used information from the audits to improve care and treatment.

Key messages from patient safety panel are shared in the trust patient safety bulletin which was circulated via the communications team.

Managers told us they used information from audits to improve care and treatment. Ward level leaders shared with us weekly audits which had a focus on falls reduction, nutrition and hydration and skin assessments.

The trust shared with us some audit data for pressure area care for the medicine division for March 2022. This showed poor compliance for areas including 'Is there a management plan in place for repositioning the patient in the SSKIN booklet', 'has a registered professional carried out a full skin inspection on each shift', 'Is there evidence of interventions for 'at risk patients' documented in the clinical notes', has the wound chart been completed in full for pressure ulcers that are present on the body in this episode of care'.

Lessons learned from pressure ulcer and falls multi-disciplinary team (MDT) meeting were shared at the patient safety panel and were included in the patient safety bulletin. Learning from the MDT meeting was shared at the trust improvement group.

The trust's lead nurse for quality and patient safety has accessed completed reports and action plans for specific clinical areas to inform educational programmes.

Mortality and morbidity reviews showed standards of care were looked at and actions for improvements were identified.

Lessons learnt from never events and serious incidents are available on the trust intranet in a learning library within the quality and safety page. This also provided access to never event learning from the West Yorkshire Association of Acute Trusts (WYAAT). The patient safety teams meet quarterly as a WYAAT to share learning from never events and serious incidents where there is an opportunity for wider learning. This was also a forum to share good practice and support from other trusts.

The division audited falls and pressure ulcers grade three and above. They shared with us action plans for improvements.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. There were no medical patients outlying on non-medical wards on the day of inspection.

Competent staff

The service made sure staff were competent for their roles; however not all staff had received an appraisal. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Medical care (including older people's care)

The trust shared trust wide appraisal data with us following the inspection for the medicine division which evidenced nursing appraisal compliance as 73% this did not meet the trust target of 85%. Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal.

Appraisal compliance was a standing agenda item on monthly divisional management meetings and was also discussed in the workforce metrics presented at monthly finance and performance committee. It was also an agenda item for 1:1's and at department and team level meetings.

The division aims to complete appraisals within the April to June appraisal season. Managers told us that organisational challenges continued to affect the ability of staff to undertake appraisal due to both availability of appraiser and appraisee, with clinical staff having to work clinically.

Staff explained that they received additional training relevant to their role. Some wards had access to clinical practice educators.

Staff told us the trust had a dedicated continuous professional development team to support with education. We spoke with one clinical educator with end of life specialism who told us
they provided 1-1 training sessions with individuals and also provided sessions to larger groups if and when required. Clinical educators as a group have different specialisms within them, but can also provide training and support in areas such as electronic records, new nutrition, and hydration documentation etc.

Junior doctors we spoke with confirmed they had access to educational and clinical supervision and were well supported.

Managers gave all new staff a full induction tailored to their role before they started work.

When new nursing and midwifery staff commence induction at the trust, they attend clinical orientation. The medicines optimisation nurses (part of the medicines optimisation and pharmacy services team) teach for two whole days on the scheme. On induction qualified nursing staff undertake a training day concentrating wholly on the deteriorating patient.

Nursing staff were not permitted to administer medicines independently without attending the medicines sessions and without completing the medicines administration competencies in their workbook. At 25 March 2022, 420 workbooks had been issued to Band 5 staff working in the division of medicine (which included medical wards, emergency departments and the urgent treatment centre) and 394 had been completed and returned, giving a compliance rate of 94%.

The medicines optimisation group receive monthly updates on staff compliance with mandatory training on medicines. Level 2 mandatory training on medicines is for all staff who administer medicines. At 25 March 2022, 665 out of 778 staff (86%) in the division of medicine were compliant with Level 2 mandatory training in medicines.

All qualified nurses working on general wards attend either an in house automated external defibrillator (AED) training session or an immediate life support (RCUK) Course. Both included training in the recognition of the deteriorating patient. The trust provided data which showed nursing staff at the DDH site to be 73% compliant with regard yearly training and 66.4% compliant with regard three yearly training for resuscitation training.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a hand over meeting on ward 8 where the ward sister led the meeting. In attendance was foundation year 4 locum doctor, who knew the hospital well, one physiotherapist and assistant, one pharmacist, one trainee physiotherapist and a nurse discharge co-ordinator.

There was good overall multidisciplinary team input. No occupational therapist support was at the meeting. The physiotherapist told us they would pass on any issues to the occupational therapist if there were any patient concerns.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We observed an example of a referral during inspection, staff told us the psychiatric liaison team were efficient in streaming referrals to ensure patients were seen and reviewed quickly.

Patients had their care pathway reviewed by relevant consultants

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of 10 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission. Staff could call for support from doctors and other clinical professionals, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services. In some areas staff told us there was access to therapies (such as physiotherapy and occupational therapy) seven days a week. However, this was not the case in all areas, there was a reduced service at the weekend on the stroke rehabilitation unit for occupational therapy (OT) and physiotherapy. Staff told us that OT and PT will soon offer a seven-day service on the stroke and neurological unit at DDH provided through a dilution of the current weekday service.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We noted examples in nursing notes of staff formally assessing patient's capacity and taking appropriate actions to ensure safe care and treatment. Patient care records reflected day to day decision making in respect to patient care and documentation of capacity for example receiving personal care. For more complex medical or nursing decisions formal capacity assessments were documented either in clinical notes or using the trusts IT system on the MCA template. We noted one example where a Deprivation of Liberty Safeguards (DoLs) had been completed in paper format and on the trust IT system; however, this was not supported by a capacity assessment or best interest decision making.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There were examples in patient notes where consent had been sought appropriately to enable safe care and treatment. Consent training compliance showed a compliance rate of 80% across the medicine division for both nursing and medical staff. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Level one training was part of the core training and completion was 85%. Level two and three training was role specific and completion rates were at 72% and 84% respectively. All three were below the trust target.

Compliance with mandatory training requirements at MCA level 1, 2 and 3 are monitored on the safeguarding dashboard.

Mental Capacity Act and Deprivation of Liberty forms were available on the intranet and the junior doctors were aware of this.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw two examples where staff had completed relevant MCA documentation and followed appropriate guidance to request a Mental Health Act assessment for a patient. Information documented was appropriate and legible.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical care (including older people's care)

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness. Staff did not always respect patient's privacy and dignity but worked hard to meet patient's needs. Staff told us due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.

Staff were mostly discreet with patient care, however, there were incidents where we observed patient dignity was not upheld. For example, one patient was observed mobilising with a zimmer frame with one hand whilst holding their pyjama bottoms with the other hand. The patient's privacy & dignity was not respected, the nurse in the bay observed the patient struggling to manage and did not offer assistance. We observed some patients without pyjama tops nursed in bed with some patients not covered with sheets to protect their privacy and dignity.

Staff understood the individual needs of patients living with dementia and had a variety of strategies in place to facilitate for example distraction boxes and reminiscence walls. However, interventions were not seen at the time of the inspection due to the Covid Pandemic.

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when providing care and treatment and nursing and medical staff spoke with patients in private to maintain confidentiality.

Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Emotional support

Staff did not always give emotional support to patients, families and carers to minimise their distress. They did not always understand patients' personal, cultural, and religious needs.

We observed differing examples of emotional support for patients, on one ward we observed staff comfort a patient who was visibly upset. However, on another ward a patient who was visibly confused was left to mobilise around the ward even though the patient was a COVID 19 contact requiring restriction in a COVID contact bay. The patient required 1:1 support to manage the IPC risk and the patients varying confusion.

Staff did not always give patients and those close to them help, emotional support and advice when they needed it. Upon review of electronic and paper records, we could not find a section to record patient's individual spiritual and religious beliefs. However, post inspection the trust highlighted there was a section on the nursing standard assessment called 'pastoral, spiritual and religious care need', where if a need was indicated, a care plan was then generated.

Medical care (including older people's care)

Posters where displayed advertising John's campaign for patients who were living with dementia to allow a carer to stay with the patient. (John's campaign is a national movement to promote the rights and choices of people living with dementia).

Call bells were not always in reach of patients, particularly for patients who required assistance. This was a risk as it meant some patients who were vulnerable were unable to attract the attention of staff if they needed to access care or support.

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Visiting had resumed on some of the wards with people being able to book time slots and visits, however, some visitors could visit longer or at other times at ward managers discretion.

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. As visiting was restricted on most of the wards we visited, we only spoke with relatives of two patients. However, they told us that staff communicated well with them and kept them up to date with ongoing care plans and decision making.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. The trust uses an IT platform for the hospital site giving patients and visitors detailed information regarding hospital accessibility. The detailed access guides include all about the venue's access using figures and photographs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust participated in the Friends and Family Test (FFT). Survey results provided by the trust for February 2022 evidenced a response rate of 57% across medical wards at DDH against a target of 20%, however, two wards had response rates below the 20% target. The trust explained that sickness levels in February 2022 had affected the response rates on some wards, for example ward 9.

Family and Friends Test feedback posters were only visible on one ward we visited. Post inspection the trust clarified that 'welcome information boards' contained FFT results data which were updated monthly with the previous months data.

The trust shared data for the last patient survey which was undertaken in November 2020. The survey was site specific, 26% of patients responded to the survey, with 73% of the patients were over 66 years old. The survey showed 76% of patients had confidence in nurses against other similar external organisations which scored an average of 96%. Patients felt they were treated with privacy and respect scored 77% verses 96%. Patients felt they were given enough notice surrounding discharge scored 61% verses 84%. Patients rated their overall experience as 7/10 or more scored 60% verses 76%.

Is the service responsive?

Requires Improvement 

Medical care (including older people's care)

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The elderly care department has two acute admission units dedicated for those who are older and those with frailty needs over the age of 65. These dedicated elderly care facilities were based on Ward 41 at Pinderfields (Pinderfields Acute Care of the Elderly or PACE Unit) and Ward 9 at Dewsbury and District Hospital (Dewsbury Acute Care of the Elderly or DACE Unit).

Each of these units aimed to provide a comprehensive care of the elderly assessment of each patients' needs considering their physical, mental, and holistic needs.

The remit of the assessment wards was to discharge those patients who are suitable for rapid/ early discharge within 72 hours of admission or move patients to the most appropriate ward or service for ongoing care.

DDH benefits from support by the acute frailty team previously named the rapid elderly assessment care team, dedicated to ensuring that comprehensive care of the elderly assessment is completed on every patient. The team also supported those with advanced frailty on other wards at DDH.

The hospital had a dedicated orthogeriatric unit. This unit directly admitted such patients, to ensure that they have rapid assessments by orthopaedic surgeons and that around the time of the operation they receive a review by a geriatrician, who then also takes over their care 72 hours after surgery.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

There were no mixed sex breaches on the wards we visited.

Meeting people's individual needs

The service was not always inclusive and did not take account of patient's individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. On admission to the ward each patient received individual assessments, including risk- based assessments, and personalised assessments and subsequent care plans for cultural and spiritual needs.

Medical care (including older people's care)

We did not observe dedicated areas to meet the needs of patients living with dementia. For example, on ward 9 the dementia room was being used by therapy staff to complete patient records and undertake patient mobility assessments. The area was also being used to store mobility aids. Post inspection the trust told us the dedicated areas were not utilised due to COVID-19 pandemic restrictions.

The trust had a hospital passport for patients living with dementia. They were supported to receive individualised care by use of the Mid Yorkshire (MY) hospital passport. The MY hospital passport included information that would support hospital staff to provide individualised care. However, we did not always see these in use where applicable.

We observed on inspection that patients did not have access to watch television. Most of the wards had radios; however, we noticed many of the radios were low volume and the radio stations were not of a genre in keeping with the demographic on the wards. On the discharge lounge patients had access to televisions; however, staff told us that signal strength was not of good quality therefore none of the televisions were used in this area.

The service had information leaflets available in languages spoken by the patients and local community. The trust had a multi faith chaplaincy which offered a range of spiritual and holistic care. Prayer rooms and chapels were available, and chaplains could visit individuals by arrangement.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved sometimes multiple times in order to admit them to the right place once a bed became available. However, the service moved patients only when there was a clear medical reason or in their best interest.

We inspected the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine what treatment pathway was required. There were differing pathway options available within the medicine speciality.

The hospital had significant capacity problems due to the high number of patients who were medically fit for discharge and there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID 19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

Due to complexities in assessing patients who needed onward care, and the lack of care packages available to be purchased or arranged by social services, there were long delays in discharging patient's home. The staffing shortages in adult social care providers had a detrimental effect on the whole system of access and flow for medical care.

On the day of inspection, the hospital site had 95 medically optimised fit for discharge patients. The trust reported 96 patients as being super stranded. The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital. We noted a large number of patients on the medicine wards we inspected with the right to reside (R2R) who

had been in hospital over a period of several weeks. One patient on ward 11 had a length of stay over 56 days. 'Reason to reside' is a national policy to help identify patients to ensure that their care is delivered in the most appropriate place. R2R also provided a way of identifying patient discharge pathways to ensure that when patients are identified as safe to leave hospital care their discharge was timely and met their individual needs.

On ward 8, nine out of 25 patients were medically fit for discharge and on ward 10, 13 out of 34 were medically fit for discharge. Patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home.

Managers recognised the impact that delayed discharges were having on flow in the service and were aware of the poor flow through the wider care system locally. They had discussed improvement plans with social care colleagues and felt there was a high level of system working towards resolving these issues.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

The service moved patients only when there was a clear medical reason or in their best interest. It was recognised as adding stress and anxiety for patients if they were moved. Staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number of delays and took action to prevent them.

Managers instigated meetings to address long length of stay and discharges. The trust had instigated a ward based roll out of a mechanism to capture reasons to reside data at source during ward and board rounds to facilitate a high-quality MDT discussion about patient care and predicted date of discharge to support earlier discharge planning.

The trust had an integrated transfer of care team involving all members of the system which incorporated members of the hospital discharge team, social care, local authority housing, mental health professionals, voluntary sector etc to better support patients discharge pathways.

Staff supported patients when they were referred or transferred between services. Medical staff told us that consultants instigate daily (Monday to Friday) eConsultation with the GPs for 1-2 hrs in the afternoons to prevent admissions and plans are to expand this into a Domiciliary service.

Medical care (including older people's care)

Managers monitored patient transfers and followed national standards.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. There were no medical patients outlying on non medicine wards on the day of inspection.

The patient flow team cohort where possible any medical outlying patients on specific wards using as few locations as possible. This provides an opportunity to ensure medical staffing cover is available to review patients in a timely manner.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Complaint leaflets were available on all wards inspected.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

The trust shared with us data for complaints and compliments received between April 2021 and March 2022. 45% of all complaints the trust received were related to the division of medicine and 28% of compliments received related to the medicine division.

Information sent from the trust showed that complaints were investigated, and themes were identified. The main themes of complaints were around inappropriate discharge, coordination of medical treatment, lack of explanation of care, poor nursing care and staff attitude.

The service displayed information about how to raise a concern in patient areas in all the wards we visited.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared with us examples of complaints that they had received and investigations and outcomes that came from them. They also told us how they share learning from complaints with their team and one ward told us learning is cascaded to staff in a monthly newsletter.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had oversight of the service as a whole. Leaders understood the priorities and risks the service faced at ward level. Staff told us they were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The division of medicine was led by a deputy chief operating officer (COO).

We saw examples of leadership at site level with regard communication with matrons and ward managers. Specific medicine wards had differing leadership from onsite matrons. Staff told us they felt supported by matrons and senior nurses.

Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons at local level.

The trust offered an RCN (introduction to leadership programme) for band three and four non-medical professional workforce to support, develop and enhance their confidence as leaders. Including an RCN (developing leadership programme) for band five non-medical professional workforce to develop leadership skills that will help them progress into senior positions with an emphasis on self and practice improvement.

Staff at band six level had the opportunity to undertake the skills in practice programme. This was offered as an in-house leadership programme delivered over four months with a mini service improvement project. This programme supported registrants to become more confident with a range of situational leadership skills with practical tools and problem-solving techniques.

The trust told us that staff could access the strategic leadership programme. This programme is delivered over a seven-month period to senior leaders. With a focus on the leader within, leading teams through change and empowering and developing staff.

Senior nurse leaders within the division attended daily local huddles and a daily escalation meeting with corporate senior leaders to discuss and share ward-based escalations. Nurse staffing was reviewed twice daily, and a risk assessment made. Matrons and the deputy ADN on the DDH site attend ward areas daily to review risks (staffing, capacity, incidents) locally with ward-based teams and follow trust escalation processes where required. The DDH site attend the trust bed meetings and senior leaders in the division all contribute to a tactical rota.

The trust also instigated drop-in teams' meetings for the band 7s with the deputy director of nursing. Daily meetings and huddles took place at the DDH site with band 7 ward leaders, with IPC and with the patient flow team.

The divisional triumvirate team and senior management team alternated base attendance at the DDH and PGH sites ensuring a senior leader was always on the DDH site.

Vision and Strategy

The service shared the trust wide vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress

Medical care (including older people's care)

The Mid Yorkshire Hospitals trust has a current five-year strategy in place for 2017-2022 with a vision to achieve an excellent patient experience each and every time. This was complimented with the Mid Yorkshire (MY) quality strategy which described “the trusts ambition to improve quality, realising our ambition of an excellent patient experience and sets out the high level plan for doing so, ensuring the services meet the needs and expectations of the community we serve.”

A MY digital future strategy outlines the way in which Mid Yorkshire could invest in the application and advancement of technological innovation.

The division of medicine which currently encompassed both medical services and urgent and emergency care services did not have separate a vision or strategy as the division was led by the overarching trust vision and strategy and the strategy documents above.

The division ensured that there was a direct correlation from the divisional operating plans for each year with the trust strategic objectives directly linked to the vision and strategy (alongside the quality and digital strategy elements) which the trust executive team and trust board oversaw on a yearly basis.

To ensure the trust had sustainable plans to continue the service we reviewed the trust recruitment and retention framework 2022-2027. The focus of the trusts recruitment and retention strategy was to look after staff, helping them to feel they belong in the National Health Service. The trust continue to adopt new ways of working and delivering care to make effective use of a full range of staff skills and experience, with an additional focus of growing the healthcare professional workforce for the future and welcoming back colleagues who want to return.

The trust had a number of recruitment pipelines these included graduate nurse recruitment and retention, international nurse recruitment and retention, recruitment and retention of experienced nurses which included, suits you, return to NHS, return to Practice, trainee/nursing associate apprenticeship and retention, degree nurse apprenticeship and degree nurse Top up.

The trust also offered an acute induction programme (return to National Health Service, learning disabilities & mental health RGN).

Career cafés were offered to all nursing staff from band two and above to help sign post staff to opportunities within the trust who wish to progress in their careers and skill sets. With additional support on application writing and interview skills when requested. Along with a three steps career pathway – structure/programme to support the development of staff in the organisation

Culture

Not all staff felt respected, supported, and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff told us that staff shortages often impacted on patient care as gaps in staffing were not always filled.

Medical care (including older people's care)

Overall, we found staff morale to be low. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

Staff satisfaction and wellbeing was a standing agenda item on monthly divisional management meetings and was also discussed in the workforce metrics presented at monthly finance and performance committee. It was also an agenda item for 1:1s and at department and team level meetings.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their speciality results.

There was a divisional staff engagement improvement plan that focused predominantly on staff well-being, this was also captured on the local ward and department improvement plans to continually review staff feedback and consider necessary actions.

The division reviewed the most recent staff survey and identified the key areas surrounding, visibility and engagement, safety and governance and speciality specific actions

The division work closely with human resources, occupational health, organisational development, and the freedom to speak up guardian ensure staff have every opportunity to share feedback and were signposted to appropriate support where necessary.

The trust provided evidence to support staff health and wellbeing. For example, senior nurse huddles, wellbeing conversations and supporting ward managers. Team of the week and MY star awards nominations were introduced within the division to recognise teams and individuals.

During the pandemic the division had supported and offered to staff the use of clinical psychology sessions (individual or group). Divisional compassion and kindness week were planned for May 2022 to coincide with international nurses' day. This would focus on both patient and staff experience.

The trust shared the most recent staff wellbeing and engagement action plan (June 2021 – April 2022) which included concerns raised by staff, actions to address with responsible named leads and action dates.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities, however we found some examples where processes were not undertaken in line with guidance. Staff had regular opportunities to meet, discuss and learn from the performance of the service. However, we were not always assured that performance from audit was accurately measured.

Ward health check audit results highlighted variable levels of compliance surrounding differing audits for example storage of equipment in unlocked storerooms, resuscitation trolley daily checks and skin assessments. Senior leaders were aware of audit results and could explain actions to address these. Ward health check audits were undertaken by members of the corporate nursing and quality team. However, we lacked assurance that senior leaders were sighted on

risks surrounding some non-compliance. For example, the ward health check audit for the ward environment 'has the resuscitation equipment been checked daily and documented within the last seven days' showed that audit compliance was good with the exception of wards 2 and 5/6. The data evidenced the remainder of the wards inspected were compliant; however, this was not reflective of what we found whilst on inspection.

We also asked the trust to provide audit results where they had checked the compliance scores of ward environment checks to clarify that storeroom doors were locked and secure. We reviewed the trusts health check audit data for March 2022 which evidenced good compliance except for ward 2. The data evidenced that wards 5/6, 8, 9,10 and 15 were compliant; however, this was not reflective of what we found whilst on inspection. This was also highlighted as a should do action at the last inspection in 2018. We were not assured of senior leadership oversight of the ongoing risk.

Post inspection the trust clarified that the way in which health check audits are completed only allowed the wards a 0% or 100% score, which was sometimes not representative of actual compliance levels. The trust was reviewing the way in which this data was collected and used.

We reviewed the division of medicine governance structure which showed the structure included a resource and performance committee, risk committee and a quality committee.

We reviewed the minutes of the divisional clinical governance meeting for February 2022. Items were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. We noted discussion such as mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

We reviewed the integrated governance report March 2022 which evidenced 37 incidents had been reported in February 2022 where safeguarding was highlighted / triggered. In addition, the safeguarding team had been contacted on 17 separate occasions requesting advice and support

Themes of the incidents highlighted pressure ulcers and falls remain as the highest reported incidents.

The trust developed and rapidly implemented alternative governance arrangements for the division which was adapted and flexed to the needs of the division throughout the pandemic. A divisional bronze structure was rapidly implemented during the pandemic. This was flexed to meet the needs of the division to ensure rapid decision making and dissemination and cascading of board to ward information. This currently remains twice weekly.

The trust had introduced a virtual infection prevention review (VIPR) meeting in response to COVID with a focus on positive COVID cases. Information was shared at the daily bed meeting to reduce bed losses and maintain patient flow.

Senior leaders told us robust COVID-19 governance arrangements were developed and implemented which included a quality impact assessment process for service changes during the pandemic.

The division established a COVID 19 response team to compassionately manage the duty of candour process and patients medical and nursing reviews where hospital onset COVID 19 infection (HOCI) was identified. The governance arrangements for this team were developed and were in alignment with the serious incident framework. Although the team was managed in the medicine division this was a trust wide team who worked alongside a range of corporate teams and external partners. This has been commissioned for a further year.

Medical care (including older people's care)

Management of risk, issues, and performance

Leaders and teams mostly used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We reviewed the medicine risk register created April 2022. All the risks had action owners, updates on progress, mitigation, and review dates.

The leadership team were aware of some of their main risks and could explain the actions in place to mitigate their risks. Some risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

During inspection we had highlighted concerns regarding significant numbers of patients being nursed in bed, including during mealtimes. Senior leaders instigated a walk round post inspection and advised us that a working group had been instigated to review the concerns raised. Findings were that there was a lack of confidence from nursing staff with regard ambulating patients and staff feared patients were are at risk of falls. Senior leaders told us the last two years focus had been on caring for unwell patients and supporting patient discharges and therefore the culture had shifted away from rehabilitation.

We were not assured of senior leadership oversight surrounding the potential risk of harm associated with reduced mobility in hospital settings; especially in older adults where this cohort of patients were particularly vulnerable to the detrimental effects of immobility.

Following the inspection, the trust provided an updated surrounding the working group which included actions to address concerns raised at the time of the inspection. The groups action plan included actions related to improving staff awareness of the importance of mobility as well as actions to encourage improved practice in relation to positioning and support at mealtimes. These actions included:

- Relaunch of PJ paralysis within the trust to educate staff and patients of the benefits of sitting out and good positioning at mealtimes and keeping active whilst in hospital.
- Ensuring there was a clear escalation for wards regarding appropriate staffing levels to position patients who remained in bed at mealtimes, support with feeding and hydrating patients at mealtimes.
- Launch a supportive mealtime project at DDH

The trust also provided additional information post inspection to support the management and risk assessment of nutrition and hydration when nursing patients in bed at mealtimes. Nurses and healthcare assistants would undertake a risk assessment as required at each meal service, taking into consideration the patient's preference, condition, risk factors and requirements for support.

There were several risks specific to the DDH site for the division of medicine. The division had listed falls as a moderate risk within in-patient areas due to inadequate falls prevention and management resulting in harm to patients. Patients within the DOM were listed as at risk of falls which could result in harm. Senior leaders told us of a number of initiatives to mitigate risks which included a re-focus on ward huddles, revisiting the falls bundle a review of patients requiring enhanced care and requesting bank and agency staff if required.

Another example of risk was listed as patients at risk of skin damage due to poor compliance against pressure ulcer prevention and management strategies. This was listed as a moderate risk. The DOM monitor and review all pressure

ulcers (PU) through the PU monthly divisional PU quality group. The DOM are active members of the trust PU improvement group and attend the corporate PU panel. All hospital acquired PU resulting in harm were investigated at SI/SE level. PU were reviewed and monitored via the monthly divisional speciality performance meetings and lessons learnt shared at monthly divisional governance meetings.

The trust has instigated a live patient dashboard (plus) identifying patients with a NEWS of five or more. Patients were flagged on a report manager system which is monitored by the CCOT team. Since the audit was conducted, a number of quality improvement (QI) initiatives had been undertaken, particularly the sepsis quality improvement project, and a focus on the deteriorating patient in the division of medicine.

The trust Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) was not yet live within the trust therefore training had not commenced. The trust approved a business case to introduce ReSPECT and there is agreement with the two local clinical commissioning groups (CCG) to introduce this across the footprint with an outline timeframe for the project of 18 months, which commenced at the beginning of March 2022 with the development of the project team. The 18-month period is based on discussions with other patches that have adopted ReSPECT.

The ReSPECT model process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure; however, staff did not always adhere to trust policy with regard data security. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trolleys were left unlocked on all the wards we visited. Computers with personal information were left open with staff identification cards.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system. However, staff spoke about the difficulties in using both paper and electronic records with many complaining of the system being too slow and difficulties sometimes having access to IT equipment.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles. This was sometimes slowed down by connection issues with the software system that was in use.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

Medical care (including older people's care)

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust offered a senior nurse huddle meeting between the divisional assistant directors of nursing (ADN's) and corporate team, with opportunity to share the operational pressures and remove barriers for the approval and action of escalated concerns. This commenced daily at the height of the pandemic and remains in place to date.

The deputy director of nursing (DoN) meets with ward managers every Wednesday, providing a chance for ward managers to express concerns they had or ask for advice and support on issues.

Matron meetings were arranged monthly to provide opportunity for the divisional and corporate matrons to talk through issues in an action learning with the deputy director of nursing.

The trust had appointed a wellbeing guardian who was a senior member of the executive team. This demonstrated that they had a commitment to support staff health and wellbeing within the trust.

On ward 11 we saw a notice board where staff were able to nominate other staff members as a thank you for hard work and dedication. The board was called proud cloud, staff told us it was a way to thank colleagues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

Staff told us the clinical professional development team has created a bespoke support package to develop skills and knowledge and leadership across division of medicine wards.

New Frailty champions have been identified for each ward with a significant interest shown by staff for this role.

Staff told us that dementia friendly activities and afternoon tea was an activity in place prior to the COVID 19 Pandemic. This was paused during the main waves of the pandemic but as soon as it was safe to do so, was recommenced. This supported patient experience and engagement with activities.

Ward 5/6 had been fully transformed into a bespoke Neuro/Stroke rehabilitation Unit. There was a significant investment in the environment to ensure that this provided a good patent experience for patients who are on a rehabilitation pathway.

Maternity

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service did not always meet the trust target for mandatory and role specific training.

The mandatory training was comprehensive and met the needs of women and staff. We saw whiteboards in various managers offices displaying compliance levels for the completion of mandatory and core specific training courses. Mandatory training included infection control and equality and diversity and core specific training included conflict resolution, resuscitation and medicines management.

All staff we spoke with confirmed they had received, and kept up to date, with their mandatory and core specific training.

The overall compliance for mandatory training across the maternity service was 92% for April 2022. However, compliance rates against mental capacity act level 1, fire safety and information governance did not reach the trust target of 90% for April 2022.

The overall compliance for midwifery core specific training across the maternity service was 84% for April 2022. The compliance rates against consent, mental capacity act level 3 and patient safety did not meet the trust target of 85%.

In 2020 the trust paused the requirement for mandatory training due to the main priorities of patient safety during the pandemic responses and this impacted on compliance rates.

Midwifery staff completed a range of multidisciplinary team (MDT) maternity skills and drills training. This included cardiotocography CTG monitoring, situational awareness, human factors, practical obstetric multidisciplinary training (PROMPT) and maternal acute illness management (MAIMs).

There were two clinical educators who delivered MDT simulation training for medical emergencies such as eclampsia and fetal bradycardia. They told us this was based on feedback from skills and drills, incidents, audits or complaints.

Managers told us they monitored mandatory training compliance on a monthly basis and alerted staff when they needed to update their training by email.

Safeguarding

The service did not always meet the trust target for level 3 adults safeguarding training. However, staff understood how to recognise, report and protect women from abuse and the service worked well with other agencies to do so.

All staff we spoke with confirmed they had received, and kept up to date, their safeguarding training.

Midwives undertook refresher safeguarding supervision training four times each year and compliance rate was 96%.

For May 2022, the overall compliance for adult and children safeguarding level 1 and 2 training was above the trust target. However, the compliance against the level 3 core specific adult safeguarding training was below the trust target.

The service had plans to deliver a new training program to all staff which was based on domestic abuse, stalking and honour-based violence (DASH 2009).

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They had access to safeguarding relating guidance including female genital mutilation (FGM) which referenced appropriate legislation and evidenced based practice.

All staff knew how to make referrals to the named safeguarding lead or manager.

The service ensured maternity areas were safe and every door was securely locked. We observed staff being compliant with ward security by using security passes and asking women and visitors to use the CCTV/intercom system.

Staff had a clear guidance to follow in the event of child abduction. The service completed a child abduction simulation exercise in April 2022 in which learning points were identified, immediate actions completed and shared with staff as part of the MDT safety brief.

The service displayed safeguarding posters with local safeguarding contact numbers for anyone concerned about the welfare of any individual.

We reviewed electronic records and patient whiteboards which included a symbol to notify staff if women and / or families were subject to a child protection or child in need plan.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. We reviewed cleaning schedules which outlined when, what and how areas were cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, and monthly audits showed high compliance rates. The domestic supervisor also carried out audit checks of cleaning standards and cleaning record completion.

We reviewed hand hygiene audit results which showed the compliance had improved in the last six months and showed high compliance against the trust target of 98%.

Staff followed infection control principles including the use of personal protective equipment (PPE) and being compliant with bare arms below elbows. There were hand gel sanitisers on the entrance to all areas and hand washing facilities. We saw hand hygiene posters above sinks to provide a visual guide to hand washing.

Staff cleaned equipment after patient contact and labelled equipment with an “I am clean sticker” to show when it was last cleaned.

Environment and equipment

The service did not always maintain, service or replace equipment. Software licences had expired on cardiotocography (CTG) machines which had also exceeded their lifespan. Staff could not always access equipment easily. However, the design and use of facilities and premises kept people safe. Staff were trained to use equipment and managed clinical waste well.

Women could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance.

For example, the Bronte birth centre (a midwifery led unit) had appropriate facilities and transfer escalation procedures to Pinderfields Hospital.

The service had suitable facilities to meet the needs of women's families. All women in confirmed labour were admitted to a single birthing room with en-suite facilities and birthing pools were available. We saw gasses were piped into these rooms. All rooms had emergency pull cords.

There were accessible toilets for people with limited mobility.

We observed that staff were assigned to complete equipment checks at daily meetings / safety huddles. Staff completed appropriate daily safety checks of emergency adult and neonatal resuscitation equipment.

Most electrical equipment had been safety tested within the last 12 months.

However, we found a cardiotocography (CTG) machine had expired the service date of March 2022. This meant there was a risk of staff not being able to accurately monitor the fetal heart rate pattern to assess the wellbeing of the baby and identify any signs of deterioration.

We escalated this immediately to managers who explained the CTG machines had reached the end of their 7 to 8 year lifespan. This meant there was also an increased risk of equipment failure.

The service had CTG machines waiting to be dispatched. However, we heard varying reasons for this delay from managers such as no electronically interface screens or laptops or trolleys were available. The risk register provided more information that the software license used to analyse the CTG data remotely had expired. This meant the service was not meeting the national guidance recommendations. There was an increased risk of women being transferred or admitted unnecessarily and an increased risk of human error when reviewing fetal heart rates.

The trust used an equipment management system to monitor the maintenance and service history for all medical devices. We reviewed an audit of three months compliance for high, medium and low risk maintenance completion. The trust did not meet the trust IPEM standard target of 80% for December 2021 or January 2022 for medium and low risk maintenance completion. This was due to absence and operational pressures from the Omicron COVID-19 variant. In February 2022 we saw that these rates had improved and were over the trust target.

The service did not always have enough suitable equipment to help them to safely care for women and babies. For example, the flat bed scales had been condemned and one was borrowed from elsewhere on the day of inspection. Community staff said there was a shortage of mouth pieces used to detect carbon monoxide levels in patients' breath as a screening test for cigarette consumption. However, following the inspection the trust informed us there was a national shortage of mouth pieces. We did not see any plans to mitigate this risk.

We reviewed the risk register information which contained the risk for CTG machines, however it did not show the lack of equipment overall.

Community midwives had access to emergency equipment at the hospital. The service had a lone working policy.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. They identified and quickly acted upon women at risk of deterioration

Staff used a modified early obstetric warning score (MEOWS) and Newborn Early Warning Trigger & Track (NEWTT) to identify women and babies at risk of deterioration.

The service had appropriate escalation policies in relation to a deteriorating patient, such as emergency evacuation from a birthing pool and sepsis management. Staff from Bronte birth centre provided examples when they used MEOWS to identity, escalate and emergency transfer women to Pinderfields Hospital. They also had access to the A&E department and cardiac arrest team.

The sepsis pathway was embedded in maternity care and staff were reminded of the guidance and appropriate escalation, at daily / safety huddle meetings.

Staff completed regular risk assessments in line with local, system wide and best practice guidelines. We saw assessments completed for high BMI, gestational diabetes, eclampsia and venous thromboembolism (VTE).

Women were asked about their general health and emotional wellbeing at every appointment and this information was updated onto their maternity personalised plan.

Staff would follow guidance to discuss the risks and benefits for perinatal care including preferred birthing location. Perinatal care is the period of time from pregnancy to up to a year after giving birth.

Women who were considered as low risk were offered to be reviewed in community and / or hospital antenatal clinics. They had a provisional plan to give birth at home, or at the Bronte birth centre (which is a standalone service) at Dewsbury or Pinderfields birth centres (which is an alongside unit).

Women who were considered as high risk were reviewed at the consultant led antenatal clinics at Pinderfields and cared for by the continuity teams with a plan to deliver at Pinderfields hospital.

Women were instructed to call the birth centre or midwife when they commenced labour and were told where to attend depending on their personalised plan and the current staffing and acuity situation.

The service had 24-hour access to mental health liaison and specialist mental health support if there were any concerns about a woman's mental health.

We observed staff using the situation, background, action and result (SBAR) framework to complete appropriate handovers. This meant all necessary key information was shared to keep women and babies safe when handing over their care to others.

We requested but, did not receive the audit results relating to Maternity at the time of writing this report. However, following the inspection the trust provided results from recent audits and these showed mixed results when compared to the previous audit results in 2020. For example;

- There was a significant improvement in the documentation of risk assessments on admission "Intrapartum/ Antepartum Fetal Heart Monitoring and Fresh Eyes". However, standards had deteriorated for documenting the 30 minute reviews and two hourly coordinator reviews.
- There were significant reductions for woman waiting less than 24 hours for artificial rupture of membranes however, there was unclear evidence of consistent communication regarding the risks associated with induction of labour. There were also delays in starting the induction process and the trust were auditing these reasons and had put appropriate recommendations in place.

However, the trust did not submit audits for the world health organisation (WHO) surgical safety checklists.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The Bronte birth centre was a midwifery led unit (a standalone unit) which meant there was no planned medical staffing.

We reviewed data for planned versus actual staffing information for each ward / unit and this showed regular staffing gaps within the rota's for both registered nurses and healthcare assistants. The service did not display the data in meaningful way. It was not RAG colour rated to show when the actual matched the planned number of staffing.

Managers told us they reviewed and planned midwifery staffing to meet a midwife to birth ratio of 1:24. This was based on the most recent Birth rate plus (BR+) acuity assessment in May 2020 and national guidance recommendations. The Trust made significant investments in the midwifery workforce in summer 2020 to meet the Birthrate Plus recommended planned staffing models.

At the time of the inspection the service was following the staffing escalation policy. We observed the manager of the day holding multiple daily staffing meetings to assess midwife staffing levels across all three hospital sites using the BR+ tool. They were focused on providing safe care ensuring a ratio of one midwife to one woman in established labour and discussed the numbers of women in labour and numbers waiting for artificial rupture of the membranes (ARM).

We reviewed the average midwife to birth ratio which was 1:26 for the last six months for the maternity service.

Managers adjusted staffing levels accordingly to manage the risk. They redeployed staff from the community, continuity and birth centres to support the Pinderfields labour ward and antenatal and postnatal ward. This meant that the Dewsbury birth centre was regularly closed.

Managers told us they would plan the rota one month in advance and checked weekend staffing establishments in advance.

The service had two continuity teams who provided antenatal, intrapartum and postnatal care to women identified as low risk wishing to birth at Bronte Birth Centre. This service was under monthly review following the recommendations of the Ockenden report and had recently been reduced from three to two teams.

The Community Matron and Managers reviewed community midwifery caseloads per quarter; making adjustment as necessary to maintain caseload size to approximately one RM to 98 per year. In 2022 the caseloads were slightly less that the nationally recommended average per year to facilitate the planned sessional rotation. In March 2022 the community midwives had a caseload of 1:66.

Community midwives told us that when they were on-call they could be supporting births at home, in birth centres, or at maternity units depending upon staffing escalation. They reported this was impacting their time to deliver community care for woman.

We were informed the service had a high vacancy rate of approximately 16 whole time equivalent (WTE). The service had an active running recruitment advert for midwifery staff.

The average turnover rate was 1.5% for registered nursing and midwifery staff and 1.6% for unregistered support workers. This calculated as 1.5% average turnover rate for the maternity service. We were told the turnover rate was higher compared to previous years. The main reasons given by midwifery staff for leaving was retirement, reduced hours, further education and training and relocation to smaller units.

In April 2022 the average sickness rate was 12.5% for registered nursing and midwifery staff and 8.5% for unregistered support workers. This calculated as average sickness rate of 10.5% across the midwifery service. We heard that the January 2022 sickness rate was more than double the rate in January 2021(5%).

In September 2021, a decision was made to permanently suspend all antenatal bookings at the Bronte birth centre team in response to high sickness level of 47%. At the time of the inspection there were 62 women who remained under the care of the birth centre and continuity teams until they gave birth.

Managers told us they would request bank and agency staffing from NHS Professionals (NHSP) or PULSE a leading recruitment agency for the UK healthcare sector. They preferred to use staff who were already known to the service and who had already completed their full induction.

In March 2022, 7,198 hours were covered by bank and agency staff with 91% of shifts were covered by NHSSP and 9% were covered with agency.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Maternity

We reviewed eight electronic medical records which accurately recorded women's choices and risk assessments. All entries were electronically dated and timed. We reviewed an appropriate referral to an antenatal clinic based on risk.

Women could access, and contribute to, their online personalised maternity care plan. This included birth plan discussions, summaries of clinic visits, screening and other test results, contact numbers and details of future appointments.

All staff involved in the women's perinatal care could access women's medical records. The service shared discharge information in a timely way with women and GP's.

Electronic records were stored securely. We saw paper medical records in outpatient departments which staff said were tracked in and out electronically.

We observed staff maintaining the confidentiality of women. They locked computer screens when unattended, ensured printed confidential information was not left unattended and ensured conversations were discreet.

Staff told us health visitors issued the personalised child health record (red book) to each child.

The service's risk register identified a risk that community safeguarding information recorded before 2019 was not easily accessible if needed for any serious case reviews or litigation cases. This was partly due to the migration of paper records onto the trust's electronic record system however, the service was looking into possible solutions.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

The service displayed posters to remind staff about the process of; ordering medicines to take out (TTO) and prescribing medicines with approved patient group directions (PGDs). PGD's allow appropriately trained, nominated healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription.

Staff reviewed women's medicines regularly and provided advice to women and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. We reviewed three completed prescription charts in the service, two were completed accurately and one was missing the recordings of weight, allergy and venous thromboembolism (VTE) assessments.

Staff appropriately stored all medicines, including controlled drugs (CD) and medical gasses with restricted access to authorised staff.

All medicines stock were in date.

Community midwives collected home birth equipment, including medicines and medical gases, from a locked storeroom at Bronte birth centre.

The service had made improvements to the dispensing 'to take out' (TTO) medicines based on feedback from audits, patient feedback and CQC survey results with an aim to reduce discharge delays and poor patient experience.

Maternity

We reviewed data for staff within the Family and Clinical Support Services Division which showed 94% of staff were compliant with level 2 mandatory training on medicines and was within trust target.

Incidents

Staff recognised and reported incidents and near misses. Managers shared lessons learned from incidents with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had a comprehensive incident reporting policy. Staff were aware of the importance of reporting incidents and raising concerns with managers. They knew what incidents to report such as maternity red flags and how to report them on the electronic incident reporting system. There were 31 datix raised in the last six months relating to staffing at the triage unit, however, we heard staff did not always report staffing issues on datix.

In the last six months, the service had two never events which were serious patient safety incidents. On the same day in January 2022 there were two incidents of retained swabs. In February 2022 there was a maternal death relating to obstetric haemorrhage and this was reported to the healthcare safety investigation branch (HSIB).

Managers shared safety incident information and lessons learned on ward / unit governance learning boards. The top three incident reported themes displayed were delayed induction of labour, blood loss of more than 1500mls and 3rd and 4th degree tears.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff met at monthly departmental team meetings to discuss the feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff. There were folders on ward/unit with weekly newsletters.

Managers reviewed, and discussed, incidents which were graded as moderate and severe harm discussed at the perinatal mortality review tool (PMRT) meetings.

We spoke with staff and reviewed 12 months of datix incidents which showed that staff were not always debriefed or supported following serious incidents such as an obstetric emergency. This was recognised by leaders as an area for improvement following clinical incidents and complaints.

Between 01 May 2021 to 26 April 2022, the service had submitted 14 cases to the healthcare safety investigation branch (HSIB), four were declined, six were ongoing and four were completed.

We reviewed the safety recommendations following three HSIB investigations and the associated actions plans for the service. One of the recommendations was to ensure recognition of an abnormal antenatal cardiotocography (CTG). This was concerning particularly when we have still found during our inspection concerns about the equipment which could impact on staff's ability to detect deterioration of the baby.

Maternity

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We saw national guidance posters and flowcharts on wards/ units.

The safeguarding guidance including female genital mutilation (FGM) which referenced appropriate legislation and evidenced based practice. The emergency escalation policy was in line with national guidance and Ockenden report recommendations (2020).

The service would update policies and deliver training when best practice and new guidance was released. For example, the preterm labour birth guidelines and maternity skills training were both in line with the Saving Babies' Lives Care Bundle version 2 (SBLCB v2) and National Institute for Health & Care Excellence (NICE) guidance.

We reviewed eight medical notes and received information from four women which demonstrated the service was managed in accordance with best practice and national guidance. Women were asked about their general health and wellbeing at every antenatal appointment, and they were given a named midwife throughout their pregnancy.

The trust had an operational plan for the Bronte and Pinderfields birth centres which complied with the “safer childbirth; minimum standards for the organisation and delivery of care in labour” guidelines from The Royal College of Obstetricians and Gynaecologists (RCOG).

Staff told us the transitional care policy had recently been rewritten to include new escalation protocols for women needing medical input at the antenatal clinic at Dewsbury. The current version had a review date of March 2021.

Most staff we spoke with knew how to access policies for guidance.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with had completed role specific training on the mental capacity act however, the compliance rate for mental capacity act training did not meet the trust target.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers.

The service demonstrated full compliance with all elements of the saving babies lives care bundle (version 2) and submitted their final local maternity system (LMS) survey in June 2021. The standards had been successfully implemented for;

- reducing smoking in pregnancy
- risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
- raising awareness of reduced fetal movement
- effective fetal monitoring during labour
- reducing preterm births.

The service had self-assessed its position in response to the final Ockenden report (2022) against all 93 recommendations across 15 immediate and essential actions. They had 55 actions which were RAG rated green; 25 actions which were RAG rated amber and 7 actions which were RAG rated red. The service provided a monthly report to the Maternity Surveillance Group which detailed progress, gaps and challenges in achieving, and embedding, all essential and immediate actions.

The service had also recruited a clinical educator to implement cardiotocography CTG training for medical and midwifery staff.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

Staff completed regular comfort rounds to make sure women had enough to eat and drink.

There was a range of menu options available which included special dietary requirements. The service also displayed information where food and drink was available to purchase.

Staff told us women were provided with breastfeeding guidance prior to discharge. The service had a breastfeeding specialised midwife and a peer supporter programme. We spoke to one woman who said they were supported by staff with breastfeeding /bottle feeding their baby.

Community midwives visited the women's home on the first day and then it depended on whether they were breastfeeding or bottle feeding as to when they arranged their second visit.

The success rate for women commencing breastfeeding was 70% across the maternity system in the last 12 months. This did not meet the national target of 76%.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

We received information from one woman who confirmed they received adequate pain relief during labour soon after requesting it.

Staff told us that women in birth centres could use the birthing pool to help them manage their pain. There was a consultant anaesthetist available 24 hours seven days for women who required epidurals.

The service had a task and finish group to improve the delays in prescribing pain relief medication. As a result there is a new process which is being embedded and the last audit showed 97% of medicines were given on time.

Maternity

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

The service carried out a comprehensive programme of audits however, due to system pressures audits was suspended for two months in January and February 2022 and recommenced in March 2022.

Managers told us they completed regular environmental which were all satisfactory with no themes.

We obtained information from national clinical audits which demonstrated the service complied with all ten safety actions in the NHS Resolution Maternity Incentive Scheme.

The service achieved 100% compliance for the last four pain management audits. This was based on pain management recorded discussions, if pain relief was received within 30 minutes of request and if an epidural was received within 30 minutes of request.

We also saw examples of how the trust bench marked against the healthcare safety investigation branch (HSIB) national learning reports and across the local maternity system (LMS).

The service had maternity dashboard to monitor clinical performance and governance and displayed a visual chart to monitor performance over the previous six months. It showed multiple activity indicators for every month such as the number of babies born before arrival.

The dashboard did not always show the comparison data for the trust, regional or similar sized services for all metrics. For example, managers were unable to compare the metrics for woman who required 3rd or 4th degree tears following vaginal births.

In addition, there was no visual traffic colour code system to use for benchmarking performance and this did not follow national guidance from Royal College of Obstetricians and Gynaecologists (RCOG).

Following the inspection, the trust informed us they used the data from a regional maternity dashboard data to measure the progress against national and regional trend data and discussed this at the maternity quality surveillance group meetings.

In the CQC maternity services survey 2021 the service scored better than expected for “Did a midwife or health visitor ask you about your mental health”. Women we received information from told us they were asked about their mental health at every appointment.

In the same survey the trust scored worse than expected for all five questions “whether the women had the opportunity to ask questions about their labour and their birth”, “whether they had skin to skin contact shortly after the birth”, “if concerns were taken seriously”, “if staff were able to help when they needed it” and “if their discharge was delayed”.

The CQIMS (Clinical Quality Improvement Metrics) data up until October 2021 identified areas of clinical quality improvement for the service which included reducing the number of women having a caesarean section with no previous births and women who had a postpartum haemorrhage (PPH) of 1500mls or more.

Maternity

The number of women who had a post-partum haemorrhage of more than 1500mls was 1.3% which was better than the Yorkshire and Humber region average of 3.4%.

Managers shared and made sure staff understood information from the audits using team meetings, safety huddles and weekly newsletters.

The service was accredited by UNICEF a baby friendly initiative and had completed stages 1 and 2 and were working towards stage 3.

Competent staff

Managers did not always appraise midwifery staff's work performance to make sure they were competent for their roles. However, they held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. The service could develop individual plans for new starters if necessary.

All newly qualified midwives had 18 months to complete a competency booklet which had been created within local maternity system (LMS).

The trust employed specialist midwives for preceptorship and students. They managed a programme of continuous recruitment and provided support to new starters such as students, return to practice midwives and developed individual learning programs.

Managers supported staff to develop through yearly, constructive appraisals of their work. The professional midwifery advocates (PMA) wrote directly to every midwife to offer restorative clinical supervision if required.

The appraisal rates for midwifery staff was 69% and below the trust target of 85%. Management explained this was reflective of the high number of absences in the workforce.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

We heard positive examples of when staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge such phlebotomy courses. The trust had employed a specialist retention midwife to support career development and monitor staff experience.

There were high levels of staff redeployment, especially community midwives, onto wards / units with higher acuity women. We received varying information, some staff used this as an opportunity to keep up-skilled whilst other staff lacked confidence and skills in these high-risk areas. We heard the service had implemented a planned sessional rotation of community midwives, so they spend timing working on the labour ward rather than block periods of rotation.

Midwives were trained to worked in specialist roles for example, vulnerable women, young people, domestic violence, bereavement, safeguarding, perinatal mental health and breastfeeding.

Multidisciplinary working (MDT)

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We observed managers attending staffing escalation team meetings.

We observed safety daily huddle meetings at different times of the day. Staff in attendance discussed staffing updates and redeployment plans, the numbers of artificial rupture of the membranes (ARM's) and any safety briefings. These were minuted by the midwife of the day and anything of concern was escalated to the senior management team.

Staff we spoke with worked well together.

Managers had regular monthly meetings with GP's, health visitors and specialist midwives and the safeguarding team to discuss care for women and any safeguarding concerns.

Staff referred women for mental health assessments by the perinatal mental health (PNMH) team when they showed signs of mental ill health, depression.

Seven-day services

Key services were available seven days a week to support timely care.

There was always a consultant in A&E for any obstetric emergencies.

Staff were supported by other hospital services such as mental health services, diagnostic screening and pharmaceutical help and advice 24 hours a day, seven days a week.

The service had a midwife on call who could provide support to women 24 hours a day.

Women were advised to call their chosen birth location at the onset of labour. If the birth centre was closed the calls would be diverted to the triage unit.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service displayed easy to read posters.

We saw information promoting healthy lifestyles and a list of support organisations. For example, we saw a poster encouraging physical activity for pregnant women and the importance of checking emotional wellbeing.

The majority of the posters had a website address or QR code links for people to obtain further information using their smart phones.

The service had various initiatives to promote healthy lifestyles. Staff would assess women's health at every appointment and support any individual needs. There were specialist midwives to support women about smoking cessation, obesity and those dependent on alcohol or drugs.

Maternity

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty. However, not all staff had completed mandatory training on the mental capacity act.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available at every appointment. We reviewed two electronic records which showed a clear record of consent discussions such as place of delivery, method of delivery and any risks explained.

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. When women could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff we spoke with said there had been a significant rise in mental health referrals since 2020. Perinatal specialist midwives supported women to ensure they have access to the right perinatal mental health support. We heard an example when additional support was given to women who had birth anxiety.

Staff we spoke with had completed role specific training on the mental capacity act. However, the compliance data for mental capacity training completion was below the trust target for levels 1, 2 and 3. This meant not all staff had completed mental capacity act training.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. They were welcoming and introduced themselves to women and their visitors.

Women said staff treated them well and with kindness. We received information from seven women who all gave positive feedback "excellent care and would highly recommend people to birth here", "amazing, staff really nice and accommodating".

Feedback from social media and friends and family tests (FFT) were all positive and confirmed that staff to be very caring.

Maternity

We observed staff delivering personalised care to women and their family.

We heard positive ways staff helped create a comfortable atmosphere during labour. For example, the birthing pools had mood lighting.

We received information from five women who confirmed staff respected their privacy and dignity "yes always using curtains". Staff demonstrated attention to detail when ensuring privacy and dignity of women and those accompanying them. For example, staff used privacy curtains for women in bays or kept doors closed and carried out conversations in private.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs.

Staff shared positive examples of how they understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff cared for surrogate women, their birthing partner and new parents. They arranged for family members of Islamic faith to offer prayers virtually during the pandemic for the new-born baby. They were also aware of the differing cultural requirements in relation to termination of pregnancy.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. We received information from four women whose emotional wellbeing was checked, and re-assessed by staff at every antenatal and postnatal appointment.

Staff provided positive examples of when they provided emotional support and care to women and their families for example for positive screening results, high risk pregnancies, babies who did not survive pregnancies and if a termination was required.

Staff from the continuity teams would form bonds with women and families. For example, staff cared for a mother throughout her pregnancy knowing that the baby would not survive after birth.

We saw examples of when staff discussed the emotional care of women during handovers and safety briefs.

Specialist bereavement midwives were available to provide additional support and bereavement follow up support to family members.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The service was able to use areas on the ward which women and their families could use in the event of unexpected news.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service had a care pathway for women who were expecting twins or multiple births.

They demonstrated the need for sensitivity, individualised communication and good listening skills. Community midwives would continue to care for bereaved women and families at postnatal home appointments. Staff were able to signpost them to various charities and support groups.

We saw a poster which stated “we would like to remember the babies that are not here with us today that were lost in pregnancy, born sleeping or passed away in their first few weeks of life. We send their loved ones our deepest sympathies”.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their pregnancy care and treatment with clear information at every appointment.

Women could access their own Maternity electronic notes via a PC, tablet device or mobile phone and one woman had quoted it “contained details of each appointment, easier than keeping lots of paperwork”.

We received positive feedback from six women who said they were able to ask questions at appointments, “all staff are open and approachable”.

Staff provided examples which demonstrated an awareness of how they used different communication aids to speak with women, families and carers.

Women and their families could give feedback on the service and staff supported them to do this. The service displayed friends and family test posters and feedback cards and submission boxes were present on all the areas visited. There was also an option to leave feedback online or by QR code. All community laptops displayed accessible QR codes.

Women were supported to make informed decisions about their own care and treatment depending on the stage of their pregnancy. Staff recorded women’s wishes and preferences as part of care planning processes. Staff told us they discussed the risks and benefits of giving the baby a vitamin K injection with a woman of Islamic faith, because it contains pork / animal products.

We received positive feedback from three women who said they had enough information to decide their own pregnancy birth plan based on discussed risks and benefits “both at my routine appointments and extra appointments I requested at 40 weeks”.

The Bronte birth centre displayed a poster of their recent friends and family results from March 2022 which showed a 64% response rates with 100% positive responses. Quotes included “all the staff was amazing they took good care of me during labour and after care” and “We would recommend this birth centre to others” and “she (midwife) seemed to know exactly the kind of support I needed at any given point in my labour – whether that be gentle encouragement, firm guidance or time alone with my birth partner. I felt totally in control and supported with my birth choices”.

Maternity

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care

Managers planned and organised services across all three maternity sites to meet the needs of the local population.

Staff made sure women were aware of alternative low risk birthing locations if their chosen birth centre was not open or if the community team were not available to attend a home birth. This was recorded as part of their care plan and women were advised to telephone the unit or their midwife when in labour.

Staff were able to plan home births, and postnatal appointment home visits, as part of the routine assessment. They also visited women in prison. We heard positive reviews about the continuity and community teams for example four women who said they had a named midwife, and it was easy to contact them, “loved seeing the same (midwife) and felt more comfortable”.

This service had an operational plan which described the arrangements to ensure that antenatal, intrapartum and immediate postnatal care was safe and accessible for women who live within the Mid Yorkshire geographical areas.

The service displayed posters proving information and a list of support organisations, for women who felt isolated and had no support, were homeless or seeing asylum, were from an ethnic minority background and families who had children in care.

The Bronte birth centre was utilised for community and continuity antenatal appointments which would normally take place at GP surgeries. This meant women were seen at same place they planned to deliver at.

The facilities and premises were appropriate for the services being delivered. The service provided a free bus service for women and families which operated hourly between each hospital site from 8 am to 8 pm weekdays and 1 pm to 8 pm on the weekend and bank holidays.

There were beds available for the women’s birthing partner to stay on the ward / unit.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems, learning disabilities and dementia. There were clear guidelines for referrals to the perinatal mental health team.

Specialist midwives provided additional care and support to women. For example, there were clinics for diabetes, fetal medicine, perinatal mental health, multiple pregnancy, pregnancy loss, infant feeling and birth matters. They reviewed women who were being cared for on non-maternity wards/ units.

In addition, the trust collected data which showed that there was a significantly high number of women using the service who were current smokers compared to the national average. In response to this the service had implemented a smoking cessation clinic.

Staff provided examples of how and when they could refer onto termination services.

Managers monitored and took action to minimise missed appointments. We heard of a recent quality improvement project where the service amended the content of the appointment letters to improve the 'did not attend' (DNA) rate.

Managers ensured that women who did not attend appointments were contacted by community midwives who would be able to re-book an appointment.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The service had a complex needs team who provided the necessary care and support for women living with mental health problems, learning disabilities and dementia, received the to meet all their needs.

The trust collected data which showed that there was a significantly low number of women using the service whose babies had their first feed with breast milk. The service had positive examples to show this was being addressed such as employing a specialist breastfeeding midwife and an infant feeding clinic.

All women, and staff involved their perinatal care, had access to an online personalised wellbeing care plan "My Maternity notes". It detailed all pregnancy conversations such as preferred location of birth, test results and appointments and a weekly summary of what to expect.

Women were able to record the practical ways staff could provide additional support, for example declaring any known triggers which may exacerbate birth anxieties.

The service had a standard colour scheme for the patient whiteboards to identify different stages of pregnancy. There were symbols to identify women who required bereavement or breastfeeding support and anyone with a child protection or child in need plan.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service displayed easy read posters in accessible formats to meet the needs of women with sight conditions, learning difficulties or dyslexia. Most posters had a QR code for smart phone access for further information.

Information was available in all languages spoken by women and local community for example posters and discharge videos.

Managers made sure staff, women, loved ones and carers could get help from translation service interpreters or British sign language (BSL) when needed. The service had two link workers who supported women for language barriers.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids, such as a white board and a pen and clear transparent masks, to help women become partners in their care and treatment.

Access and flow

Women could access the service when they needed it and received the right care promptly.

Woman we received information from had been offered a choice appointment dates and times for their perinatal appointments.

The continuity service ensured women were seen regularly throughout their pregnancy. The maternity dashboard showed an average of 14% of women were booked onto a continuity pathway over the last six months.

Managers were supported by delivery suite coordinators to manage the access and flow into the maternity service effectively. There were daily MDT meetings held to discuss the numbers and acuity for women who were planned for artificial rupture of membranes (ARM) or caesarean sections, unplanned and emergencies.

Managers worked to keep the number of birth centre closures to a minimum, and there were 138 closures between September 2021 and March 2022. During periods of staffing escalation these centres would close to allow staff to be redeployed to fill staffing gaps (and / or provide 1:1 labour care) in. This was to ensure there was 1: 1 care on the theatres, labour ward, antenatal and postnatal ward at Pinderfields hospital. From April 2021 to March 2022 98% of women experienced 1:1 care in established labour at Dewsbury hospital.

The Bronte birth centre would also close if the local ambulance service could not guarantee safe transfer to Pinderfields hospital which was a 15-minute journey.

The service had an escalation policy to deal with the management of an obstetric emergency and staff knew to phone 2222 and state obstetric emergency and location. Staff told us they received skills and drills training for birthing pool evacuation and neonatal transfers.

There was a triage unit at Pinderfields hospital for women who could be reassessed and medical reviews if they had any concerns. We saw a poster explaining how the triage system worked.

We heard that women, particularly those who did not have English as their first language, regularly turned up to the Bronte birth centre when it was closed. Managers told us there were signs on birth centre doors with the triage telephone numbers. We saw this new phone service at the triage unit which took all diverted calls from the closed birth centres.

At times when the service was full or in staffing escalation women were given the opportunity to be transferred to a local hospital however, there were similar challenges reported across the local maternity system (LMS) and region. The trust submitted daily ‘sit rep’s’ to the regional maternity team to ensure the regional team are briefed on the service’s position.

We reviewed the action plan following the action plan following the last inspection in 2018. The service had made significant changes to improve access and flow across the service. The service were planning rotas four weeks in advance as opposed to one week. There was a reduction in triage delays and artificial rupture of the membranes (ARM) delays. The service reported red flag incidents in line with NICE safe midwifery staffing guidelines.

Maternity

Women were normally discharged from the birth centres, antenatal day units and labour ward the same day. Women who required further observations were moved onto the postnatal ward at Pinderfields hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information in different languages about how to raise a concern in patient areas. We saw posters stating “we are listening” with contact information and a QR code for smartphone users to leave online feedback. The trust offered a drop-in session to allow women and their families to talk to the patient advise liaison service (PALS) team face to face.

Staff understood the policy on complaints and knew how to handle them.

Managers responded appropriately to online complaints. They investigated all complaints promptly which involved speaking to identified staff.

Managers shared feedback from complaints in various formats such as at meetings and newsletters and on whiteboards.

We heard positive ways of how learning was used to improve the service to minimise the risk of repeat issues.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The midwifery and women’s health service was managed by a well-defined leadership team. It was led by a Director of midwifery (DOM) with support from a head of clinical services.

The leadership structure chart was clear and comprehensive.

The service had five maternity safety champions which included executive and non-executive directors.

The service had a non-executive director who reported to the board and who was also a safety champion.

Staff spoke highly of the director of midwifery (DOM).

Maternity

The leadership team were visible and approachable. They attended daily handovers and safety huddles. The matrons visited each site every week. However, some staff said they would appreciate a more visible presence from the matrons and leadership team.

Staff we spoke with told us how management had supported them to take on more senior roles and develop their careers, with a view to succession planning. We heard examples of staff completing their RCN leadership skills course.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However not all staff were aware of the vision and strategy for the future of the service.

The head of clinical services delivered a presentation to staff on the strategy, priorities and risks for their services in February 2022. This aligned with the trust strategic objectives.

The first priority focused on quality and safety to improve patient and staff experience;

- keeping patients safe at all times
- providing excellent patient experience
- delivering expected outcomes
- being an excellent employer.

The second priority focused on performance;

- being well led and governed with sound finances
- having an effective partnership that better supports patient care
- providing excellent research, development and innovation opportunities.

The service were working extensively with the maternity voice partnership (MVP) and also the safety recommendations from the Ockenden report to develop the next strategy due for release 2023.

Although leaders had shared the plans for the new strategy in various team meetings not all staff understood the work being done to improve staff experience. We heard many examples from staff who did not know the future plans for the Bronte birth centre and what this meant for the birth centre staff, community and continuity midwives.

Culture

Staff felt respected, supported and valued by colleagues. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and their families could raise concerns without fear.

We heard positive examples of how staff felt working within their local team such as “good”, “friendly” and “kind culture”.

There were supportive working relationships between the hospital, community and medical staff across all three sites.

Maternity

The service displayed a number of posters for the Mid Yorkshire (MY) Maternity phone line and contact emails for staff to access if they required confidential support from professional midwifery advocate team.

We saw positive ways managers and coordinators supported staff's wellbeing such as checking to see that everyone had time to have a break. However, most staff we spoke with were unable to take a break due to workload.

The 2021 NHS staff survey results for women's services directorate showed that staff scored less than the organisation for "we each have a voice that counts" and "morale".

This was a similar theme found on inspection and from intelligence. Many staff we had contact with did not feel supported or valued within the wider team. They felt their voice had not been heard by leaders who were also reported to "lack insight".

Leaders were aware of this cultural theme from issues raised via the Freedom to Speak Up Guardian. The service had implemented a number of actions as a result of these findings such as recruiting Freedom to Speak Up Ambassadors by the end of May 2022. We heard that matrons would be working alongside staff to understand the pressures they experience and learn how to be more supportive and visible at times of need.

Following our inspection visit the service sent a survey to staff asking for their communication and engagement preferences and had set up an email address for staff to raise concerns.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. They were given opportunities to meet, discuss and learn from the performance of the service.

Maternity service is part of the Family and Clinical Support Services Division.

The service had a formalised governance framework and processes to support the safe and effective delivery of care.

Leaders had monthly MDT meetings to discuss quality and safety issues.

We reviewed three clinical governance meeting minutes which were held monthly within the Division of Families and Clinical Services and chaired by the Divisional Clinical Director. They had regular attendance by senior leaders and clinical governance. There was a standard agenda which covered quality, safety and performance issues.

We saw examples of an effective governance structure for communicating quality, safety and performance issues. We saw how issues could be escalated up to the clinical governance meetings and divisional management team and also how information was shared back to sub committees and all staff.

Each area/ unit had a governance learning board which were updated every month. These were used to share the top three; things that have gone well, risks, datix themes and things to improve. They also displayed patient feedback, the number of complaints and compliments, learning from incidents and staff achievements. At the bottom it highlighted the compliance of mandatory and role specific training completion, appraisals, and sickness rates.

Managers held regular ward / unit face to face and virtual meetings with their staff including community staff. Staff discussed quality and safety issues and learning from recent incidents, audit outcomes or feedback from complaints.

Maternity

Management of risk, issues and performance

Leaders used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, leaders did not always identify actions to reduce the impact of risks in a timely way.

Leaders demonstrated they had the knowledge and oversight of the service's main risks and understood the challenge of risks in terms of quality, improvements, and performance.

The service had an embedded perinatal clinical quality surveillance model and the Maternity Quality Surveillance Group met on a monthly basis. This group was able to corroborate the information from different sources and discuss a range of issues such as risks, Ockenden updates and learning from serious incidents and HSIB recommendations.

The service had a comprehensive electronic risk register and risks were reviewed monthly and escalated appropriately through divisional meetings. Managers used a RAG rated system to monitor the ongoing risks and each had an associated action plan with a named manager. This confirmed known risks and issues found on this inspection such as short delays in time from admission to triage and delayed induction of labour. They used both balloon catheter dilators and prostaglandin pessaries to help with labour admission planning.

We acknowledged the service had experienced some extremely challenging periods with high levels of activity and acuity at the same time as reduced staffing levels due to vacancy and sickness.

The manager of the day had good oversight of what was happening across each site to maintain and ensure a safe and effective delivery of care and treatment. The focus of safe staffing activities was to meet the provision of 1:1 care for women in established labour and reduce any delays of induction of labour. The leaders were aware the unsustainability of the current staffing models.

Leaders and senior staff met daily when the service was in staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff in an attempt to meet the planned staffing levels and they would close low acuity birthing centres. All non-essential study leave was cancelled, and specialist non-clinical midwives and managers were deployed to support clinical activity.

The overall staffing position and impact such as delays in induction and red flags were reported on a monthly basis to the trust Board via the monthly executive led Maternity Quality Surveillance Group (MQSG).

Leaders were aware of the negative impacts across the service in terms of staff experience such as low morale and satisfaction, and inability to take rest breaks for drink and food.

They had identified common themes and trends over the last six months for staff working at the triage unit. These included the service not meeting the agreed staffing levels to successfully implement Birmingham Symptom Specific Obstetric Triage System (BSOTS). We heard of recent improvements with the BOSTS system such as the addition of a third midwife.

The service demonstrated appropriate actions taken to mitigate the risks. They completed a comprehensive review of midwifery staffing to determine the future workforce model and national maternity standards and guidelines. The service required investment for an additional 15.71 WTE midwives with a further 3.30 WTE to make some interim roles substantive (DOM, maternity support workers and 24/7 ward clerk cover) to ensure safe service. The next Birthrate Plus review assessment was booked for quarter 4 in 2023.

Maternity

We reviewed the most up to date action plan following the last inspection in 2018 and the service was on track with the recommendations.

The service participated in a national staffing survey which bench-marked staff satisfaction with other trusts.

The trust commissioned an external company to look into staffing issues and some areas have been identified to prioritise improvement actions for staff experience.

The service had identified the delay in receiving the new cardiotocography (CTG) machines and interfaced screens on the risk register. They were aware that the equipment had expired their lifespan and had not been safety tested within the last 12 months. Managers acknowledged the communication with the medical physics department could have been improved. However the service had not addressed this risk within suitable timeframes as the software license had expired in December 2019 but actually stopped working in February 2021. This meant there was no oversight of license expiry dates or forward planning to mitigate the ongoing risk. This was of particular concern as there had been incidents and HSIB recommendations that related to CTG monitoring; equipment that may not be functioning properly would impact on staff's ability to detect deterioration during labour.

Information Management

The service collected reliable data and analysed it. Most staff could find the data they needed. Staff could use data to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Important information such as policies and minutes of meetings were easily accessible to staff. Data management systems were integrated and secure.

Information governance was included in mandatory training.

Staff could easily access the electronic patient record systems and care records.

The community team had access to SystmOne to aid the sharing of information between the hospital and community with GP's and other health professionals.

Notifications were submitted to external organisations as required. For example, the service submitted staffing positions for the previous 24 hours to the Local Maternity System (LMS) and NHS England and Improvement (NHSE/I).

Engagement

Leaders actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, leaders were not always effective in their communication or engagement with staff.

Leaders we spoke with acknowledged the impact of system wide issues such as recruitment, retention, sickness and shift fill on staff experience.

They were aware of themes and trends escalating from datix raised, the Freedom to Speak up Guardian, and anonymous whistle-blowers to the CQC. The main themes emerging were that staff felt unhappy being asked to move to work on an area or unit they don't feel comfortable or skilled to be working on. Staff were worried and anxious about the quality of the care and treatment provided to women and their families. In addition, there were a lot of newly qualified staff.

Leaders offered engagement opportunities for staff to discuss the reasons for planned community rotations and redeployment such as open meetings, 1:1 meeting, HR meetings and union meetings. The service set up a specialised concerns email address and well led surgeries and time out events. However, staff continued to feel unsupported and unable to understand the decisions made at senior level.

Staff had been asked to provide feedback on the best time for them to be informed of any redeployment decision. They had also been asked about their preferred route of leadership engagement.

There was a monthly staff quiz with prizes and weekly newsletters for each area.

We reviewed the 2021 staff survey for the women's services division. The directorate scored lower than the organisation in all nine questions and most significantly lower for "we are safe and healthy", "we work flexibly" and "morale". This was a representation of the concerns raised by staff during this inspection. In response to this the service set up a culture and workforce group and created a staff engagement and culture improvement action plan 2022-2023. We saw many actions had been completed.

The service gathered views from women who used their maternity services from family and friends' tests (FFT), QR codes, complaints and compliments. Managers would build improvements into their individual ward action plans.

We reviewed the patient experience highlight report from March 2022 which feeds into the patient experience sub-committee. It summarised how the service made improvements to the planning and delivery from feedback.

The service successfully collaborated and met with the local Maternity Voices Partnership (MVP) in Calderdale, Kirklees and Wakefield who connect with women who represent the local population. The MVP group held focus groups with women to discuss induction of labour and also discharge expectations. This resulted in positive changes made to the service such as a discharge video and the feedback has been very positive.

The service ensured the voices of women from Black, Asian and ethnic minority backgrounds (BAME) were heard and their opinions addressed. The maternity dashboard showed that BAME women made up 28% of births in the last year up to March 2022. In response to maternity survey results from 2020 the service made sure information could be easily translated into various languages and ensured face to face bookings.

Managers shared the 2021 CQC maternity survey results with all staff. Managers had updated ward action plans to focus on patient experience and areas for improvement.

We heard of positive ways the service had made significant improvements. They had increased the number of skilled midwives to complete new-born examinations. They added the five questions which were significantly lower than the national average onto the friend and family test and will review these responses against complaints every month.

The service completed a maternity survey (March 2020 – August 2020) and feedback combined with local and national intelligence helped the service improve in several ways.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Maternity

The service shared positive examples of continually learning and commitment to professional development.

Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience.

There was a strong record of collaboration work with local Maternity Voices Partnership (MVP) Calderdale, Kirklees and Wakefield who connect with women who represent the local population.

The service collaborated with regional universities and charities to support research studies. They have participated in the obstetric anal sphincter injuries 2 (OASI2) research and helped with a 'big babies' trial for when babies were bigger than expected. They also contribute towards 'Tommy's national rainbow clinic study; which is a specialist service for women and families following stillbirth, pregnancy loss and neonatal death.

We heard of many ways staff were recognised for their achievements such as the trust's GRATix scheme which is an initiative for staff to say thank you to each other and make their colleagues feel valued and appreciated.

Services for children and young people

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff. Most staff had completed training in line with trust guidance.

Nursing staff received and kept up to date with their mandatory training.

Medical staff received and kept up to date with their mandatory training.

We requested but the trust did not provide data on the levels of mandatory training compliance of medical staff or how managers monitored medical staff mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of children, young people, and staff. The trust target for core mandatory and statutory training (MAST) was 90% and 85% for role specific. Overall mandatory compliance was 90.6% and 81.4% for role specific for children and young people services. Mandatory topics included fire safety, mental capacity act, health, safety and welfare, infection prevention and control, information governance, moving and handling and safeguarding.

Data provided from the trust showed that children's services were meeting the Trust target of 90% in most training apart from information governance, mental capacity and fire safety. The trust informed us that there is a service recovery plan, which is monitored through the divisional senior management team. This includes planned protected time to complete relevant training. In addition, periodically throughout the year, the Organisational Development team select specific Mandatory and Statutory Training (MAST) subjects and contact non-compliant staff directly prompting them to complete and how to access the training.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

Clinical staff received and completed training on recognising and responding to children and young people with mental health, learning disabilities and autism. Additional training is delivered around the 'Complex Child' from the Children's Learning Disability team (CTLD) to staff. These sessions run at least twice a year; however, session availability is increased pending demand and new starters. The content includes ASD/ADHD, learning disability/ difficulty. This is a nursing education package and is offered to all registered nursing staff, new starters or people wanting a refresher

Nursing managers monitored mandatory training and alerted staff when they needed to update their training by their work email. Staff we spoke with told us they were given protected time to complete training.

Staff knew how to access the sepsis policy on the trust intranet.

Medical Sepsis training was part of the junior doctor induction program spotting the sick child.

Nursing staff sepsis training was part of the training within the deteriorating patient/ High dependency Unit (HDU) training days. Additionally, staff completed a further training day.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff we spoke with told us they had received face to face training and completed level 1, 2 and 3. Medical staff received training specific for their role on how to recognise and report abuse.

We reviewed role specific safeguarding training level 2 compliance was 84.3% adults and 90.6% children. Level 3 compliance for children was 77.9% which was below the trusts target. The drop in compliance was due to the pause in availability during the COVID 19 pandemic. The division has included planned protected time to complete relevant training and to mitigate risk until all relevant staff are retrained, the Safeguarding and Complex needs teams are available to provide advice and support at ward level for safeguarding concerns. This includes the daily presence of a team member on site, to help review patients who have identified additional needs or safeguarding concerns, support risk assessment processes and facilitate escalation if required.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff were aware of female genital mutilation (FGM) and Child sexual exploitation and told us these subjects were covered in their safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

All staff had received training and knew how to recognise an adult or child at risk. Nursing managers told us staff received safeguarding supervision sessions and any specific cases learning would be discussed and disseminated throughout the department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff we spoke with knew the name of both the named safeguarding children's nurses. Staff knew how to report concerns and were able to tell us the procedure they would follow. For example, one of staff gives us an example when they had suspected abuse and how they referred. Information was visible throughout the department for staff, patients, and visitors to see. This included the details of who to contact. The service displayed safeguarding posters with local safeguarding contact numbers for anyone concerned about the welfare of any individual.

Services for children and young people

We reviewed patient electronic records which included a symbol to notify staff if children and or families were subjected to a child protection plan or at risk. Staff followed safe procedures for children visiting the CAU. The children's assessment unit (CAU) of the department was located next to the emergency department (ED). Children were booked in at reception and directed to the children's waiting room, which was secure with an intercom system to control entry.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves, and others from infection. They kept equipment and the premises visibly clean.

The Children's Assessment Unit was visibly clean, tidy, and free from dust. There were suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service performed well for cleanliness and displayed March 2022 audit results which showed 100% compliance rates for hand hygiene, bare below the elbow, cleaning, and contamination and 91% environmental audit scores.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were compliant with bare below the elbows. At the entrance to the unit's hand sanitisers were available. Hand washing facilities with hand hygiene posters provided guidance to hand washing where readily available

On the children's assessment unit, we saw an infection prevention and control board which provided useful information for patients and parents.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All equipment had I am clean stickers in place to indicate cleaning had taken place. Disposable curtains were clean and labelled to show dates of their last change. Curtains were routinely changed every three months and were also changed before this is visibly dirty in line with policy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Children, young people, and their families could reach call bells and staff responded quickly when called. We only saw one child and their family attend the children's assessment unit staff did respond quickly when called.

The design of the environment followed national guidance. The children's assessment unit was located next to the accident and emergency department. The children's assessment unit has 5 cubicles, 3 beds, a treatment room, and a waiting room.

Staff carried out daily safety checks of specialist equipment. We observed staff checking the equipment on the resuscitation trolley and records were completed. Tamper proof tags were used correctly in line with local policy. Electrical equipment all had Portable Appliance Testing (PAT) testing stickers and dates present.

The service had suitable facilities to meet the needs of children and young people's families.

There were accessible toilets for people and nappy changing facilities for parents with children within the department.

Services for children and young people

The service had enough suitable equipment to help them to safely care for children and young people. We checked a range of consumables items including syringes and dressings. All were within their expiry date. All sharp boxes that we looked at were signed, dated, and stored appropriately.

Staff disposed of clinical waste safely. We saw different coloured waste bins and sharp boxes for different types of waste such as general waste, clinical waste swabs and dressings.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service used a paediatric advanced warning score (PAWS) to assess, detect and respond to any child deterioration.

We reviewed the November 21 PAWS audit data, which included data from March to September 2021. This showed overall compliance with target, but below average compliance in three of the seven standards. The Trust explained that cancellation of 'Deteriorating Child' study days during the pandemic had impacted on PAWs compliance, however they had introduced several measures to improve compliance.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were completed for every child young person on admission and were reviewed regularly.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep children and young people safe. The children's assessment unit was open from 10 am to 10 pm so did not take any referrals after 8 pm. If a child or young person required overnight admission, they were transferred to Pinderfields General Hospital.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. Staffing levels for the children's assessment unit were one qualified and one health care assistant from 09.00 to 22.00 and one trained member of staff and one health care assistant from 1100 to 24.00.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. At the time of the inspection staffing for nurses and healthcare matched the planned numbers for children's and young people division. However, we reviewed the data for the last 12 months planned versus actual staffing information for each ward/unit.

Services for children and young people

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe. Medical staff rotated between Dewsbury and Pinderfields Hospital. Consultant cover was between 10.00 to 22.00. Outside of these hours the consultant at Pinderfields was contacted.

The medical staff matched the planned number on the day of inspection. We received the percentage of junior doctors allocated to each paediatric rota. In March 2022 there was only 82% of Senior House Officer's (SHO's) and 62% of registrars available to cover these rotas.

Following the inspection, the trust submitted additional information. This showed the average fill rate between January and June 2022 was 100% for consultant staff, 96.5% of specialist medical doctors and 74% for junior doctors. They reported that gaps were filled using substantive and locum staff. However, In June 2022 the trust achieved 74% fill rate for junior doctors which meant that not all shifts were covered."

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We reviewed one set of records which were comprehensive and completed appropriately.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Records were accessible to all staff. The system alerts staff to a child at risk or under a child protection plan.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

There was appropriate, secure, storage facilities for medicines. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked in line with the providers policy. Controlled drugs were kept in separate locked cupboards and appropriate checks recorded. We saw records for electronic fridge temperatures, and all were within acceptable limits.

All medicines we checked were within their expiry date. Oxygen cylinders were full and within expiry date.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Services for children and young people

Staff knew what incidents to report and how to report them. Staff that we spoke with knew what incidents to report and how to report them using the electronic reporting system.

The trust provided data of seven serious incidents (SIs) declared in 2021/22. The trust used a serious incident tracker to monitor timeliness for investigations. This included the date for a root cause analysis (RCA) was due and when the incident had been discussed at the patient safety panel.

A patient safety bulletin was disseminated to all staff which detailed shared learning from incidents or other concerns. Staff confirmed that they did receive these by email and were available on the staff intranet.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The service had a comprehensive incident reporting policy and staff were aware of the importance of reporting incidents.

The service had not had any never events.

Managers shared learning with their staff about never events that happened elsewhere. We observed that incidents were discussed at handovers and safety huddles. Managers displayed on my quality boards learning from recent incidents/ datix.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to children and young people's care.

Staff met at monthly meetings to discuss feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff. Patient safety learning bulletins were disseminated and available on the staff intranet.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations. Incidents were investigated thoroughly and discussed at the Paediatric Significant Events meeting. Actions and learning points were identified and followed up at the next meeting.

Managers debriefed and supported staff after any serious incident. Staff told us that they were debrief by the consultants after any serious incidents.

Managers acted in response to patient safety alerts within the deadline and monitored changes.

Services for children and young people

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies, procedures, and guidelines on the intranet. Policies and procedures were evidence based on national guidance including National Institute for Health and Care Excellence (NICE) guidance.

The service had gained the United Nations International Children's Emergency Fund (UNICEF) baby friendly accreditation stage one and two and were striving to achieve UNICEF accreditation stage 3.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. All staff had received core training in consent, mental capacity and deprivation of liberty safeguards as part of mandatory and statutory training.

Nutrition and hydration

Staff gave children, young people, and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people, and their families' religious, cultural, and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. The service provided children and young people with a sandwich and a drink whilst they were a patient on CAU.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Children’s services used a paediatric pain scoring tool. It was used alongside the PAWS chart. Children were prescribed appropriate pain relief.

Patient outcomes

Services for children and young people

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes. (*note to inspectors to name the accreditation scheme relevant to the service inspected, or delete if not applicable*)

The service participated in relevant national clinical audits. The trust took part in several audits, including National Paediatric Diabetes Audit, National neonatal audit programme (NNAP), seizures and Epilepsies in children and young people, Asthma national audit and neonatal infection.

Data showed that in the 2020/21 Paediatric diabetes audits showed lower performance than previous years. Results were affected due to non-face to face contact with patients due to pandemic. As the data reported covered the previous year and with the understanding that face-to-face clinics were back up and running, it was agreed to await the next report and review. At the time the summary was completed the National report had not been published therefore no comparisons to national data were possible.

In the 2020 National Neonatal Audit Programme (NNAP) data showed lower than national and slight reduction on previous years. It is to note that the data reported was from 2020 (published late 2021) and a lot of work had already been undertaken to address areas of poor performance as the team had access to their local data before National reports were published which they acted upon.

Managers and staff used the results to improve children and young people's outcomes. The trust had a paediatric audit lead within the consultant body who worked with the audit department. Audits were presented to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) meetings. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The service was accredited by UNICEF a baby friendly initiative and had completed stages 1 and 2 and were working towards stage 3.

Managers used information from the audits to improve care and treatment. Managers told us that audits were used to identify areas of learning and improvements.

Managers shared and made sure staff understood information from the audits using team meetings, safety huddles and newsletters.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The clinical educators supported the learning and development needs of staff. The service had 4.65 WTE two clinical educators that supported the development and learning of staff. Staff told us that the clinical educators had a strong presence across the department and were supportive.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of children, young people, and their families. All staff had received training in paediatric basic life support trained (PBLS).

The lead clinical educator for Paediatrics developed an online training package recognising a deteriorating child for staff working with children in adult areas. Additionally, a competency matrix was completed depending on practitioner role and area of care.

Services for children and young people

Staff from neonates and paediatrics had completed bereavement training that had been delivered by an external hospice. Staff told us that they found this training useful and give them the skills to deal with specific situations.

Managers gave all new staff a full induction tailored to their role before they started work. All staff completed the three-day trust induction and then a further two days specific for paediatrics and or neonates. All new Band 5 staff were rotated across all areas of pediatrics for the first six months to gain experience and confidence and to mitigate risks if any area was below safe staffing levels.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers and staff told us that some staff appraisals were overdue to organisational pressures. Due to both the availability of appraiser and appraisee with staff having to work clinically. The trust target was 85% compliance for nursing appraisal. Data received for April 2022 was significantly below the expected level. A recovery plan which included scheduling all outstanding appraisals and cleansing data had begun and the improvement was seen in the change from the April to May data.

Medical staff compliance rates were above the trusts target.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers were supportive and encourage staff to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist core competencies were available dependant on your role. Staff were supported to complete and given protected time to achieve.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit children, young people, and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care.Different teams of healthcare professionals worked together as a multidisciplinary team (MDT). We observed an MDT meeting which was consultant led and included nurses and play therapists.

Seven-day services

Key services were available seven days a week to support timely patient care. Consultants were available 10 am to 10 pm Monday to Sunday.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Children services had access to other services such as diagnostic, laboratory and mental health seven days a week

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Services for children and young people

The service had relevant information promoting healthy lifestyles and support on wards/units. Children's assessment Unit had a wall of information to promote healthy eating and infection control.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Staff made sure children, young people and their families consented to treatment based on all the information available. Parents we spoke with said they have been fully involved in the consent process.

When children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture, and traditions.

Staff clearly recorded consent in the children and young people's records. We saw evidence of consent forms appropriately completed

Staff understood Gillick Competence and Fraser Guidelines and how to support children who wished to make decisions about their treatment. 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 implications of those decisions.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff told us that they could access policies on the intranet.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Services for children and young people

Staff were discreet and responsive when caring for children, young people, and their families. Staff took time to interact with children, young people, and their families in a respectful and considerate way. Staff were friendly, caring, and helpful.

Children, young people, and their families said staff treated them well and with kindness. We saw staff respected privacy and dignity and talked to children, young people, and their families in an appropriate manner. We observed staff introducing themselves to the parents and the child.

Staff followed policy to keep care and treatment confidential.

Emotional support

Staff provided emotional support to children, young people, and their families to minimise their distress. They understood children and young people's personal, cultural, and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. CAU play specialists were able to provide support to children to alleviate their anxieties.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. The service benefited from a complex care team that supports children and young people with mental health, learning disabilities and autism.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people, and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Parents told us they were fully informed 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 parents' concerns and requests and would work with them to provide the best care for that child. They were encouraged to ask questions.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary. Staff provided examples which demonstrated an awareness of how they used different communication aids to speak to children and their families.

Children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed friends and family posters and we saw family and friend's cards and submission boxes on all areas we visited. There was an option for people to leave feedback online or by QR code

Patients gave positive feedback about the service.

Services for children and young people

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The service had appointed an inpatient transitioning nurse that liaise between paediatrics and adult services for children transitioning. They provided support to the young person and their families.

The service had a children's community team for learning disability (LD). The team included specialist nurses that support children and young people and families up to the age of 18 years with LD. Services offered included helping to understand and manage children's behaviours.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people, and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. The service had a complex care team who provided the necessary care and support for children and young people to meet their needs

Wards were designed to meet the needs of children, young people, and their families.

Staff used transition plans to support young people moving on to adult services.

Staff supported children and young people living with complex health care needs by using 'This is me*' documents and passports. The service used health passports which supported young people, aged 14 plus who had a learning disability, and their parents to have confidence in sharing important information with medical staff such as communication needs, support needs, understanding behaviour, baseline health information, how to take your medication, keeping safe, and if they had e any fears for example having a blood test. We did see these in use where applicable.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

Services for children and young people

The service did not have information leaflets available in languages spoken by the children, young people, their families, and local community.The service did not physically have information leaflets available on the ward in languages spoken by children,young young people , their families and local communities. It would be challenging for the trust to store leaflets in every language. However, a number printed on the back of every leaflet to phone, if parents and carers would like the leaflet in another language. This is verbally told to families and carers when they are given a leaflet and staff can assist them to acquire they leaflet if they are having difficulties.

Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed. Staff told us that they could circulate a message on the computer system to ask for any staff member that could speak a required language to support with patient communication. Staff told us that this was usually responded to quickly if someone could speak the desired language. They could also access a specific translation service if required.

Children, young people, and their families were given a choice of food and drink to meet their cultural and religious preferences. We observed different dietary requirements being met to meet the needs of cultural preferences.

Staff had access to communication aids to help children, young people and their families' become partners in their care and treatment. Staff told us they used whiteboards to help patients communicate. Staff could also access writing aids so that parents could write things down if English was not their first language.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to. The children's assessment unit accepted referrals from General Practitioners (GPs), accident and emergency, birthing unit and direct from families. Any child or young person that needed to be admitted were transferred to Pinderfields Hospital.

Managers monitored patient transfers and followed national standards.We reviewed three inter hospital transfers from Dewsbury CAU to Pinderfields site for children who were acutely unwell. There was a clear transfer documentation which included the use of Safer Transfer of Paediatric Patient (STOPP). PAWS observations had been completed before, during and after transfer.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people, and their families in the investigation of their complaint.

Children, young people, and their families knew how to complain or raise concerns. The trust shared with us data for complaints received between April 2020 and March 2021. Across both sites there were 22 complaints which included themes identified included clinical treatment, communication and staff attitudes and behaviours.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters in all areas on how to raise a complaint.

Staff understood the policy on complaints and knew how to handle them.

Services for children and young people

Managers investigated complaints and identified themes. They investigated all complaints promptly and spoke with identified staff.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff in various formats such as meetings, newsletter and on whiteboards.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Children's Services at the Trust was managed by a well-defined leadership team. It sits within the wider Division of Families and Clinical Support Services (FACSS); The divisional triumvirate structure is underpinned by speciality triumvirate teams. This includes a Deputy Director of Operations (management lead), Head of Clinical Service (medical lead) and Assistant Director of Nursing (children's services. The speciality triumvirate is supported by a Children's Governance Manager, in addition to the wider divisional governance and support team for joint working.

Leaders were visible, supportive, and approachable. The matrons visited each site every week and attended team meetings. Staff told us they knew who they were and how to contact them.

Leaders supported staff to develop their skills and more senior roles. Band 7s completed the RCN leadership programme and Band 6 clinical educator development programme.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision and a quality strategy which focused on keeping patients safe at all times, providing excellent patient experiences that deliver expected outcomes, being an excellent employer, being a well led and governance

service with sound finances, have effective partnerships that support better care and provide excellent research, development, and innovation opportunities. Children's services had clear priorities and operational plan which focused on staffing, safety, and costs. Key objectives across the trust were to maintain effective relationships and good working with external partners. Staff were aware of the vision and strategy

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt respected and valued. They were encouraged to be open and honest and believed their views were listened to.

Ward leaders spoke highly and praised their teams for the work they had done during pandemic and continued to do so afterwards.

The trusts patient safety team undertakes quarterly audits of compliance against the duty of candour regulatory requirements. We reviewed the data provided to us and found that the trust was successful in achieving 100% compliance providing patients with verbal and written notification of duty of care within ten working days of an incident being reported.

Duty of Candour is included in Mandatory training, Nursing Induction programmes, Datix Reporting and Investigation training and Root Cause Analysis training. Staff had access to the Quality and Safety intranet page and the Duty of Candour documentation.

During the pandemic, the trust recognised that they needed to ensure the wellbeing and safety of their staff and developed a range of initiatives. Wobble room/ areas were set up. These safe spaces were set up for staff to go to for time out, have a cry, sit quietly, recuperate and reflection. The number of rooms have now reduced, but staff can still access them if needed.

The Trust appointed a clinical psychologist to work on staff services before the pandemic which meant the Trust were in a strong position to support staff during the pandemic. The team was increased and expanded during the pandemic, but the service is still nearly at capacity. The Trust has the MY Wellbeing Matters Service in place which allows staff to access rapid intervention from trained psychologists. Recently a Staff Wellbeing Hub has been set up through the upcoming ICS which is centrally funded and will allow staff to access training packages as well as support.

The Trust has a comprehensive Bullying and Harassment Policy which is up to date and accessible to all staff on the Trust Intranet. The policy sets out a clear commitment to eliminate all forms of bullying and harassment.

The service had recently recruited a freedom to speak up guardian.

The service had a Freedom to Speak up Guardian who worked closely with the service.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Services for children and young people

Children and young people services is part of the Family and Clinical Support Services Division. The divisional clinical director was the divisional governance lead.

The trust shared with us the last three clinical governance meetings for January, February, and March 2022. These occurred monthly and showed good attendance. There was a standard agenda which covered quality, safety issues and performance data.

Service leads identified their top three risks. These were reflected on the risk register; measures put in place to mitigate the risks and were regularly reviewed.

Managers held regular ward face to face and virtual meetings with their staff including community staff. Staff told us they discussed quality and safety issues and any learning from recent incidents, audit outcomes or feedback from complaints.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Ward level leaders had good oversight of their team's risks, issues, and performance through on going ward level audits, improvement plans and top three risks. The trust had implemented the display of 'My Quality' Boards on the wards which included performance metrics, top risks, things to improve, positive theme and improvements.

We spoke with senior managers and consultants who were aware of the individual risks on the CAU which was based around safe and effective service delivery due to sickness, patient safety and wellbeing due to non-adherence to PAWS and a failure to escalate clinical concerns and risk of patient harm due to a lack of anti-ligature provision in areas where young people with mental health needs are cared for.

Monthly risk meetings looked at identified risks, themes were fed up into governance.

We acknowledged the service had faced some extremely challenging times with high levels of acuity at the same time as reduced staffing due to the pandemic and sickness.

Daily managers had good oversight of what was happening across the children's and young people service to ensure a safe delivery of care and treatment.

Senior leaders met daily to discuss any staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff across the service to meet the planned staffing levels.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to policies and guidance on the trust intranet. Staff could easily access the electronic patient record system and care records.

The community team had access to SystmOne to aid the sharing between the hospital and community.

Data management systems were integrated and secure.

Mandatory training covered information governance and data security that all staff completed.

Discharge summaries and medication letters were routinely sent to GPs and other relevant professionals within 24 hours of discharge.

The service works closely with System Partners. Unplanned care ED (Emergency Departments), 111 referrals and discusses with commissions to how to improve access and demand on services.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Wards displayed staff engagement boards that included general information about ward performance in various areas.

We saw celebrating success boards across all areas and thank you cards showing appreciation to staff.

Family and friends test boxes and posters were displayed across children and young people services, this gives patients and their families the chance to give open and honest feedback about their care.

Staff told us there was a freedom to speak up guardian available in the trust and were encouraged to speak about any concerns.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service shared many positive examples of continually learning and commitment to professional development. The children's assessment unit was undergoing a project to redesign to make better use of the space they had so work can be performed efficiently, effectively, and safely.

Pinderfields Hospital

Aberford Road
Wakefield
WF1 4DG
Tel: 08448118110
www.midyorks.nhs.uk

Description of this hospital

The Pinderfields Hospital building was opened in 2011; is the largest of the Trust's three hospitals and is the main site for patients requiring acute care. A range of inpatient, outpatient, diagnostic and maternity services are provided. The hospital provides both urgent and emergency care as well as services such as elective surgery. It is a designated Major Trauma Unit where urgent and emergency surgery is carried out and has a helicopter landing site close to the Emergency Department. Pinderfields is the busiest hospital within the Trust. In any one year there may be over 127,000 attendances to the A&E and over 58,000 emergency admissions.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however it was not everyone completed it.

Nursing and medical staff received mandatory training.

The trust provided us with data after our site visits which showed that core mandatory and statutory training compliance was at 89.6% and role specific mandatory and statutory training compliance was at 79.7%. We were told compliance in UEC was further impacted by operational pressures over the winter period and arising from the Omicron variant of COVID-19. Managers monitored compliance rates at service and individual level. Since our last inspection, the Trust had implemented the Electronic Staff Record (ESR) which automatically notifies staff and managers when an individual is required to undertake training.

The training refresher dates were based on the dates the staff member joined the department which meant the training was spread over the year. This meant there would always be staff who were trained in a specific discipline.

Staff told us that they were given time at work to complete their mandatory training, however this was not always achieved and sometimes training was completed outside of working hours.

The programme of mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. This was done through staff being sent an alert by email as to when the training needed to be completed by. The trust had implemented the Electronic Staff Record (ESR) which automatically notifies staff and managers when an individual is required to undertake training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Urgent and emergency services

Nursing staff received training specific for their role on how to recognise and report abuse. Staff we spoke to were able to tell us where to access safeguarding information, how to create an alert and who the safeguarding lead for the department was. Staff we spoke with were able to explain the safeguarding process and were able to tell us about examples of safeguarding referrals they had made. We saw evidence that senior nurses were trained to level three in safeguarding.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were able to tell us where to access safeguarding information, how to create an alert and who the safeguarding lead for the department was. Staff we spoke with were able to explain the tell us about examples of safeguarding referrals they had made.

Data supplied by the trust showed Medical staff training compliance was 93.1% for Safeguarding level one training and 88.2% for Safeguarding level three training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The service displayed posters in the patient toilets which had tear off paper slips with contact details for services that helped people experiencing domestic abuse. We saw that some people had taken numbers from the poster.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were able to explain the safeguarding reporting procedures and they were able to tell us about examples of safeguarding referrals they had made.

Staff followed safe procedures for children visiting the department.

There was an area set aside in the department, away from the treatment bays, dedicated to safeguarding where staff could speak to patients privately and make referrals. There were wall charts and documents displayed which staff told us they used for reference purposes.

Staff we spoke with were able to explain the arrangements that would be put in place to enable staff to remain safe, which included use of a dedicated room, use of bays in view of the nurses station, increased nursing support and supervision of patients by security staff prior to the patient being assessed or treated.

We saw evidence of a trust wide Adults Safeguarding policy which followed intercollegiate guidance and was due for review August 2024 and a Children's Safeguarding policy which followed intercollegiate guidance and was due for review December 2023.

The Deputy Director of Operations and Matron for Urgent and Emergency Care had trust wide responsibility for safeguarding. Within the Urgent and Emergency Care department we saw evidence oversight of vulnerable patients was provided by the mental health psychiatric liaison team.

The trust was compliant with DBS legislation.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Areas and furnishing were not always visibly clean. We saw examples of areas in the department visibly unclean for more than 90 minutes, this included the reception waiting room and seating area.

Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly.

Staff did not always label equipment to show when it was last cleaned. We saw multiple examples of shared equipment such as commodes and intravenous infusion pumps with no clean sticker on in the clean utility storage.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw examples of staff not always changing their gloves or washing their hands between cleaning.

Staff did not always clean equipment after patient contact. We saw multiple examples of staff not cleaning equipment in-between patients. We saw examples of equipment used to transfer patients by ambulance staff not being cleaned after use. The patient assisted transfer (PAT) slides were stored on the floor. We also saw examples of monitoring equipment used and not wiped down clean between patients.

Not all disposable curtains were dated and not all sharps boxes were signed, or changed when full.

The department had a red area for patients who tested positive for Covid-19, and a green area for patients who tested negative. During inspection we observed staff moving between the red and green zones not donning and doffing or changing their PPE in line with trust guidance. This meant there was an increased risk of spreading infection.

There were sinks in the department however some sinks were blocked with equipment meaning staff did not always have access to the facilities.

We saw an audit display board with hand hygiene audits figures displayed as ‘no data’.

All staff in the department were bare below the elbows.

The service had a COVID-19 area which was used to see and treat patients with confirmed or suspected COVID-19 and they competed point of care testing for COVID-19. Patients were asked at reception about COVID-19 status or symptoms and streamed to the COVID -19 area if indicated. There was a different entrance for suspected COVID-19 patients. None Covid-19 positive patients entered through the main department reception waiting room.

The department had their own COVID-19 swabbing area with results provided within one hour.

There were notices displayed reminding the public to wear face coverings. We saw examples of patients coming to the department without face coverings who were then provided with one.

The trust submitted last 11 months IPC audit data. This showed average compliance against the 13 IPC standards audited of 97% against the 95% target for Pinderfields ED. The last audit was completed in December 2021 and reported 98%. The audits identified 100% compliance with bare below the elbow requirements, however, compliance below the

95% target for hand hygiene. No audits were completed in January and February 2022 due to operational pressures and the COVID-19 pandemic. The trust also submitted environment audits for the previous 11 months. These identified compliance of 99.4% for cleaning requirements to be completed by nursing staff and 97% for housekeeping staff, against a target of 95%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. However, staff were trained to use equipment.

All patient bays had access to call bells, however they were not always within reach, including for those patients who were unable to mobilise, and staff did not always respond quickly when called. We saw at least nine examples of patients with no access to call bells who also had bed rails in situ. This posed a risk to patients as they could not always call for assistance when they needed to. We saw two examples of elderly patients at increased risk of falls climbing down the bed trolley to attract attention.

The service had a mental health assessment room which was minimally furnished with sturdy furniture and designed to be ligature free. However, the room was not visible from the nurses station.

Visibility of the main waiting area for adults from reception was poor and the layout did not meet the needs of the department. A system was not always in place for checking on patients who were not in view of staff.

The waiting area had fixed metal seats with some labelled not to sit on to maintain social distancing. The seats were facing away from the reception area. We observed one patient in a wheelchair behind a pillar, meaning they were not visible from reception.

We saw examples of doctors coming into the adult's reception area and calling for patients. However, on three occasions patients at the back of reception or behind the pillar could not hear who was being called for.

The children's waiting room was partially visible through two glass panels from the nurses' station in the children's part of the department. We were told there was a system in place for regularly checking the waiting area and we saw this in practice.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed the daily departmental checklists for each area for the previous seven days. We saw gaps in daily checks across all department areas, including gaps checking resuscitation equipment and PPE availability. This meant the department managers were not assured that all checks were completed to provide safe care and treatment.

The majors department did not have a resuscitation trolley. We were told that the resuscitation equipment was removed as it was not being regularly checked, and that the removal had been risk assessed. The trust told us there was a process in place if a patient had a cardiac arrest, patients would be taken to the resuscitation department. The layout and the busyness of the department meant we had concerns about the efficiency of a time-critical transfer from majors into resuscitation. These concerns were raised with the trust at the time of inspection. Following the inspection, the service has reinstated a designated resuscitation trolley in the majors department. On our second visit to the department, the resuscitation trolley in majors had been checked in line with Trust policy.

In the children's department and resuscitation there was a resuscitation trolley. The trolley held a defibrillator machine and other standard equipment. There was evidence the equipment had been checked.

The department had multiple airflow outlets which were uncovered. There was a previous never event in which a patient was connected to an airflow outlet instead of an oxygen outlet. As a result of learning from this incident we were told all airflow outlets in the department were covered, however on inspection we saw only one with a cover in place. This was escalated to the trust who took immediate action. On day two of our inspection, all airflow outlets in the department had an appropriate cover in place.

We saw numerous examples of electrical equipment that had not been PAT tested. There were plug sockets that were damaged, and we saw one plug socket which had been secured with micropore tape still in use.

We saw an oxygen cylinder that was out of date and multiple examples of incorrect storage of oxygen cylinders within the department.

The service had suitable facilities to meet the needs of patients' families. There were designated relative rooms within the department where relatives and loved ones could wait. Staff told us these were also used as rooms for breaking bad news. There were signs on the door to indicate whether the room was in use, and we saw these were used during the inspection.

The service had enough suitable equipment to help them to safely care for patients. Staff we spoke with said they had the equipment they needed to care for patients safely. However the departments risk register states unavailability of medical equipment as an amber risk. The risk register makes specific reference to pumps that assist in the giving of time critical medications.

Staff did not always dispose of clinical waste safely. We saw examples of sharps bins stored inappropriately at patients' bed sides. We also saw sharps bins which were over-filled. We escalated concerns to the trust, and they told us questions had been added to the ED Health Check, to include a section that the ED demonstrated safe storage of sharps and IV equipment and medicines. The ED Health Check was completed the week of the 1 April 2022, with no significant concerns identified. However, on our return visit in April 2022 we saw sharp bins being stored at patients' bed sides around knee height with the opening open, this meant there was an increased risk of the sharps box being knocked over and its contents spilled.

There were no notices in different languages displayed to provide patients or families information.

There was a vending machine and toilet facilities. The vending machine was fully stocked and there was access to water.

The front reception desk was at height whereby patients in wheelchairs could speak to reception staff. There was a hearing loop system in the public reception area.

The trust had a Fire Safety policy which was in date and provided staff with clear guidance to follow. There was evidence of a departmental fire evacuation plan.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. However, staff did not always act upon the outcomes of these tools.

Urgent and emergency services

Patients who walked into the department provided their details to reception staff. If the reception staff had any concerns, they escalated to the nurse to help identify the most appropriate care pathway. Two staff members advised us that there are not always the appropriately skilled nurses on duty to fulfil the streaming role.

At the time of the inspection we saw no evidence of formal guidance, a standard operating procedure (SOP), or designated pathways in place for the streaming role. Staff who performed the streaming role told us they used their professional judgement to risk assess and prioritise treatment.

Following the last inspection, we told the trust it must ensure that, where clinical streaming is undertaken by a receptionist, all patients are then triaged by a registered practitioner in line with best practice guidance. The national target for triaging is within 15 minutes of booking in at the reception desk, however the trust did not always meet this target. Eight out of ten patient records that we reviewed did not meet the 15-minute national target for triage. During our visit we saw triage times up to and in excess of 60 minutes.

We were informed by staff patients sometimes left the public waiting area prior to treatment due to extended waiting times. We saw evidence the trust had a process for staff to follow for patients who had chosen to leave the department prior to assessment by a clinician, or those patients who have left after assessment by a clinician. Staff we spoke with told us the patients who left the department were not reviewed or followed up. However, the trust submitted evidence of compliance with the department process.

We saw nine examples of patients in the department during the inspection who had not had their observations recorded in line with the local policy or national guidelines. Recording observations is important for clinical staff to monitor patients. In the examples we saw, two patients' records showed National Early Warning Score 2 (NEWS2) had been incorrectly calculated, and two patients' records showed some vital signs were not recorded. A trust audit showed that 15% of a sample had NEWS2 observations missing.

We spoke to four staff members who could describe the trigger for medical review of a deteriorating patient where sepsis might be indicated. The service had recently introduced a new sepsis pathway for escalation. We were told this was ensuring a prompt response from medical staff, we saw some examples of this happening during our inspection, however this was not consistent. The trust submitted data to show Sepsis compliance within the department between the months of April 2021 and February 2022. During this period there were a total of 646 patients that required sepsis screening, of these 83.1% (537) received sepsis screening in accordance with the local protocol. During the same period there were 541 patients who were diagnosed with sepsis, of these 75.4% (408) received IV antibiotic within 1 hour of diagnosis.

Following the 2018 inspection we told the trust it should ensure consistency in the care of patients with sepsis. We saw evidence of a '5TOP' quality improvement initiative to ensure timeliness of escalation and sepsis screening for patients who trigger high NEWS2 scores and a quality improvement plan which was split into three phases: education, performance monitoring/data collection and self-monitoring. We did not see evidence of consistency in the care of patients with potential sepsis.

During our inspection we saw a patient who had presented following a fall and a head injury, who was routinely taking blood thinning medication. The patient had not had their Glasgow Coma Scale (GCS) recorded. The GCS is a tool used to assess a person's level of consciousness. This was not in-line with the National Institute of Health and Care Excellence (NICE) guidance. We escalated this at the time, we were told staff were busy and senior nurses were supporting care delivery. We requested the patient's notes, however the trust did not provide the record as requested.

Urgent and emergency services

Staff told us they were made aware in advance of an ambulance attending and to the acuity of the patient so their treatment could be prioritised. We saw examples of this happening in practice.

Staff did not always complete risk assessments for each patient on admission / arrival. We saw examples of elderly frail patients in the department who had not had a pressure ulcer risk assessment completed. We also saw an example of pressure ulcer risks assessments completed inaccurately, for example one patient had been identified as having vulnerable skin, but the risk assessment tool was completed as low risk. The department had long waiting time for inpatient beds, we saw elderly frail patients waiting in the department up to eight hours. Not all risk assessment outcomes were implemented. We saw some examples of patients with pressure relieving mattresses in place, however there was not a consistent approach to risk assessment interventions.

The department did not have a specific risk assessment for the use of trolley rails. We asked staff and we were told there was not a risk assessment and every patient routinely had trolley rails up. However, we observed patients with and without trolley rails in place that had presented to the department following a fall which meant there was an inconsistent approach in the use of trolley rails used by staff. The long waits in the department meant that not everyone was suitable for trolley rails, and we saw two examples of elderly patients attempting to climb over the trolley rails. This posed a risk to patients as they were not appropriately assessed for trolley rails to be used in the delivery of their care.

On day one of the inspection eight out of ten patients did not have a call bell within reach. We escalated this on the day to ensure patients were given the means to gain the attention of staff. We also saw an example of a patient with trolley rails in place and no call bell who was actively trying to climb down the bed to get attention, we escalated this at the time to a member of staff. On day two of the inspection this had improved, and all patients had access to call bells.

Staff we spoke to knew about specific risk issues, such as pressure areas, falls and sepsis however they told us they did not always have time to complete patient risk assessments or respond to risk assessments that had been completed. We reviewed 15 sets of patient records looking specifically at risk assessments. We saw risk assessments were inconsistently completed on both site visits.

We saw three examples of patients with existing wounds where a full skin assessment had not taken place. Staff we spoke to told us that there was a body map that can be printed off from the trusts intranet, however staff found it time consuming and so they told us that body maps were rarely completed. We did not see any examples of completed body maps in the department. This meant that patients with existing or new wounds or pressure damage were not being monitored accurately.

We reviewed four sets of patients notes who were admitted following a fall or were identified as at risk of falls. We were told all patients identified as at increased risk of falls wear a red wristband. However, the trust told us that green wristbands were used for patients at high risk of falls. None of the four patients were wearing a falls risk wristband. Falls risk assessments were not always accurate, for example we reviewed one patient record that identified them as at higher risk of falls on one page, and then low risk of falls on another.

We requested a further six sets of patient notes after our inspection, this was because we had concerns about the trust's assessment and response to patient risk, however the trust did not provide the data as requested or information on any actions taken.

We observed multiple patients without an identification wristband in place. We raised this with the trust during inspection. During the remainder of our inspection all patients had wristbands in place.

The service had 24-hour access to mental health liaison and specialist mental health support. We saw one patient in the department who was seen within an hour referral to liaison psychiatry During inspection we saw evidence of patients undertaking psychosocial assessments. For paediatrics, there was a CAMHS service available 8 am to 8 pm, with psychiatric liaison available overnight.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw evidence of staff undertaking psychosocial assessments of patients. Staff we spoke with knew how to access mental health support for patients. The trust had a restraint and sedation policy for the emergency department with a clear pathway in place.

Staff shared key information to keep patients safe when handing over their care to others. We observed handovers at two different point in the inspection. We observed that patients' physical conditions were discussed.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

Nurse staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing staff to keep patients safe. However, the service did have enough support staff.

The number of nurses did not always match the planned numbers. We reviewed the registered nurse and health care assistant staff rota records for March 2022. It showed for registered nurses the department worked below planned staffing levels. Registered nurse shifts were split into long days, early shifts (Monday to Friday), twilight shifts and night shifts. The data provided by the trust showed that 74% of long days, 61% of early shifts, 58% of twilight shifts and 64% of night shifts were below the planned nurse staffing levels. Staff told us staffing numbers within the Paediatric emergency department regularly did not meet the Royal College of Paediatrics and Child Health (RCPCH) standard of two trained nurses on each shift. However, the trust told us nurse staffing for the paediatric ED and Children's Assessment Unit (CAU) is planned on a combined roster to cover the two services. Operationally, services are always managed to ensure two registered nurses are on the paediatric ED. The paediatric emergency department had a paediatric trained registered nurse 24 hours a day, seven days a week.

The number of healthcare assistants generally exceeded the planned numbers. Healthcare assistant shifts were split into early shifts, late shifts, twilight shifts and night shifts. The data provided by the trust showed that 9.6% of early shifts, 9.6% of late shifts, 87% of twilight shifts and 6.5% of night shifts were below planned staffing levels.

Healthcare assistant shifts were often above the planned staffing levels. The data provided by the trust showed for March 2022 showed that 74% of early shifts, 71% of late shifts and 80% of night shifts had more healthcare assistant than planned.

In February 2022 there were the following whole time equivalent (WTE) vacancies in Pinderfields Urgent and Emergency Care department; Advanced Nurse Practitioner 4.16, Trainee Nurse associate 2.0, registered nurse 8.22, nursing associate 1.08.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could not always adjust staffing levels daily according to the needs of patients. We were told that the department manager escalated staffing concerns to the matron, and senior leadership teams, however it was difficult to find registered nurses from other departments due to shortages elsewhere.

We reviewed the sickness rate for registered nurses and support workers for February 2022. The registered nurse staffing sickness rate was 6.41% and the support to nursing staff sickness rate was 19.7%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The trust provided rosters which demonstrated the service had enough medical staff to keep patients safe.

The trust told us that in the event that appropriate locum support cannot be secured, the responsibility for patient safety and ensuring appropriate medical cover remains with the Divisional Clinical Director, Head of Clinical Service and Divisional Director of Operations.

We saw evidence that medical workforce rosters were computer based which identified additional demand before the commencement of each rotation of shifts.

In the financial year 2021/22, the trust had two new staff added to the substantive medical workforce who worked across both urgent emergency care departments. In the same period two staff from the medical workforce left the trust; one due to retirement and one to work abroad.

Managers could access locums when they needed additional medical staff. We were told that known rota gaps which had not been filled translated into shift gaps. Shift gaps were advertised through the trusts internal medical bank and the agency locum market. Bank and agency locums were then put forward to fill shifts. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The junior doctors we spoke to felt that they were well supported in the department with ready access to seniors 24 hours a day, seven days a week. The junior doctor spoke positively about the skill mix, and number of doctors on shift.

We were told the service always had a consultant on call during evenings and weekends. We visited the department out of hours and saw there was a consultant in the department. We reviewed evidence that demonstrated the service met the RCEM standard of 16 hours of consultant presence in the department each day, 7 days a week. The department had a designated consultant on-call for the department between the hours of 0:00 and 08:00 on a Category A basis as part of the job plan. In the two months of rosters we reviewed, there were no gaps in the 12-hour consultant presence in the department or on-call.

Other staff groups we spoke to were not aware of the paediatric emergency medicine consultant working regular shifts within the department and we were unable to gain assurance with the data provided.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date however they were not always easily available to all staff providing care, and they were not always stored securely.

Patient notes were comprehensive however staff could not always access them easily. We saw multiple examples of records being mixed up. This included one example of blood results for a patient. During both of our visits, we observed staff looking for patient notes and being unable to find the records they were looking for.

Records were not always stored securely. Paper records were stored in trays and on desks in the department. The desks were not always attended, and confidentiality was not always ensured. Following the last inspection, we told the trust it must ensure that patient information is managed appropriately, and that confidentiality is maintained.

The trust provided an audit of documentation which included records kept in the emergency department and the paediatric emergency department at Pinderfields. The audit had been completed in November 2021, December 2021 and March 2022. The audit showed consistent compliance for paediatric and mostly below trust targets for adults.

Medicines

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines were stored securely with only appropriate staff having access via an automated dispensing system. Second checks were mandatory via fingerprint for controlled drugs and only senior staff could rectify any discrepancies.

Fridge temperatures were monitored centrally, and alerts given to the department if they went above recommended fridge temperatures.

We looked at five medicine records in the Emergency Department at Pinderfields. In two of the five records we looked at it had not been identified that the patient was prescribed critical medicines. For example, one patient had been admitted for over 21 hours and had no epilepsy medicine administered or no rationale documented as to why this was omitted.

Staff on the department told us patients self- administered medicines when appropriate and this would be documented in their notes however policies provided to use by the trust post inspection stated self-administration was not to be used in the emergency department.

Allergies were recorded in all five of the records we looked at however two of the patients did not have a red wrist band to alert staff of these allergies.

Patient Group Directions (PGD, permits the supply of prescription only medicines without an individual prescription, by an authorised competent healthcare professional) were available to use in the department with the appropriate authorisation.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Controlled stationary was appropriately secured, and we saw the processes used to track their use.

Staff followed current national practice to check patients had the correct medicines.

There was no clinical pharmacy service for the Emergency Department therefore medicines reconciliation fell under the scope of the clinicians in the clerking process. However, there was a dedicated Advanced Clinical Pharmacist who works across the Emergency Departments and Acute Assessment Area to support good governance and practice relating to medicines. In the records we looked at only two had medicines listed, however this was not a comprehensive reconciliation as no strengths/doses were recorded. The trust provided evidence that inpatients in an acute setting have a reconciled list of their medicines within 24 hours of admission in line with NICE guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The trust provided us with medicines management training compliance rates for the department. Most staff undertaking medicines management training completed the Medicines Management Level 2 module. Compliance was reported at 89%, achieving the target for role-specific training of 85%.

The department conducted a quarterly audit of controlled drugs jointly with the pharmacy service. The trust data showed the last controlled drug audit that completed was in February 2022. This reported good overall compliance with the audit standards of 88% and identified no areas of concern for escalation to the Controlled Drugs Accountable Officer. The audit reported 89% compliance with the daily CD checks and 100% compliance with the monthly CD checks.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, some staff told us they did not always report incidents.

Staff knew what incidents to report and how to report them. Staff we spoke with could explain how to use the online reporting system and provided appropriate examples of when they had reported an incident. However, some staff told us they did not always report incidents when the department was busy. Staff did not always raise concerns and report incidents and near misses in line with trust policy.

Managers shared learning with their staff about never events that happened elsewhere. A senior nurse told us they shared learning with staff in relation to incidents and never events that had occurred elsewhere. Staff we spoke with gave examples of incidents and learning that had been shared. Managers debriefed and supported staff after any serious incident. Some staff told us they were supported after incidents, however two members of staff told managers did not always protect the anonymity of staff involved in serious incidents.

Staff reported serious incidents clearly and in line with trust policy.

Most staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Some junior members of staff we spoke to were unsure about duty of candour, however they explained they would seek guidance from senior staff.

Urgent and emergency services

Staff told us they received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. We saw evidence that discussion around feedback and improvements were discussed at department meetings. For staff that were unable to attend, information was sent out by email so that everyone in the team had an opportunity to contribute. Staff we spoke to told us they felt listened to when making suggestions to improve patient care.

Managers investigated incidents. We saw evidence that incidents underwent root cause analysis by managers.

Managers debriefed and supported staff after any serious incident. Some staff told us they were supported after incidents, however two members of staff told managers did not always protect the anonymity of staff involved in serious incidents.

During inspection we reviewed the minutes of the Division of Medicine (DOM) Divisional Clinical Governance Meeting 24 February 2022.The minutes week commencing 28 January 2022 there were 124 incidents overdue and week commencing 9 March there were 161 incident overdue across the trusts Urgent and Emergency Care departments. However, data supplied by the trust evidences a reduction in March 2022, in line with recovery plans.

This did not provide any assurance incidents were being managed and investigated promptly.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw one patient being referred to liaison psychiatry and receiving an assessment within one hour of being referred by the department.

The trust had established a governance process for the dissemination, implementation and monitoring of national institute of clinical excellence (NICE) guidance.

The trust had a policy “An Organisation-wide Document for the Dissemination, Implementation and Monitoring of NICE guidance, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and other National Inquiries”, issued December 2021 and approved January 2022, which covered the processes.

Newly received NICE Guidance was discussed at the Specialty Governance Meetings, Divisional Governance Meetings and the NICE Internal Panel.

We saw evidence the trust used a NICE tracker to record any new guidance which required action. The tracker recorded if the trust were compliant with the guidance or if not, what progress was made toward compliance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At the two handover meetings we observed, staff did not always routinely refer to the psychological and emotional needs of patients, their relatives and carers. We saw two examples of verbal handovers meetings where the psychological or emotional needs of patients, their relatives and carers were not referred to. However, when reviewing the written handover templates, we did see evidence of these aspects of care being recorded.

The hospital employed security staff to assist staff in dealing with violent or aggressive patients or family members. However, staff told us that security covered the whole hospital site and sometimes were not available when needed. The risk of violent and aggressive behaviour was reflected in the service risk register and actions were jointly reviewed by the security and ED team.

We requested the Emergency Departments' quality and safety dashboard which aligned with clinical indicators specific to the department. The dashboard showed good compliance with NEWS. However, SBAR, sepsis screening and sepsis antibiotics within 1 hour were consistently low compliance. The data supplied showed audits from between April 2021 and February 2022. The quality dashboards did not evidence an improvement in the time frame against most quality measures within the time period.

Nutrition and hydration

Staff did not always ensure patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We did not see consistent evidence of intentional rounding for patients in the department, or their nutrition and hydration needs being met. The department had trays of water with glasses ready for patients to help themselves however, these stations were not always visible to patients when the department was busy. Patients who required assistance with mobility or were in bed trolleys were unable to access hydration and relied on staff. On the first visit, we observed patients shouting multiple times for drinks, and two patients told us they had been in the department over two hours and had not been offered a drink.

We did not see any evidence of intentional rounding in the waiting room. However, there were vending machines in the main waiting area and access to water.

We saw evidence of a trust wide Emergency Department health check of nutrition and hydration management through a monthly audit. The audits showed good compliance with standards for, refreshments being offered to the patient where applicable, offering hand hygiene at key points and mouth care being provided to nil by mouth (NBM) for vulnerable patients in November, December and March.

We saw evidence of a paediatric Emergency Department health check of nutrition and hydration management through a monthly audit. The audits showed below target compliance with standards for, completion of hydration assessments and refreshments being offered to the patient where applicable, vulnerable patients in November, December and March.

We saw evidence that patients religious, cultural and other needs were taken into consideration when providing access to nutrition and hydration.

Urgent and emergency services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools. However, staff did not always give pain relief in a timely way, and not all patients had a call bell to alert staff if they were in pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients did not always receive pain relief soon after it was identified they needed it or they requested it. Staff told us there were delays in administering pain relief, depending on the time of day and how busy the department was. We saw examples of patients waiting for pain relief. One patient waited over four hours for pain relief having had their pain assessed at five out of ten using a recognised tool. We observed a number of patients who did not have call bells within reach. This meant they could not alert staff if they were in pain.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements, however they did not always evidence that good outcomes were achieved for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. We saw evidence of three national clinical audits. These included an orthopaedic audit which was awaiting publication, a pain in children audit which was published January 2022 and was awaiting an action plan being agreed and signed off, and an infection control audit, which was published March 2022, with a draft report in progress.

There was some evidence that the managers and staff used the results to improve patients' outcomes. For example, there was some evidence of new equipment being used to reduce pressure damage in the Emergency Department. However, use was inconsistent and there was not a separate audit to measure the effectiveness or outcome of this intervention alone.

There was some evidence that managers used information from the audits to improve care and treatment. For example, the trust collected audit information of compliance with NEWS2. Some audits data had shown improvements, however the improvements were not always sustained.

We saw evidence that managers shared and made sure staff understood information from the audits. There were dashboards displaying audit data in the department, however they were not always up to date. Staff told us that audit information was shared at staff meetings. We saw minutes of staff meetings that included audit details and whether targets were achieved. Managers and staff told us that emails containing information about ward audits were sent for people to read who were unable to attend the department meetings.

The trusts unplanned re-attendance rate within seven days at Pinderfields Emergency Department was in 9% December against a trust average of 7.8%, 10% in January against a trust average of 7.9% and 10% in February against a trust average of 8.1%.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Urgent and emergency services

Staff were qualified and had the right skills and knowledge to meet the needs of patients. Managers told us that skill mix with the registered nurse staffing was a concern and they had plans to develop junior staff competencies and ensure an appropriate mix of experienced and junior staff.

Managers gave all new staff a full induction tailored to their role before they started work. The service had a process in place for staff requiring additional support, if required, after their induction. We saw examples of this in practice.

Managers supported most staff to develop through yearly, constructive appraisals of their work. We saw evidence staff had quarterly one-to-one meetings with nurse managers to discuss progress of any objectives or training needs identified in the annual appraisal. However, the Urgent and Emergency care nursing appraisal rate was at 73.9%, which was below the trust target. This was currently being addressed by managers on the department.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We saw evidence that band six nurses were given additional responsibilities to improve performance and develop their skills, this included mandatory training oversight for specific members of the team. We saw evidence of processes to allow staff to have continuous professional development (CPD), which included the process for study leave for non-medical staff, the process for accessing CPD funding streams, different pathways through nursing and which training programmes were available internally to support development. The trust had organisational development pages on the trust intranet site which highlighted the courses and support available to enhance staff learning.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. We saw evidence of processes to allow staff to have continuous professional development and protected time for study days and teaching. The appraisal rate for medical staff working in urgent and emergency care services was 100% at the time of our inspection.

The clinical educators supported the learning and development needs of staff. We saw an example of clinical education taking place through a simulation session. Staff we spoke to told us that the simulation sessions happened regularly.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence that relevant information from team meetings were displayed on the staff notice board. Staff had access to paper copies of key points discussed within team meetings, as well as electronic copies of meeting minutes.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were provided with allocated time to enable them to complete training. However, we were told this is not always possible and some staff do complete training in their own time.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us that the senior nurses had been supportive of any training needs.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. On inspection a nurse manager gave us examples of nursing staff who were on an additional support action place. This involved enhanced mentoring and monitoring. The action plans were formalised to monitor progression and achievement of defined outcomes.

Urgent and emergency services

The junior doctors we spoke to told us they were well supported in the department with access to senior doctors seven days a week, 24 hours a day. However, some doctors told us they had been called out of teaching sessions several times when the department was busy.

One junior doctor we spoke to told us the induction was 'excellent' and that it provided 'the right information for them to work in the department'.

At the time of inspection, the department had vacancies in both medical and nursing staffing.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw examples of meetings involving members of the multidisciplinary team discussing patient care. We saw examples of effective and equitable input from different professionals.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

The trust adopted the clinical standard set by the Royal College of Physicians and the Seven Day Services Clinical Standards, which was for consultant review of emergency admissions within 14 hours of admission. In line with the clinical standards, the trust had some pathways which did not require 14 hours consultant review. The standards apply to admissions to hospital and findings from the inspection relating to the acute assessment unit are detailed under the medical care core service.

Staff had access to diagnostic services and mental health services 24 hours a day. Support from doctors was available 24 hours a day, however there is not always a consultant on site out of hours. Due to clinical pressures during night shift and weekends, staff told us it was not always possible to seek medical advice in a timely manner. We were told this was not audited.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the department. We saw multiple information leaflets and posters within the department for both physical and mental health needs.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included patients who had drug or alcohol dependency.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care. Three members of staff were not able to explain how and when they would assess a persons capacity. However, they told us that they would ask a more senior member of the team to help them.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. However, when patients did not have capacity to consent and staff made decision in their best interests, this was not always documented.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly record consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Nursing staff we spoke to in the paediatric department could describe the principles and provide examples.

Most staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust submitted data which showed that training level compliance for Mental Capacity Act (including Deprivation of Liberty), the trust target was 85%, level one compliance was 84.3%, level two was 70.5% and level three was 90%. was 89.7%. This was below the trust target.

We observed a capacity assessment undertaken as part of the ED triage process and recorded on the front of the ED card. A separate risk assessment was completed for patients attending with mental health needs. Compliance with completion of the MH risk assessment is audited monthly and included in the Quality and Safety Dashboard. Compliance across the department was 89% against a trust target of 85%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw one example where staff had completed relevant Mental Capacity Act documentation and followed appropriate guidance to request a Mental Health Act assessment for a patient. Information documented was appropriate and legible.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Urgent and emergency services

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treat patients with compassion and kindness, took into account of their individual needs. However, did not always respect. their privacy and dignity

Patients we spoke to said staff treated them well and with kindness.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs. We saw nursing staff demonstrated empathy when having difficult conversations.

Staff took time to interact with patients and those close to them in a respectful and considerate way during assessment and treatment. However, we observed multiple junior medical staff not responding to patients who shouted for help, some of which were not visible to staff.

Junior doctors did not always follow policy to keep patient care and treatment confidential. We saw examples of clinical examinations taking place in the corridor, including medical questions about proposed intimate medical examinations. This meant that privacy and dignity was not always be maintained.

Staff were not always discreet and responsive when caring for patients. We saw examples of curtains not being fully drawn to protect the dignity and privacy of patients in the department when receiving personal care or having conversations about their care, diagnosis or treatment.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. However, all staff groups told us they did not always have time to care for patients to meet holistic needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. However, the availability of staff due to the pressures and layout of the department meant patients were not always responded to in a timely way.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Urgent and emergency services

Staff we spoke with understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, staff told us that due to departmental pressure they were not always able to provide the level of emotional support to patients, families and carers that they would like to.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Due to COVID-19 restrictions only patients who required carer support, or patients who were reaching the end of their life were allowed into department accompanied.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary. We saw examples of staff explaining medical conditions in jargon-free language. We saw one example of the language line interpretation service being used for a patient who did not speak English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department there were patient and family feedback forms available, which could be submitted anonymously.

We reviewed the February 2022 friends and family test results. The data showed 4107 patients attended the department, 532 or 13% submitted a response, of these 63.9% were positive and 28.2% were negative.

Staff supported patients to make informed decisions about their care. We saw examples of staff explaining to patients the choices about their care within the department using jargon-free language.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. We saw evidence that individual needs of patients with complex needs, learning difficulties and dementia were taken account of. The service had an electronic system that sent out an alert trust wide if a patient came into the department who spoke another language. This alert asked if any members of staff could come to the department to translate.

The waiting area had reading material in relation to the services provided however the material was not in multiple languages which did not reflect the local demographic. There was wi-fi and television access. There were toilet facilities within the seated public waiting area.

Urgent and emergency services

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered. The Emergency Department had the facilities required to care for patients, however the lay out of the department made it challenging for staff to see patients at all time. The department was often over-crowded, particularly in the majors section, however this was reflected on the risk register.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the access to emergency mental health support within the department. We saw examples of prompt response times from psychiatric liaison teams.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw evidence of systems in place to support patients with complex needs, learning difficulties and dementia. This included a system of care passports, and an escalation process if enhanced supervision was required.

The service relieved pressure on other departments when they could treat patients in a day. The department had a minor injuries service, in which we saw patients assessed and treated without being admitted into the main department.

The service had signage on the walls and different coloured directional footprints on the floor with the department name for patients to follow which were to assist patients to navigate through the emergency department.

The trust measured the re-attendance rate, and collected information on how many self-presenting patients or patients that came via ambulance had left the department before being seen.

We did not see evidence that the trust recorded how many patients were recorded as missing patients as per the protocol with West Yorkshire Police, what were the outcomes and if there was any feedback from patients to identify the reasons why they left or if the trust had taken any action in response to the information.

We reviewed the trusts 'How to achieve safe, sustainable care in our Emergency Departments report'. The report was informed by the 2021 Royal College of Emergency Medicine (RCEM) Cares document and was used to inform the operating plan for 2022.

The document contained five domains and outlined the (RCEM) system wide plan to improve patient care. There were five areas considered; crowding, access, retention, experience, and safety. The senior management team reviewed the document and then triangulated this with workforce, activity and performance/standards as part of the operating planning process.

Several actions to bring about improvement were still ongoing at the time of the inspection.

The trust's Emergency Department had been working alongside the system wide transformation programme to reflect the needs of the population. This included being part of the long-term strategic work as well as developing short term actions such as more integrated working with the walk-in centre though piloting a new model of staffing.

Urgent and emergency services

The trust was represented on the multi-agency forum established and embedded for the collaborative review and management of frequent users of urgent and acute care services locally to determine individual patient management plans and alternative pathways.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw examples of this is patient records that we reviewed. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw two examples of information from passports being used to inform the care of patients.

We saw evidence that training in dementia was part of mandatory training.

We saw evidence reasonable adjustments had been made so people with a physical disability could access the service. These included a ramp to the public access, lowered reception desk, wide enough spaces in the department for wheelchair access and disabled toilet facilities. However, when the department was busy, and the layout in majors, it was difficult for wheelchair uses to mobilise.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with were able to give examples of communication tools such as Makaton and picture books. Staff had access to communication aids to help patients become partners in their care and treatment.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff told us the demographic of the area was diverse and it would be difficult to capture all the languages spoken in leaflet form.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpreters. The service had an electronic system that sent out an alert trust wide if a patient came into the department who spoke another language. This alert asked if any members of staff could come to the department to translate.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We saw evidence of a trust Enhanced Care of Children and Adults Policy which was due for review in April 2025. It was recognised patients may have changing clinical, mental health, psychological and social needs and may require varying degrees of support including observation to be offered during these phases.

The policy aimed to safeguard both staff and people who used services by helping to prevent and manage situations where patients may present with behaviours that were challenging or were at risk to self or others, providing guidance for safe management. Staff we spoke with were aware of the policy and escalation process in place to escalate to the staffing bleep holder and patient flow team, however they told us that the additional support was not always available due to staffing.

Urgent and emergency services

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed, however patients did not always receive treatment within agreed timeframes and national targets. The department had seen an increase in attendances, and waiting times for treatment, decisions to admit and admission had increased and did not meet the national standard.

From May 2019, the trust had been a pilot site for the new Emergency Care Standards (ECS) and therefore no longer operated against the four-hour target. Managers monitored waiting times and made sure patients could access emergency services when needed, however patients did not always receive treatment within agreed timeframes. The department had seen an increase in attendances, and waiting times for treatment, decisions to admit and admissions had increased, reflective of national pressures.

Managers and staff worked to make sure patients did not stay longer than they needed to, however this was not always achieved. The department did not display what the average waiting time was.

The number of patients leaving the service before being seen for treatments was low. On inspection we were told some patients had left the department overnight prior to treatment. Staff told us there was no system in place to identify if any of these patients were at risk or required to be followed up/traced. Staff were unable to tell us how many had left at the time. However, the trust provided us with evidence that a process is in place to identify patients at risk and for follow up, should they leave the department. An audit shared by the trust evidenced compliance with the departmental process.

Staff supported patients when they were referred or transferred between services.

Patients could not all access the department in a timely way and the trust faced known challenges with access and flow. During inspection we reviewed 15 records. Nine patients had breached the four-hour admission time. Seven of the fifteen patients had been waiting in the department between four and 12 hours. In addition, one patient had been in the department in excess of 14 hours.

On our second visit, we spoke to five patients. Four out of five patients had been waiting more than the 15 minute national target for triage. One patient had a wait in excess of 60 minutes.

We reviewed the trust's performance against the following indicators for a six month period September 2021 to February 2022. The data showed the percentage of patients in the department for over six hours, the percentage of admissions achieving a four hour wait target, the percentage of admissions waiting 4-12 hours from decision to admit to admission and the percentage of patients leaving before being seen.

Since 2019, the service had been a pilot site for the new emergency care standards, and as such did not operate against the 4-hour standard. Information shared by the trust showed in 2021/22, 95% of patients attending the department at Pinderfields spent less than 12 hours from arrival in the department.

The performance data submitted by the trust showed patients were more likely to wait for over four hours to receive care at Pinderfields emergency department than in the trust's other urgent and emergency services.

Urgent and emergency services

The ambulance handover times against performance target for the months December 2021 to February 2022 had been validated and submitted nationally. It showed that Pinderfields did not meet the under 15-minutes performance target, the under 30-minutes performance target or the over 60-minute performance target.

We saw evidence the trust had an ambulance handover flow chart with actions for staff to take to attempt to prevent ambulance handover breaches.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The nurse manager told us they had would deal with complaints and conclude them if they could at department level. The nurse manager could differentiate between complaints which would require a formal investigation and those which could be immediately resolved. The senior nurses escalated complaints and felt supported to investigate and resolve.

We reviewed the trusts Management of Complaints and Concerns Policy Incorporating Patient Advice and Liaison Service (PALS) policy, which was due for review in June 2022. The document clearly outlined the staff roles and responsibilities in the investigation of complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. We saw examples of learning shared with staff from recent complaints.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We saw evidence the nurse management leaders had the skills, knowledge and experience.

The Head of Clinical Service for Emergency Medicine had responsibility and accountability for Emergency Medicine at the Emergency Departments in the trust.

They were supported by the Assistant Director of Nursing and Deputy Director of Operations.

Nurse managers we spoke with understood the challenges to quality and sustainability. This was evidenced by the departmental training compliance levels, high levels of audit compliance and low staff vacancy levels.

We saw evidence of a departmental action plan which was red, amber and green (RAG) rated. We saw evidence of progress against most of the actions. However, improvements were not always sustained and there was consistent key performance indicators below trust target.

Senior leaders told us they had obtained clinical commissioning group (CCG) funding to fund a trust wide urgent and emergency care lead. The role was to produce a strategic plan regarding accessibility to urgent care.

Despite the best efforts of the local leaders within the department to improve safety, this was not always evidenced in the daily operation of the department. We were told senior leaders and executive leaders were not routinely visible in the department.

Vision and Strategy

The service had a clear vision for what it wanted to achieve, as part of the wider Division of Medicine, and a strategy to put this into action developed with all relevant stakeholders.

The trust provided data to evidence that the vision and strategy were focused on promoting patient safety, ongoing improvement and development and sustainability of services which aligned to local plans within the wider health economy.

We were also provided with data to evidence leaders and staff within the wider Division of Medicine understood the vision and strategy and how to monitor them.

However, due to systematic pressures and flow throughout the hospital, wasn't always implemented.

Culture

Most staff felt respected, supported and valued however not all staff felt this way . They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most nursing staff we spoke with told us they felt supported, respected and valued by their managers. We spoke to nine members of nursing staff, two members of staff told us that there was a culture of support for some but not all staff. One member of staff told us some staff experienced a blame culture.

Most nursing staff we spoke with expressed positive views of working in the department and felt proud to be working in the department. Staff told us they felt the trust welcomed diversity amongst the workforce, however there were some staff members that felt they were not treated equally.

Managers told us of the improvements made to improve staff safety. We saw evidence this included the locking of access doors into the department. Staff told us that although there were security staff available within the hospital they were not dedicated to the department. Staff told us that security were not always available when needed and that there was a culture of 'putting up with' rude or aggressive patients. This was reflected on the department risk register. Some staff we spoke with told us they did not always feel safe, particularly at weekends and out of hours.

Staff received training in duty of candour and senior staff we spoke to could explain what the principles of duty of candour were and gave examples of when they had been applied them.

Managers gave us examples of the action taken in relation to staff to address behaviour and performance issues. We were told there were four members of staff currently on a performance management action plan.

Most staff we spoke with told us the department had an open and honest culture.

We saw evidence of annual nursing staff appraisals supported by one-to-one meeting which contributed toward staff development and career progression. However, the appraisal rate was below trust target.

Managers and most staff told us of there was a cooperative and supportive relationship between staff. We saw evidence of staff working collaboratively, sharing responsibility to resolve conflict quickly.

We saw evidence of a Prevention and Management of Violence and Aggression Policy. The aim and purpose of the policy was to ensure, so far as is reasonably practicable, that Mid Yorkshire NHS trust employees and persons working for Mid Yorkshire NHS trust were not exposed to significant risk to their health and safety and outlined the steps to assess risk of harm from violence at work.

The staff wellbeing internal audit conducted in February 2022 reported an overall level of assurance of working in the department and feeling safe.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw evidence the trust had an Urgent and Emergency Care governance meeting which was to ensure there were systems and processes in place across Pinderfields and Dewsbury Emergency Departments to have robust scrutiny relating to quality and safety.

Under quality and safety assurance the areas of clinical quality and safety and planning and driving continuous improvement were listed as areas the meeting would cover.

We saw evidence in the minutes of Emergency and Diagnostic Clinical Governance Meeting that serious incidents, morbidity and mortality information were agenda items.

We saw there were gaps in audit data and consistent failure to meet targets in some audit areas.

The trust told us this had been caused by winter pressures, the Omicron variant and high attendances at the Emergency Department.

We reviewed a copy of the minutes from the most recent morbidity and mortality meeting which demonstrated a patient scenario from the Emergency Department had been discussed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

We saw evidence the trust had a process to manage risk.

The senior Emergency Medicine team met quarterly to review the services' ongoing risks that were recorded and to consider any new or emerging risks requiring adding to the risk register. The risks were aligned to operating plans and featured as an agenda item in speciality governance meetings, which occurred monthly where staff could escalate risks outside of the quarterly review cycle. This was completed for each trust site.

The most recent review of risk took place on the 29th March 2022 and discussed the current risks recorded for the Pinderfields site, and a further 12 risks recorded as whole service risks.

Once a risk review had been undertaken, any changes were shared with the Assistant Director of Nursing and Head of Governance for the Division.

In accordance with the divisional risk process, any new risks or changes to risk scores which scored at 12 or above, were discussed at the Divisional Management Team meeting. All risk changes and risks scored greater than 12 were presented at both Divisional Management Team meeting and Divisional Governance Group Meeting. All risks scored 12 were presented to the Risk Committee on a bi-monthly basis.

From May 2019, the Emergency Departments across the Trust had been pilot sites for the new Emergency Care Standards, and as such no longer operated against the four-hour target.

We reviewed the Urgent and Emergency Care risk register created April 2022. All the risks had action owners, updates on progress, mitigation and review dates. There were 10 risks specific to Pinderfields Emergency Department.

Information Management

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. However, in some areas, analysis did not result in performance improvement, examples included improvement in the standards of patient records, national early warning score records and improvement in the time taken to triage patients.

There were clear and robust service performance measures, which were reported and monitored, however, we did not see evidence some areas of repeated under performance were identified, and improvement action implemented.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We saw evidence there were gaps in the collection of information through the audit process.

Urgent and emergency services

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The trust had a freedom to speak up guardian.

The trust had a dedicated equality and diversity policy. Leaders and staffed talked about the diversity of staff and being inclusive.

During the booking in process the receptionist asked if the if they required any reasonable adjustments in relation to; learning disabilities, autism, or dementia. If the patient answered yes, the receptionist would ask if they have a MY passport.

Situation, background, assessment, recommendation (SBAR) stickers had been created to ensure staff were communicating patient care using a structured approach. Included in the SBAR stickers were key safety and quality measures such as skin assessments/pressure damage/falls risks/DNAR status, communication needs and recent NEWS score and actions/escalations. However, although these improvements were in place, they did not always lead to sustained improvement and was not embedded into practice.

The trust collaborated with local authority services.

We saw evidence of changes that had been made to the service as a result of feedback. This included, carers lanyards and the employment of a Patient Liaison Officer in the department to support the nursing and medical teams in maintaining effective communication with patients' families and loved ones.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We saw evidence of use of Simulation teachings (SIM).

These were an experiential learning technique where nursing and medical staff were presented with a situation that replicated an event or real-life scenario that had occurred within the Emergency Department. The training occurred within the department environment.

We requested the risk assessment for continuing SIM training when the trust was at OPAL 3 or OPAL 4 and were provided with a document which stated the Emergency Department consultant in charge had the final decision regarding whether the simulation training should proceed.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff. However; not all staff had completed the training in line with trust guidance.

The trust set a target of 90% for completion of core mandatory training and 80% for completion of role specific mandatory training. Not all staff had completed their mandatory training. We requested trust data to reflect training split into nursing and medical staff training compliance at site level. We did not receive this information at the time of writing this report. Leaders told us that medical staff worked across sites, so it was not possible to allocate them to one site or another in relation to training compliance. Due to timescales to provide data the trust was unable to provide a breakdown of compliance by staff in nursing and medical groups. However, managers outlined the processes in place to manage compliance with core and role-specific training for both staff groups.

Training on mental health awareness and dementia awareness was incorporated in the trust's safeguarding training package, in line with the approach set out in the trust's mental health strategy. At the time of inspection, the trust provided training on complex needs (including mental health, learning disabilities, and autism) completed as part of the safeguarding Level 3 (adults and children) training. 85% of eligible staff at the trust were compliant with this training requirement. Following our inspection, the trust informed us that the next phase of the roll out of complex needs training (within safeguarding Level 2 adults and children) was to be instigated in May 2022.

The trust target was 90% for completion of core mandatory training and 85% for role specific mandatory training. The trust shared with us training data which showed that compliance for nursing and medical staff training was 89.2% for core mandatory training and 79.5% for role specific training, both were below the trust targets. The service and wider trust recognised that it was in a recovery phase for mandatory training compliance, after a risk-based decision was agreed by the executive team to pause mandatory training in 2020/21 to prioritise patient safety as part of the pandemic response. Compliance in medical care was further impacted by operational pressures over the winter period and arising from the Omicron variant of COVID-19. Managers monitored compliance rates at service and individual level. Since the last inspection, the trust had implemented the electronic staff record (ESR) which automatically notified staff and managers when an individual was required to undertake training.

Resuscitation training had one of the lowest completion rates at 72%. The risk of staff not being able to complete training due to operational pressures had been recognised by the trust and added to the risk register in March 2022.

Managers monitored mandatory training and alerted staff when they needed to update their training.

NEW2 training compliance for nursing staff was 65.6%, the target was 85%. The trust told us that this figure could fluctuate depending on staff turnover and staff sickness. The service and wider recognised that it was in a recovery phase for mandatory training compliance, after a risk-based decision was agreed by the executive team to pause mandatory training where safe to do so in 2020/21, to prioritise patient safety as part of the pandemic response. Following inspection, the trust informed us that compliance had increased to 73% for NEWS2 training.

Training for medical staff was during the F1 teaching programme. A Foundation doctor (FY1 or FY2 also known as a house officer) was a grade of medical practitioner undertaking the Foundation Programme, a two-year, general postgraduate medical training programme which formed the bridge between medical school and specialist/general practice training. The trust had recently instigated NEWS2 training onto the junior doctors induction programme.

Safeguarding training was included in the mandatory training platform. All staff were trained to level one and there was role specific training to level two and three.

Staff told us that face to face training sessions had increased recently, managers were able to schedule training slots for staff for basic life support training and moving and handling.

Due to staffing pressures, staff across wards could have time allocated on the rota to complete online training outside of their clinical shifts. This was included in their working hours and supported flexible learning.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw examples of how managers on individual wards monitored mandatory training.

Resuscitation training was part of the core specific training for both nursing and medical staff. Leaders told us that face to face training had been difficult to facilitate due to operational pressures, however they had tried to make training accessible to staff by adding in drop in sessions that staff could attend at short notice if they had availability.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse; however, not all staff had completed the training in line with trust guidance.

The service had systems and processes in place to protect children and adults from abuse and neglect.

Staff received training on how to recognise and report abuse. The trust provided data to evidence nurse and medical staff compliance surrounding safeguarding training. Safeguarding level one completion was at 93.4% and the trust target was 90%. Safeguarding level two was at 84.8% and level three 85.3%, the trust target was 85%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff demonstrated awareness and understanding of safeguarding. They knew how to make a safeguarding referral and who to inform if they had concerns. We spoke with varying grades of staff from ward clerk to ward manager and they could all describe to us the process surrounding safeguarding referrals.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Wards we visited displayed safeguarding posters that included details of how to contact the safeguarding team.

The trust had up to date safeguarding policies for adults and children.

The trust had a safeguarding lead and they represented the trust at meetings. Staff we spoke with knew who the safeguarding lead was and how to contact them. There was also a specific member of the team dedicated to investigating concerns relating to domestic violence.

The wards we visited had booklets and posters displayed that had specific contact details for relevant local authority teams and both internal/external specialist teams.

Cleanliness, infection control and hygiene

Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Ward areas were mostly clean and had suitable furnishings which were clean and maintained.

The service generally performed well for cleanliness. However, some patient records files were torn and non-wipe clean across the medical wards. This posed an infection risk to patients and staff.

We observed two members of staff on gate 11 leaving a COVID-19 positive bay, they did not change masks or gloves and donning and doffing facilities outside of the bay were unsuitable.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE).

Staff we spoke to were aware of current infection prevention and control guidelines, including the process for screening patients for Covid-19, MRSA and Clostridium Difficile prior to and during an admission to wards.

The areas we visited had enough supplies of personal protective equipment (PPE), however staff did not always use it in line with trust policy.

There was information displayed at ward entrances about appropriate PPE usage and an area for staff to don and doff PPE with supplies of surgical face masks and aprons and with access to a hand washing sink, hand wash and alcohol gel hand rub.

Staff commented that the quality of the aprons used as part of their PPE were poor and this added time onto the donning/doffing process. Following the inspection, the trust told us that as PPE is provided via a national system, they were unable to influence what was received. However, based on staff feedback, the trust did remove some aprons from use as they were deemed unsuitable.

Some staff were seen to be leaving patient areas in PPE and going to other patients to provide care without changing gloves or washing hands.

On both inspections in March and April, disposable curtains were not dated in line with the trust process on all wards we inspected. This posed an infection risk as it was unclear how long they had been hung, or when they needed to be changed.

Cleaning records did not have a space for a signature, so it was unclear if an area had been cleaned. However, the areas that we did visit did appear clean. Following the inspection, the trust implemented new documentation to allow for signatures to be included.

Gate 12 did not display IPC information around the ward.

All staff that we observed were compliant with being bare below the elbow. However, the use of hand sanitiser varied, and staff did not always use it when entering and exiting a department.

The trust had oversight of infection rates, with processes in place to investigate any confirmed infections. Staff told us that patients identified as having a current or previous infection were isolated in side rooms and appropriate signage was used to indicate the potential for infection in order to protect staff and patients.

On both inspections, in March and April there was variable use of 'I am clean' stickers used across the division. Some items did not have these on, and some had long dates on the stickers from when they were last cleaned although the items still appeared clean it could not be evidenced that they were.

Arrangements for the isolation of patients who were an infection risk were in place and there were stop signs in place to identify these areas.

Hand hygiene audits shared with us from the trust showed that on some wards staff did not always adhere to the trusts hand hygiene policy after touching a patient, after bodily fluid exposure and after leaving an environment. The overall score for hand hygiene compliance for medical wards was 82% (against a target of 85%). Leaders told us that each individual ward had action plans following low compliance in areas. An example of a ward improvement plan was shared with us.

The trusts latest local audit results show sustained improvements (April 2021 to January 2022) in the rate of screening on the electronic sepsis screening tool. Since the last report, the team have continued to scrutinise and audit the referrals to the critical care outreach team (CCOT) which favourably shows that, of all patients triggering on NEWS and referred, up to 90% of patients had a sepsis screen completed electronically.

The national annual programme for patient led audit of the care environment (PLACE) audit was suspended due to the COVID-19 pandemic and had not re-commenced nationally. However, the trust had opted to undertake the PLACE-Lite programme (a 12-month programme) until the formal PLACE audit was re-commenced in 2023. Although not a mandatory requirement, the trust us that it had opted to undertake the PLACE-Lite programme as an opportunity to review performance against key measures, highlight current challenges and identify areas of improvement.

There were designated wards for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which wards were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

Medical care (including older people's care)

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms. Staff cleaned equipment after patient contact.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well, however hazardous substances were not always stored safely.

The wards we visited had secure entry systems to gain access and they all had enough equipment for staff to suitably carry out their role. However, on both inspections in March and April, wards were not always clutter free and there were trolleys, linen towers and drink and food trolleys in the corridors.

On our inspection in April, there were multiple unsupervised equipment trolleys that stored items such as butterfly needles and cannulas.

On our inspection in March, a pantry door was propped open by a bin on gate 12, this was also a fire door that needed to be kept closed and a housekeeping cupboard that stored liquid detergents was also left unlocked.

Cleaning trolleys on gate 12 were left unattended with open and accessible liquids, including bleach on them. This was raised at the time of the inspection and the bleach was removed from the trolleys.

Clinic stores, dirty utility, laundry and linen cupboards were left open. Many of these had lock pads and were fire doors that needed to be kept shut. Some also stored alcohol solution and razors. We escalated this concern to the trust, who told us that they had made a risk-based decision to leave sluice rooms unlocked due to the IPC risk associated with using a keypad on a locked door. We raised this at the time of the inspection and leaders told us that after we raised this, they ensured all hazardous substances were removed from open sluices. On the inspection in April, we found the doors to be locked.

Resuscitation trolleys on all wards we visited were not sealed with a tamper proof seal system. However, the drug boxes/containers stored on the trolleys, all had tamper evident seals. This was compliant with current Resuscitation Council (UK) guidance.

There was mostly adequate clutter free spacing between patient beds. However, staff on gate 41 told us that if there are bed shortages, they will often squeeze an extra bed between two beds in a five bedded area. Screens were then used and there was limited privacy and dignity for patients in these spaces, there were also no oxygen ports for the extra bed placed in between two beds. We observed this practice on gate 43, a patient had a bed that was squeezed in a space that had no buzzer, no bedside table and no oxygen port. This was escalated at the time of the inspection and the patient was moved to a more suitable bed space.

During our first visit we observed several patients on wards inspected who did not have access to their nurse call alarm including frail elderly patients and patients whose care included the use of bed rails. We also noted several situations where nurse call bells were left unanswered for extended lengths of time, including one for ten minutes. However, on inspection in April we found patients had access to their call bells.

All sharps bins that we looked at were signed, dated and stored appropriately.

Medical care (including older people's care)

The wards we visited had patient care boards visible to the public which included information such as staff on the ward, who was in charge and other information such as mandatory training compliance. The boards also included applause notices including staff commendations, my health heroes and appreciation awards.

The service had suitable facilities to meet the needs of patients' families.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff did not always undertake appropriate assessment or provide support to meet patient's nutrition and hydration needs. Patient risk assessments were not always completed contemporaneously, and the care provided to mitigate risk was not always in line with the assessment.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate a deterioration in a patient's condition. However, there were two occasions during the inspection were high scoring NEWS2 scores were not escalated to the outreach team in line with trust policy. This was escalated to ward leaders at the time of the inspection and the patients were reviewed. Training in NEWS2 was below the trust's target.

Wards we visited had electronic whiteboards which provided a headline of key information for staff such as NEWS2 score, time since seen by a consultant and when observations where due.

During the first visit, we viewed the whiteboard on gate 12 and found that 26% of patients had not been reviewed by a consultant within 14 hours and three patients had been waiting between 18 and 23 hours. This was not in line with NICE best practice guidance. We asked the ward leader if any one person maintained oversight and management of the board to ensure that these patients where seen, we were told that nobody has specific oversight and it was down to the consultants to review and update the board for their own patients.

The trust undertook an immediate audit sample of 71 patients admitted as emergencies to gate 12 between Monday 21 March to Monday 28 March 2022, shows 89% of patients received a consultant review within 14 hours. This was in the context of the trust experiencing sustained high demand for urgent and emergency services during the period, operating at OPEL 3 or OPEL 4 for adult services.

Patients were regularly moved from gate 12 to other wards without being seen by a consultant within 14 hours. On the day first day of the inspection, three patients had been moved to gate 41 with no post take admission ward round completed. This added additional pressure onto consultants on those wards.

Falls risk assessments were not completed for eight patients that needed them.

On inspection in April, we visited gate 43 and observed many patients with bed sides up and information in the handover sheets did not reflect what was seen. For example, details would state bed sides were not required when they were up. We asked staff why patients documented as not requiring bed rails had them up but they said they did not know.

Audit data shared from the trust showed that on average 89% of falls risk assessments had been completed and 80% of bed rails assessments were completed in line with trust policy in March 2022.

Medical care (including older people's care)

Intentional rounding (skin and wound management, SSKIN) is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect. There were gaps in recording in patients' records including the skin and wound management record to evidence the repositioning of patient interactions about the care and support that staff provided. When we inspected in April, we found that the recording had improved.

We asked the trust to provide audits where they had checked the compliance scores of patient pressure area care completion. We reviewed the trusts health check audit data for March 2022 which evidenced low compliance and or not meeting trust the trust target rate of 85% on some wards with regard a registered professional completing a full skin inspection on each shift and recorded in the SSKIN record. For example, gate 41 scored 50%, gate 43 scored 0% and gate 45b scored 0% which did not meet the trust target of 85%.

Standing and lying blood pressures where not taken on any of the wards we visited in line with best practice and trust policy.

We observed three patients who had been transferred from A&E that were waiting in chairs by the ward coordinators station in the corridor. All three patients were waiting for beds to become available. Staff told us that patients were generally observed by the coordinator and patient observations were assessed and recorded; however, patients skin integrity was not monitored. Staff told us that patients had to endure long waits for available beds to become vacant and told us that this is a normal daily occurrence.

We were told by staff on gate 41 that it is not unusual to have many patients waiting in the corridors in beds or chairs waiting for beds to become available.

One ward we visited had a medical outlier. Medical outliers are medical patients that are being cared for in areas outside of their speciality. They were monitored appropriately by the relevant consultant and had been assessed by the SALT and physiotherapy team.

Staff told us that they had to manage requirements for 1:1 care within the staffing numbers; however, when they had escalated this no additional staffing was available. These patients were nursed closest to the nursing station to mitigate the risk.

We asked the trust to provide audits where they had checked the compliance score of nutrition and hydration completion of patient food charts and completion of the nutritional screening tool. We reviewed the trusts health check audit data for March 2022 which evidenced low compliance and or not always meeting the trust target rate of 85% on some wards. For example, gate 12 scored 0% and gate 41 scored 50% for compliance with the completion of patient food charts. Gate 12 scored 20%, gate 41 scored 60% gate 43 scored 80% for calculating the nutritional screening tool in line with trust policy.

We reviewed do not attempt cardiopulmonary resuscitation orders (DNACPR) on all wards inspected. These were appropriately completed on all occasions, showing sufficient information to provide assurances that decisions had been discussed with the patient or their family.

Audit data shared with us showed compliance for completion of falls risk assessments. Of the 5 areas that we visited, three scored 100%, one scored 80% and one scored 60%.

The trust has a sepsis improvement programme initiative. Gate 12 were at 10% for sepsis screening previously but this had now increased to 96%. This is done on patients with a NEWS2 score of five or above. Audit results shared from the trust showed that in January to March 2022, the average compliance for antibiotics administration within one hour was 77%.

The trust told us that they did not undertake NEWS2 audits for 2020/21 due to the pandemic. However, they had completed an audit for 2021/22 and although the results had not formed a formal report yet, they shared with us the highlights of the findings in the audit. Positive findings included evidence of escalation and good response times to escalation. However, improvements were needed in timeliness of observations overnight, volume of manual frequency overrides overnight, documented rationale for overrides and documentation of escalation where this has occurred.

Staff had access to tissue viability nurses who can attend the ward and assist with skin assessments.

We observed that patients at risk of falls had red wrist bands that stated they were a falls risk.

Safety huddles took place each day on all the wards that we visited. They discussed things such as general risks, DNACPR, incidents and staffing.

Gate 12 had a psychiatric liaison team on the unit which was available 24/7 (SWYFT partners).

There was good compliance with VTE risk assessments being completed in the records that we looked at. However, one risk assessment did not capture the bleeding risk associated with an oral anticoagulant the patient was prescribed.

Gate 12 had introduced a 'MY safe space' which was in the process of renovation during the inspection, this room had no ligature risks and anti-barricade doors. It is to be used specifically for patients with mental health needs. The trust shared with us some plans that indicated these safe spaces would be rolled out onto other wards within the division.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels. However, this did not always established safe levels of staffing.

The service did not have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not match the planned numbers on the wards we visited during the inspection. The trust used the safe care acuity tool to secure safe rosters and review skill mix which was reviewed twice yearly.

Staff told us that escalation of under establishment was reported as red flag incidents and discussed with senior management.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites. They discussed expected admissions and discharges, wards with closed bays and newly cleaned bays that had previously held patients undergoing screening or isolation following COVID-19 infection. Several bays and specific beds were identified as clean or requiring deep cleaning and patients were moved between bays. The ward manager

could request additional staffing levels daily according to the needs of patients. However, they explained that staff were not always provided. Following the inspection, the trust told us that a full review of all areas on all sites is undertaken twice daily and staff moves are made accordingly (wherever possible), depending on staff availability and acuity of the ward.

Staffing was a key risk for the division and had been escalated to the trust board.

The trust had ongoing recruitment for nursing staff and had recruited back to practice and international nurses to increase their establishment.

Regular staffing establishment reviews had taken place; however, the trust was not able to meet the establishments required to keep patients safe at the time of the inspection. For example, two patients requiring 1:1 care could not have this due to staffing pressures.

The site manager could adjust staffing allocations daily according to the needs of patients and staffing gaps across the footprint of the hospital, which reduced the risk to patients across wards, where staffing levels were exceptionally low.

During the inspection, only two of the wards that we visited had numbers of nurses and healthcare assistants that matched planned numbers. For example, gate 12 was short of two nurses and gate 41 was short of two nurses and two healthcare assistants.

The trust provided data for the wards inspected in the medicine directorate which evidenced registered and healthcare staff shortages. For example, on gate 41 the average nursing fill rate for February 2022 was 78% with healthcare staff showing a fill rate of 79%. Following the inspection, the trust told us that the average day time fill rate for medical wards at Pinderfields was 80.6% for registered staff and 83.8% for non-registered care staff. Average night-time was 98.8 % for registered staff and 101.8% for care staff.

Ward leaders were not always supernumerary due to low staffing numbers. Ward managers told us they were allocated dedicated managerial hours; however, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care.

The service had vacancies for registered nurses, healthcare staff and trainee nursing associates. Following the inspection, the trust shared with us vacancy rates for the division which showed overall low rates of 4% for registered nurses, 0.4% for healthcare staff. Trainee nursing associates are not funded to these positions are overfilled.

Staff told us they were regularly redeployed to other wards. Staff on Gate 43 consistently expressed significant concerns about staffing levels and shared details of incidences where staffing levels were low enough to put patients at risk of harm.

Leaders told us staffing levels were regularly reviewed.

All wards we inspected on the day of inspection had staff sickness, some staff were absent with COVID 19 symptoms or were self-isolating and some staff were on long term sick.

The trust tried to incentivise staff to work on the wards by increasing rates of pay on NHSP, but this had limited impact due to the pressures the wards faced and the trust was still struggling to recruit to fill these positions. However, the trust is making significant and ongoing efforts to recruit and retain staff. These include; recruitment of graduate, international and experienced nurses (retire and return), TNA apprenticeships and retention, degree nurse apprenticeships, internal transfer schemes, career cafes, career pathways, well-being support and staff development and leadership programmes.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Medical staff on shift did not always match the planned numbers, for example, gate 41 had two consultants but should have had three.

Consultants all reported heavy workload and told us that staffing levels were very poor and posed an increasing challenge. We were told that they often feel like they were doing yesterday's work due to the large number of unseen patients they must review after handover.

We spoke with consultants who told us there was not always a good skill mix of medical staff on each shift and said they should be supported by an SHO but these are often locums who don't know the systems well and cannot order investigations.

Some consultants that we spoke with told us they were working like registrars and felt very unsupported with their workload.

The trust provided data to evidence consultant and doctor fill rates from March 2021 to March 2022; however, this was not site specific. In elderly medicine the consultant fill rates in March 2022 did not match actual verses planned with a substantive fill rate of 91.72%.

The trust provided data to evidence medical staff sickness rates from February 2021 to January 2022; however, this was not site specific. Sickness rates for medical staff evidenced a sickness rate of 4.71% in December 2021 and 8.3% in January 2022. Leaders told us that increase in sickness was due to the prevalence of the COVID-19 pandemic in the local area.

Leaders told us that medical staffing was constantly under review. A GMC survey had triggered a review and investment to lead to a more blended workforce and physician associates have been expanded. Successful international recruitment for specific specialities had been completed a few years ago and are looking to undertake a similar recruitment again

Medical staffing was included in the division of medicines risk register which listed a high risk surrounding reduced medical staffing availability across the division due to COVID and non COVID-19 related reasons. With vacancies to medical staffing impacting on clinical service delivery and the quality and safety of care to patients and their experience. It was also noted that staffing availability also affected morale of the workforce and could affect health and wellbeing. The risk was listed for review in June 2022.

Medical care (including older people's care)

Sickness rates for medical staff evidenced a sickness rate of 8.3% in January 2022. We did not receive a summary to provide the reasoning behind the increase for example the sickness rate in December 2021 evidenced a sickness rate of 4.71%

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work

Patients were not always seen by a consultant within 14 hours. On gate 12, five patients had not been seen within 14 hours with the longest patient waiting for 26 hours. We raised our concerns with the trust at the time of the inspection, they told us that the trust adopts the clinical standard set by the Royal College of Physicians and the Seven Day Services Clinical Standards, which is for consultant review of emergency admissions within 14 hours of admission. It is therefore possible that some patients on gate 12 may have waited longer than 14 hours as reported.

Most wards had consultant led daily ward rounds on acute wards, including weekends. However, gate 11 did not have designated consultant cover on weekends. They would call the respiratory registrar if required. Staff said this did not impact patient discharges and they would still be able to discharge on weekends. However, staff told us that getting in touch with the on call medical cover was challenging and could take a long time to get a response. One staff member told us of an occasion where they had to utilise the crash call bell as no on-call consultant had attended and a patient was continuing to deteriorate.

The General Medical Council (GMC) survey had triggered a review and investment to lead to a more blended workforce, physician associates have been expanded within the division. The division has addressed the impact of internal medicine training with recruitment to backfill when trainees rotate through intensive care units (ICU). Trainee induction training is continuously under review. Senior leaders told us they are aware of the specialities that are fragile for example oncology and haematology

Records

Staff did not always keep detailed records of patient's care and treatment. Not all records were clear, contemporaneous, up-to-date, or stored securely, however they were easily available to all staff providing care.

Staff could access patient notes easily; however, they were not always comprehensive. We looked at ten full sets of patient notes and sections of patients records when looking at examples of poor care we had observed across the medical wards inspected. There were gaps in recording in patient's records including skin and wound management, lying, and standing blood pressures, height and weight, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making.

We observed a microbiology trolley left outside a patient bay with identifying patient information stickers on full display. This was a risk of patient confidentiality and not in line with trust policy or GDPR.

Records were completed legibly, and daily evaluations were evident but there were several gaps in documentation. For example, we observed in the skin and wound management, qualitative information was mostly missing to evidence interactions with patients about their care and support that staff had provided.

During patient turns for pressure care, there was no record of which side patients were moved to and when it was last completed. This meant staff could not be sure of the timing of the next turn increasing the risk of potential pressure damage, impacting on recovery. Skin and wound management is a systematic and routine check to ensure that each patient is comfortable, has adequate nutrition and hydration and is treated with dignity and respect.

Records were not stored securely on most of the wards we visited, trolleys were left unlocked, and notes were left in various areas of departments such as on trolleys and on desks. We also observed instances of staff leaving computer records open and unattended with smart cards left in.

Ward health check audits were undertaken monthly and published on the trust intranet. The audits were suspended in January and February 2022 in response to the pandemic, but the trust shared with us the audit data for March. This showed mostly good compliance for storage of bedside notes and for nursing communication sheets reflecting ongoing care. However, the audit also showed that staff did not always record details of DNACPR in nursing handover documentation and nursing staff did not always include name, signature and designation in paper notes.

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However, there were incidents where time critical medicines were not administered to patients as prescribed.

Emergency hypoglycaemic kits were not available on the wards we visited as these were on order trust wide. However, they did have a supply of medicines needed in the event of a patient requiring hypoglycaemic treatment.

The trust shared with us audit data for medicines reconciliation that were completed within 24 hours, this showed that the rates for completion were between 25% and 70% across the medicine division.

Staff followed some systems and processes to prescribe and administer medicines safely. We found that all prescription records examined had allergy status recorded. However, there were incidents where time critical medicines were not administered to patients as prescribed.

This included two medicines for prevention of epilepsy seizures and one of administration of antibiotics. One patient who was prescribed a time critical Parkinson’s Disease medication did not receive these on time.

Staff reviewed each patient’s medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were visible on the wards we visited and reviewed patients’ medicines.

Staff completed some medicines records accurately and kept them up to date. The trust used an electronic system to prescribe and record the administration of the patients’ medicines.

There were no placement records or care plans in place for two patients being administered medicines through a patch. Body maps were not in use for patients where this would be indicated. Staff told us that they are not used trust wide, however a newsletter shared with us from January 2022 stated that a trial had commenced on certain wards for use of body maps to record application and removal of patches.

During the inspection we checked patients for administration of oxygen. On one ward we found eight patients that were administered but not prescribed oxygen. Trust audit data for oxygen prescribing showed an average of only 46% of patients were prescribed oxygen on this ward over a three-month period. On our inspection in April, the trust had added MY quality boards at each ward entrance. The boards detailed the learning around the need for oxygen to be prescribed and all oxygen was prescribed for patients that needed it. An audit was completed on 26th April 2022, which showed an improved compliance rate of 83%.

Staff stored and managed all medicines and prescribing documents safely. Intravenous potassium chloride was stored separate to other IV fluids in line with guidance.

Gate 12 provided an out of hours dispensing packs to patients who needed to be prescribed some medicines to take home with them. These were for example antibiotics. However, there were nine strips of medicines out of their original packs which were available to be dispensed to these patients without the correct labelling included. Staff indicated that the strips should have been removed and returned to pharmacy, however there was stock from January 2022 still available. The provided guidance did not specifically state how these medicine strips should be managed. There was a risk they could be dispensed to patients without the legally required labelling.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. Audit data from the trust showed that across the Pinderfields hospital site, medicine reconciliation rate on Gate 41 was 40% for March 2022. The trust target is medicine reconciliation rate greater or equal to 65%. National guidance recommends undertaking medicine reconciliation within 24 hours of admission. This allowed early action to be taken in relation to discrepancies and a complete and accurate list of medicines available. Audit data across the site indicated an average rate of 48% completed within 24 hours.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

The medicine division had 28 serious incidents declared in 2021/22, 21 of these investigations were ongoing and seven had been closed. Ongoing incidents were monitored with timelines and reviewed using the incident tracker.

The trust used a serious incident tracker to monitor timelines for investigations. This included dates for when an RCA was due and when the incident had been discussed at the patient safety panel.

A patient safety bulletin was cascaded amongst staff which detailed shared learning from recent incidents. Staff we spoke with confirmed they receive these.

Medical care (including older people's care)

Discussions around deteriorating patients and learning took place at the deteriorating patient group meetings. We reviewed meeting minutes and seen evidence of shared learning and escalation of concerns.

Newly reported serious incidents are discussed at the trust patient safety panel as a standing agenda item. Key messages from patient safety panel are shared in the trust patient safety bulletin which is circulated via the communications team.

Lessons learnt from pressure ulcer and falls multi-disciplinary team (MDT) meeting were shared at the patient safety panel and were included in the patient safety bulletin. We reviewed an example of learning which evidenced a review of lessons learnt following falls. Learning from the multi-disciplinary team (MDT) meeting was shared at the trust improvement group

The trust shared with us a section from their intranet called 'SI Library', this allowed staff to access extended learning around incidents focusing on themes such as medicines, maternity and never events.

We observed that incidents were a topic of discussion at shift handovers.

Most staff raised concerns and reported incidents and near misses in line with trust policy. However, one staff member told us they were not confident with this and would report all incidents to their manager.

The service had no never events on any of the medicine wards. A never event is a serious incident that is entirely preventable.

Managers shared learning about never events with their staff and across the trust.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Lessons learned from never events and serious incidents were available on the trust intranet in a learning library within the quality and safety page. This also provides access to never event learning from the West Yorkshire Association of Acute Trusts (WYAAT). The patient safety teams meet quarterly as a WYAAT to share learning from never events and serious incidents where there is an opportunity for wider learning. This is also a forum to share good practice and support from other trusts.

Staff received feedback from investigation of incidents and lessons were shared at team meetings.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Medical care (including older people's care)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made some adjustments for patients' religious, cultural and other needs.

The service had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients. However, we observed a significant number of patients who were being nursed in bed, not repositioned during mealtimes. Following the inspection, the trust informed us it had established a working group and updated us on the work of this group which included actions to address the potential risk of harm associated with reduced mobility in hospital settings; especially in older adults where this cohort of patients were particularly vulnerable to the detrimental effects of immobility.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition (MUST), however these risk assessments were not always completed for patients that needed them.

Catering staff were informed of any dietary requirements and/or allergies each morning. This is then written down on the board in the pantry so that all subsequent snacks/meals/comfort rounds meet the needs of patients.

During the inspection staff we spoke with told us meals were bulk ordered, and patients were given a choice of two meals. We observed that those with specific needs did not get a choice of meals. However, following the inspection the trust told us that they followed a 2-week menu and a la carte menu for those with special dietary needs and patients were given a meal that suited there cultural and religious preferences if this was required.

We observed additional comfort rounds taking place with options for biscuits, tea and coffee.

Staff mostly made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. However, we observed occasions where meals were left at the bedside whilst the patient slept. One patient on gate 43 told us that as he was admitted to the ward after a meal time, he was not offered anything to eat.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed.

Patients that we spoke with had varying opinions about the food. Some said it was OK, others said it was terrible. Patients said if they could not eat the food, they were not offered alternative options.

Water jugs were in reach and patients said they were replenished frequently.

We observed nutrition boards near the main nursing station which listed patients requiring red trays, assistance with eating and drinking required, nil by mouth and patients who were diabetic requiring dietary support.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

The trust shared with us nutrition and hydration audit results for March 2022. This showed that on average 63% of the medicine division calculated the nutritional screening tool in accordance with trust policy, 64% of the division completed food charts in full and consistently and 69% of the division completed fluid balance charts in full and consistently when applicable. This was below the trust target of 85%. Following the inspection, the trust recognised the risk of patients not receiving adequate nutrition and hydration and implemented immediate actions to address this.

Pain relief

Staff assessed and monitored patients to see if they were in pain, and mostly gave pain relief in a timely way.

During the inspection, we found that staff did not always prescribe, administer and recorded pain relief accurately. We found an instance of pain relief being administered earlier than prescribed and not according to its manufacturing recommendations.

The trust shared with us audit data for pain management. The most recent audit in March 2022 showed that 100% of patients with a pain score of 2 or above were administered with pain relief.

We spoke with three patients who told us that they would receive their pain relief late and would often have to ask for it to be given.

We observed that nurses administering controlled drug pain relief always had a second nurse with them to check the medicine in line with guidance.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

The trust shared with us some audit data for pressure area care for the medicine division for March 2022. This showed poor compliance for areas including 'Is there a management plan in place for repositioning the patient in the SSKIN booklet' (54.2%), 'has a registered professional carried out a full skin inspection on each shift' (50%), 'Is there evidence

of interventions for 'at risk patients' documented in the clinical notes' (55.8%) and 'has the wound chart been completed in full for pressure ulcers that are present on the body in this episode of care' (33.3%). However, the remaining 2 questions in the audit had better compliance of 83.3% and 91%. Whilst gate 23, gate 31 and 45a had 100% compliance overall, only one other ward (A2) met the target, meaning 12 wards fell below the trust target for overall compliance with pressure care.

Managers told us they used information from audits to improve care and treatment. Ward level leaders shared with us weekly audits which had focus on falls reduction, nutrition and hydration and skin assessments.

Lessons learned from pressure ulcer and falls multi-disciplinary team (MDT) meeting were shared at the patient safety panel and are included in the patient safety bulletin. Learning from the MDT meeting was shared at the trust improvement group.

The trust's lead nurse for quality and patient safety had accessed completed reports and action plans for specific clinical areas to inform educational programmes.

The division benefited from clinical educators who supported staff with additional learning. We spoke with staff in respiratory who spoke very highly of the clinical educator based on gate 11. Managers told us that they could support staff with additional training specific to their role. For example, following an incident with insulin administration all staff were given additional training around diabetes and insulin management. Other training was offered which was specific to their role such as chest drain management and NIV ventilation and management.

Mortality and morbidity reviews showed standards of care were looked at and actions for improvements were identified.

Lessons learnt from never events and serious incidents are available on the trust intranet in a learning library within the quality and safety page. This also provides access to never event learning from the West Yorkshire Association of Acute Trusts (WYAAT). The patient safety teams meet quarterly as a WYAAT to share learning from never events and serious incidents where there is an opportunity for wider learning. This is also a forum to share good practice and support from other trusts.

The division audited falls and pressure ulcers grade three and above. They shared with us action plans for improvements.

Managers shared and made sure staff understood information from the audits.

The service participated in relevant national clinical audits.

The trust shared with us evidence of how outcomes were used to improve patient safety.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure staff were competent for their roles; however not all staff had received an appraisal.

Managers told us that supervision and appraisals had been continuing as required throughout the pandemic and that these had been of a good standard. However, this wasn't reflected in the appraisal completion rates for the division.

The division aimed to complete appraisals within the April to June appraisal season. Managers told us that organisational challenges continue to affect the ability of staff to undertake appraisal due to both availability of appraiser and appraisee, with particularly clinical staff having to work clinically. The current appraisal rate for the medicine division was at 73% and the trust target was 85%.

Staff said that they had not experienced any issues with education sessions being cancelled, and that the department had worked flexibly to accommodate these.

Staff outlined that they were given protected time to complete training, and that where sessions previously were completed face to face prior to the pandemic, the service had worked hard to ensure alternative formats for training could be provided.

Managers we spoke with told us they did not get protected management time as they were too busy and would generally have to support on the ward.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through specific competency training relevant to the staff member's role.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work.

The clinical educators supported the learning and development needs of staff. All staff that we spoke with spoke extremely highly of the clinical educators and the additional learning that they supported them to undertake. All staff told us that the clinical educators had a very strong presence on the wards.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

When new nursing staff commence induction at the trust they attended clinical orientation. The medicines optimisation nurses (part of the medicines optimisation and pharmacy services team) teach for two whole days on the scheme.

Nursing staff were not permitted to administer medicines independently without attending the medicines sessions and without completing the medicines administration competencies in their workbook. As of 25 March 2022, 420 workbooks had been issued to Band 5 staff working in the division of medicine (which includes medical wards, emergency departments and the urgent treatment centre) and 394 had been completed and returned, giving a compliance rate of 94%.

The medicines optimisation group receive monthly updates on staff compliance with mandatory training on medicines. Level 2 mandatory training on medicines is for all staff who administer medicines. On 25 March 2022, 665 out of 778 staff (86%) in the division of medicine were compliant with Level 2 mandatory training in medicines. This was compliant with the trust target of 85%.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. We spoke with the ward leaders who told us that through audits they can monitor were there may be gaps in competencies and additional training can be offered.

Managers identified poor staff performance promptly and supported staff to improve.

Staff we spoke with told us they can speak with the ward manager regarding any concerns and they can seek ad-hoc support/supervision if required.

We spoke with a newly recruited international nurse who told us they are supernumerary in the rota, to give them time to become fully adjusted and inducted into the department. They said they had received an excellent programme for continuous education and a comprehensive induction pack that they are working through. They said they were undertaking education on the trusts electronic patient record system PPM and building familiarity with this.

Newly recruited international nurses told us they were assigned a mentor to work through the induction process with. The mentor was responsible for signing off the staff member as competent in the competencies that were outlined within their induction booklet.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Different teams of healthcare professionals worked with staff in the division as a multidisciplinary team (MDT).

We observed MDT board rounds which included consultant, pharmacist, physiotherapist and ward sister.

A staff member on gate 11 described good teamwork on the unit and said that the small staff team work well together.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

We found communications in care records that showed detailed descriptions of involvement from physiotherapists and dietitians.

Patients had their care pathway reviewed by relevant consultants. For example, one patient who was residing as a medical outlier due to bed shortages, was reviewed by the appropriate consultant for their care needs. A medical outlier is a hospital inpatient classified as a medical patient but has a placement on a non-medical ward.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Most wards had consultant led daily ward rounds on acute wards, including weekends.

Medical care (including older people's care)

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Discharges were planned so they could still take place on a weekend to maintain flow out of the hospital.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Audit results shared with us from the trust showed that capacity to consent to daily nursing tasks had been considered and documented in the clinical notes. The audit results for March 22 show 91% compliance (against an 85% target). Staff gained consent from patients for their care and treatment in line with legislation and guidance. However, during the inspection we found that consent was not always recorded. The audits showed that enhanced care risk assessments were not always completed in full, with a 70% compliance (against 85% target). However, the trust told us that due to the small numbers of patients requiring enhanced care, this percentage related to 2 patients with incomplete assessments.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance.

Staff did not always clearly record consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Level one training was part of the core training and completion was 85%. Level two and three training was role specific and completion rates were at 72% and 84% respectively. All three were below the trust target.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

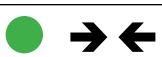
Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Medical care (including older people's care)

When reviewing the nurses station area on gate 45a, there was an area where there were blank copies of documentation stored in drawers and folders stored on top. When reviewing the folders, we found one completed capacity assessment for a patient who was no longer on the unit stored within these. It was unclear as to why this had been placed here and contained patient identifiable information. We raised this with the ward manager who immediately removed this assessment to ensure this would be sent to be stored with the patient's complete record.

Records showed that decisions around DNACPR (Do Not attempt cardiopulmonary resuscitation) were fully informed.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and mostly took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. However, upon review of electronic and paper records, we could not find a section to record patient's individual spiritual and religious beliefs. Post inspection the trust highlighted there was a section on the nursing standard assessment called 'pastoral, spiritual and religious care need', where if a need was indicated, a care plan was then generated.

On the wards we visited, most of the patients were in bed. On gate 45a we observed 11 of 19 patients in bed. We observed that there were some patients up and mobilising around the wards.

We observed that out of 46 patients, only 30 had access to their call bells. We asked staff why patients did not have the call bells in reach but there was no reason identified.

Some of the wards had access to a shared television, we observed on one ward that the volume was increased to ensure all patients could hear it. They also could access radios and books for entertainment.

The trust has been a committed advocate of the 'End PJ Paralysis' campaign since its launch in 2017, acknowledging the risks associated with reduced mobility in hospital settings; especially in the older adult where this cohort of patients are

particularly vulnerable to the detrimental effects of immobility. However, there were large numbers of patients being nursed in bed on all wards we visited. Following the inspection, leaders shared with us Following the inspection, the trust provided an update surrounding the working group which included actions to address concerns raised at the time of the inspection. The groups action plan included actions related to improving staff awareness of the importance of mobility as well as actions to encourage improved practice in relation to positioning and support at mealtimes.

The inspection team observed that were instances of patients waiting for extended periods of time to have their call bells answered.

Family and friends can visit patients on the ward and are free to bring additional items in for the patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff did not complete training on breaking bad news as part of the core or role specific training. However, they demonstrated empathy when having difficult conversations. The trust told us that it had recognised the need to provide training on advanced communication skills and a training programme was commenced in December 2021.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We observed kind interactions between patients and staff and there were instances of patients being comforted by staff members when they were visibly upset or showed distress.

We observed staff supporting a patient with dementia whose comfort was to walk around the ward. The patient was never left unattended and staff were kind and caring when they were walking around the ward together which was for long periods of time.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed multiple occasions during the inspection where staff members were discussing a patient's condition with their loved one over the phone.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment, and we did see feedback posters and boxes on the wards we visited. However, responses were quite low across the medicine division. For example, the response rates for the wards we visited were only between 1.4% and 17.5%. The overall response rate for the division was 24%, 84% of the feedback received was positive.

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care.

Patients we spoke with gave positive feedback about the service.

We spoke with one staff member who told us that they facilitate a lot of communication between families and patients. They said that they arrange for a point of contact so that information does not always have to be repeated to various family members.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The elderly care department had an acute admissions unit dedicated to those who were older and those with frailty needs over the age of 65. These care facilities were based on the PACE unit (Pinderfields Acute Care of the Elderly). The unit may take younger patients, only if previously known to a geriatrician, and this is infrequent. These are taken on an individual basis.

The PACE unit provides more complex care for those that require tests which were only available in and out of hours at Pinderfields such as endoscopic procedures or require specialist reviews.

The service benefits from the support of an Acute Frailty Team previously named the Rapid Elderly Assessment Care Team, which is dedicated to ensuring that a comprehensive geriatric assessment was completed on every patient. The team also supported those with advanced frailty on other wards.

There was a general elderly base ward that those with frailty could be transferred to. This ward would facilitate the care for patients with ongoing medical or nursing needs and provides a place of safety for those who require psychiatric evaluation or require ongoing support from social services or community services.

Staff knew about and understood the standards for mixed sex accommodation. There were no mixed sex breaches on any of the wards we visited.

Facilities and premises were appropriate for the services being delivered and the endoscopy service was JAG accredited.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

Medical care (including older people's care)

Meeting people's individual needs

The service was not always inclusive and did not take account of patients' individual needs and preferences. They coordinated care with other services and providers.

The trust shared with us information that stated the medicine division recognised that those with moderate and severe frailty needs often reside in 24-hour care. The department supported community providers and where necessary care homes to ensure individuals were offered advanced care plans. The same could be organised for those at home. Home visits could be organised for those who cannot attend outpatient appointments although visits were streamlined by virtual or telephone consultations due to the COVID 19 pandemic.

Upon review of electronic and paper records, we could not find a section to record patient's individual spiritual or cultural needs. However, after the inspection the trust highlighted there was a section on the Nursing Standard Assessment called 'Pastoral, spiritual and religious care need', where if a need is indicated, a care plan is then generated.

Patients were given a meal that suited there cultural and religious preference if this was required, however there were no options for them to choose from they were just given a meal.

The trust had a multi faith chaplaincy which offered a range of spiritual and holistic care. Prayer rooms and chapels were available, and chaplains could visit individuals by arrangement. There was also 24 hour on call availability for emergencies.

The trust had complex needs plan for 2021 to 2023 that stated a training package is developed to educate its staff on learning disabilities, autism, delirium, dementia, and mental health. The training formed part of the safeguarding level 2 and 3 training.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. On admission to the ward each patient received individual assessments, however these were mostly risk-based assessments, and they did not consider individual needs or preferences. On admission to the ward each patient received individual assessments.

The trust had a hospital passport for patients living with dementia. They were supported to receive individualised care by use of the Mid Yorkshire (MY) hospital passport. The MY hospital passport included information that would support hospital staff to provide individualised care. However, we did not always see these in use were applicable. Following the inspection, the trust told us that these are often kept at the patient bedside rather inside notes. They also stated that needs and preferences will be recorded on the patients notes to further support the passports, but we did not see evidence of this during the inspection.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that they could circulate a message on the computer system to ask for any staff members that could speak a required language to support with patient communication. Staff told us that this was usually responded to quickly if someone could speak the desired language. They could also access a specific translation service if required.

Staff had access to communication aids to help patients become partners in their care and treatment.

There was a chaplaincy service available at the hospital to facilitate any support patients and/or families may require

Medical care (including older people's care)

The hospital had a complex needs team that staff could contact for support with patients who had complex or challenging needs. For example, one staff member told us they had sought support from this team regarding a patient who was subject to DoLs to ensure all documentation was present and correct on the ward.

Staff told us that they could access whiteboards to help patients communicate who may struggle to do so verbally. Staff could also access writing aids so patients could write things down for staff.

Staff were also able to help patients with things like hearing aid battery replacements which often helps with communication.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up.

During the inspection we followed the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine which treatment pathway was required.

We observed on gate 12, three patients that were admitted to the unit that had to wait in the corridors until beds became available. Staff we spoke with told us that this was a normal occurrence for the unit. Staff on gate 41 also told us the workload was enormous and there were not enough beds for patients that needed them, this would result in additional beds being put into already full bays, or patients being left in corridors. Staff told us they were extremely pressured. Following the inspection, the trust informed us that they have a recognised and risk assessed extra capacity plan, the additional beds included in this plan all have adequate safety, privacy and dignity measures in place.

Length of stay was normally 48 hours for patients on gate 12. We observed some patients' length of stay had been extended due to access & flow issues throughout the trust. One patient had been on the unit for 10 days. Extended length of stays were reported to the patient service manager for escalation.

Step down wards were used for patients who were medically optimised for discharge but may still need rehabilitation or extra support arrangements for going home. These wards were supported by discharge coordinators to facilitate discharge to all areas for ongoing care.

The hospital had significant capacity problems with available beds due to the high number of patients who were medically fit to go home, but there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID-19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

Managers and staff worked hard to make sure patients did not stay in hospital longer than they needed too. However, staff told us that the problem due to the difficulty with arranging ongoing care in the community. The staffing shortages within adult social care providers had a detrimental effect on the whole system of access and flow for medical care.

On the first day of the inspection, the hospital had 137 medically optimised fit for discharge patients (MOFD) and 191 were super stranded. The NHS defines a super stranded patient as someone who has spent 21 days or more in hospital.

Managers recognised the impact that delayed discharges were having on flow in the service and were aware of the poor flow through the wider care system locally. They had discussed improvement plans with social care colleagues and felt there was a high level of system working towards resolving these issues.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this. Patients waited longer than 14 hours to see a consultant.

Leaders were aware of the current status of the service. Managers and clinical leaders held meetings throughout the day to discuss this and during these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

Staff told us they tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were regularly moved between wards at night.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, this was often impacted by issues in the community which was out of the trusts control.

Managers and staff started planning each patient's discharge as early as possible and there was a dedicated discharge team to support with complex discharges.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. However, given the significant strain on capacity in services it was not always possible to do this.

The trust had commenced a system development of an integrated transfer of care team incorporating members of the hospital discharge team, social care, local authority housing, mental health professionals, voluntary sector etc to better support patients discharge pathways.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The trust shared with us data for complaints and compliments received between April 2021 and March 2022. 45% of all complaints the trust received were related to the division of medicine and 28% of compliments received related to the medicine division.

Information sent from the trust showed that complaints were investigated, and themes were identified. The themes were around inappropriate discharge, coordination of medical treatment, lack of explanation of care, poor nursing care and staff attitude.

Medical care (including older people's care)

The trust shared with us the last three complaints and responses received into the division. They showed that complaints were investigated, and responses were sensitive and apologetic where appropriate.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had oversight of the service. Leaders understood the priorities and risks the service faced at ward level. Staff told us they were visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take in more senior roles.

The division of medicine was led by a director of operations (DOP), clinical director and two assistant directors of nursing (ADoN).

The service had some good examples of leadership at location level. All staff we spoke with gave positive feedback about their ward managers and matrons. Staff told us they felt supported and the ward leaders told us that they felt very supported by the senior leadership team. Staff told us how some of the senior leaders went back to support clinically at ward level during the pandemic.

Leaders understood the issues the service faced; however, actions were not always effective. For example, staffing pressures were evident throughout the medical division and the management of this was to move staff from fully staffed wards to wards that were short staffed. Staff told us this often impacted on patient care especially when managing high risk patients requiring 1:1 care and patients at risk of falls. Senior leaders told us that they move staff across the whole trust based on skills and competencies, but this was not reflected in what staff told us. Staff we spoke with said the redeployment of staff was particularly challenging for newer members of staff.

Medical care (including older people's care)

Following feedback from CQC about the number of patients being nursed in bed on our first visit, leaders commenced a working group led by the inpatient therapy service lead, comprising of divisional nursing, therapy, manual handling and corporate nursing teams. The trust identified objectives for improvements and stated that senior divisional nursing teams would monitor daily. Senior leaders told us the last two years focus had been on caring for unwell patients and supporting patient discharges and therefore the culture had shifted away from rehabilitation.

The trust offered an RCN (introduction to leadership programme) for band 3 and 4 non-medical professional workforce to support, develop and enhance their confidence as leaders. Including an RCN (developing leadership programme) for band 5 non-medical professional workforce to develop leadership skills that will help them progress into senior positions with an emphasis on self and practice improvement.

Staff at band 6 level had the opportunity to undertake the skills in practice programme. This was offered as an in-house leadership programme delivered over four months with a mini service improvement project. This programme supported registrants to become more confident with a range of situational leadership skills with practical tools and problem-solving techniques.

The trust told us that staff could access the strategic leadership programme. This programme is delivered over a seven-month period to senior leaders. With a focus on the leader within, leading teams through change and empowering and developing staff.

We spoke with leaders at ward level. They showed great leadership and understood the challenges faced by the division. Managers in the respiratory division showed very high acclaim for the matron. They said that they all felt extremely well supported by her and her presence was very much recognised and appreciated.

The manager of gate 11 told us it was a challenge getting all staff trained and competent in all areas of specialisms such as NIV, tracheostomy and chest drains. However, this was ongoing work and with the help of the clinical educator the training was taking place.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The medicine division followed the trusts overall vision and strategy. There was a current five-year strategy in place for 2017-2022 with a vision to achieve an excellent patient experience each time. This was complimented with the Mid Yorkshire (MY) quality strategy which described the trusts ambition for improve quality, realising our ambition of an excellent patient experience and sets out the high level plan for doing so, ensuring the services meet the needs and expectations of the community we serve.

The medicine division ensured that there was a direct correlation from the divisional operating plans for each year with the trust strategic objectives directly linked to the vision and strategy (alongside the quality and digital strategy elements) which the trust executive team and trust board oversee on a yearly basis.

The trust had values to support their vision. These were caring, high standards, improving and respect. Staff that we spoke with knew what the values were.

Medical care (including older people's care)

Progress of the trusts vision and strategy was monitored through various governance meetings at operational level.

At ward level, leaders shared with us ward improvement plans that identified targets and visions for improvements.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The trust shared the most recent staff wellbeing and engagement action plan (June 2021 – April 2022) which included concerns raised by staff, actions to address with responsible named leads and action dates.

The trust had several recruitment options which included graduate nurse recruitment and retention, international nurse recruitment and retention, recruitment and retention of experienced nurses which included, suits you, return to NHS, trainee/nursing associate apprenticeship and retention, degree nurse apprenticeship and degree nurse top up.

The trust told us that they offered an internal transfer scheme, this was to support the development of a career portfolio, enabling staff to transfer to other clinical areas within the organisation as a vacancy arises, if staff met the agreed essential criteria.

The trust has a comprehensive Bullying and Harassment Policy which is up to date and is accessible to all staff on the trust Intranet. The policy sets out a clear commitment to eliminate all forms of bullying and harassment.

Managers reported that in the initial months of the pandemic, there was a reduction in the reporting of incidents of both bullying and harassment This is understood to have largely been sustained, with figures collated in August 2021 showing a reduction in incidents involving all staff.

The trust recently noted an increase in the numbers of incidents being reported and some trends were identified in terms of violence and aggression towards staff from patients and families. The trust said they were actively working for improvements in this area.

There was a staff wellbeing hub set up through the upcoming ICS which was centrally funded and allowed staff to access training packages as well as support.

Managers we spoke with reported a good working culture within their teams and above to the senior leadership team. However, some staff that we spoke with said that it was difficult to feel valued when they were working under immense pressure regularly and nothing seemingly changed day to day.

Staff told us that the trust rewarded all staff with £50, an extra day holiday and a medal in response to the pandemic. Staff told us this had made them feel very much appreciated and was very much a well-received boost to morale.

The trust had set up areas that were appointed as ‘wobble/common rooms’. These safe spaces were set up to be a rest, relaxation, reflection and recuperation spaces for staff. The numbers of rooms had reduced since the height of the pandemic, but staff we spoke with told us that they could access these areas if they needed too.

The trust appointed a clinical psychologist to work on staff services before the pandemic which meant the trust were in a strong position to support staff during the pandemic. The team was increased and expanded during the pandemic, but the service is still nearly at capacity.

The trust had MY Wellbeing Matters Service in place which allowed staff to access rapid intervention from trained psychologists.

Ward leaders spoke highly and with pride about their teams working on the wards, especially through the pandemic.

Staff we spoke with were mostly complimentary about the culture of their wards. Staff said they felt very welcomed into their teams and that there was no perceived division between substantive staff and agency staff. Staff mostly said they felt that they were valued members of their teams and that all colleagues worked very well together to support each other. However, some staff we spoke with told us that they felt extreme pressures due to their workload and felt they had to just get on. Ward managers were described as compassionate visible, and the education and development opportunities available were said to be invaluable.

The trust provided evidence to support work initiatives to support staff health and wellbeing. For example, senior nurse huddle, wellbeing conversations and supporting ward managers. Team of the week and MY star awards nominations were introduced within the division to recognise teams and individuals. They also had initiatives such as 'Proud clouds' and a cup of kindness to help support staff to know they are recognised and valued.

The division reviewed the most recent staff survey and identified the key areas surrounding, visibility and engagement, safety and governance and speciality specific actions

The trust had a designated freedom to speak up guardian and staff we spoke with knew how to contact them if needed.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The trust shared with us meeting minutes for the division of medicine governance meetings. These occurred monthly and showed good attendance from the assistant director of nursing, clinical governance manager, head of governance, matrons and consultants. They discussed ongoing issues such as staffing and discussed items for the risk register.

Managers meet monthly for quality assurance meetings, information from these is then cascaded amongst their teams.

The trust shared with us minutes of the divisional clinical governance meeting for February 2022. Items for discussion were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. These included mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

The trust developed and implemented alternative governance arrangements for the division which was adapted and flexed to the needs of the division throughout the pandemic. A divisional bronze structure was rapidly implemented during the pandemic. This was flexed to meet the needs of the division to ensure rapid decision making and dissemination and cascading of board to ward information. This currently remains twice weekly.

Medical care (including older people's care)

The division established a COVID 19 response team to compassionately manage the duty of candour process and patients medical and nursing reviews where hospital onset COVID 19 infection (HOCI) was identified. The governance arrangements for this team were developed and were in alignment with the serious incident framework. Senior leaders told us robust COVID-19 governance arrangements were developed and implemented which included a quality impact assessment process for service changes during the pandemic.

Skilled members of the corporate team would complete monthly ward health check audits for the division. Senior leaders receive the audit results on a monthly basis, who meet with ward managers and matrons to discuss. Discussion is reflected in ward improvement plans to ensure these are aligned. Improvement plans are part of matron and ward managers one to one meetings.

Ward health check audit results within the division highlighted good levels of compliance surrounding resuscitation trolley checks (87%) and average compliance on the audit question in relation to the storage of equipment in unlocked storerooms (80%) .The audits showed low compliance in relation to skin assessments which was at 70% and this was recognised on the risk register.

Ward leaders told us they have a specific job description and were clear about the role they played in the governance of their area.

Learning from incidents and complaints was cascaded to staff from ward leaders. Staff we spoke with told us the process for how this happens.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Ward level leaders had good oversight of their team's risks, issues and performance through ongoing ward level audits and improvement plans. All leaders that we spoke with talked about their ward's top risks. The trust had also implemented the display of 'MY Quality' boards on the wards. This included information such as the wards top risks, ward health check score, key ward performance metrics and things to improve. The board also captured things to celebrate and the wards rising stars.

Ward managers we spoke with told us of the individual ward risks. These were predominately based around falls, staffing and pressure ulcers. When we revisited following the initial inspection, each ward had a large board on the wall which highlighted those wards top 3 risks at that time.

Divisional meeting minutes showed that the highest risk at across the division was bed availability, this was reflected in the risk register shared with us. The risk register showed risks were reviewed regularly.

Skilled members of the corporate nursing and quality undertake ward health check audits to monitor and improve practice. Leaders told us that the results are monitored, and they look for trends, themes and positive performance and sustained performance.

The senior leadership team and ward level leaders were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

Senior leaders demonstrated understanding of the trusts risk register. The items they told us that were the biggest risks for the division were reflected in the risk register. All the risks had action owners, updates on progress, mitigation, and review dates.

Senior leaders told us patients who require enhanced care, were continuously risk assessed using the workforce they have to staff this. If leaders were unable to support requests, then the risk assessment is reviewed and recorded with the mitigation and decisions. Where this occurs, this is then uploaded onto the incident data IT platform. The complex care team support the wards. Enhanced care decision making is discussed at bed meetings, senior nurse meetings for requests to be escalated and managed. Despite leaders telling us of the overarching protocol for management of enhanced care, some staff told us that when they escalate short staffing issues and difficulties managing 1:1 care, some ward leaders would tell them they have to just get on with it.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trolleys were left unlocked on all the wards we visited. Multiple computers with personal information were left open with staff identification cards.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Wards had staff engagement boards that included general information about their ward's performance in various areas.

Wellbeing conversations were mandatory for all staff wishing to have this conversation and was an opportunity to access support and advice from colleagues/ managers/ mentors in relation to dealing with the challenges over the last year and to help build resilience. Wellbeing was also an area covered within the pastoral visits and all the trusts practice educators were trained to coach and empower staff to seek the right level of support for their circumstances.

The deputy director of nursing met with ward managers weekly, providing a chance for ward managers to express concerns they had or ask for advice and support on issues they had been altered to.

Matron meetings were arranged monthly to provide opportunity for the divisional and corporate matrons to talk through issues in an action learning with the deputy director of nursing.

Ward leaders spoke proudly of how staff at ward level were recognised for hard work. They had displays such as a proud cloud which would name one member of staff and had boxes for staff to write why they were proud of their colleague.

The trust had appointed a wellbeing guardian who was a senior member of the executive team. This demonstrated that they had a commitment to support staff health and wellbeing within the trust.

Staff that we spoke with told us they were very well supported to develop and progress within their careers if they wished to do so.

Family and friends test boxes and posters were displayed on each of the wards we visited, this gives patients and their families the chance to give open and honest feedback about their care.

Senior leaders were visible within the service and ward level managers gave example of times that leaders had supported clinically during the COVID-19 pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Ward leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

Staff told us the clinical professional development team has created a bespoke support package to develop skills and knowledge and leadership across division of medicine wards.

New Frailty champions had been identified for each ward with a significant interest shown by staff for this role.

Staff told us that dementia friendly activities and afternoon tea was an activity in place prior to the COVID 19 Pandemic. This was paused during the main waves of the pandemic but as soon as it was safe to do so, it was recommenced. This supported patient experience and engagement with activities.

The trust told us that they supported staff to deliver within their roles. They had implemented a band 8 management programme with the aim to ensure the managers new and experienced could develop their practice as managers within the ward and community environments.

The trust had a variety of progression opportunities for staff of all grades. They all had different outcomes such as to enhance confidence as leaders, to develop skills that will help them progress into senior positions and a clinical leadership programme taught at master's level.

There were also learning opportunities for senior staff with a focus on the leader within, leading teams through change and empowering and developing staff.

The trust told us that they had an initiative called ‘legacy mentors. This post allows experienced nurses to stay within the organisation to support early years nurses post qualifying to ensure their skills and experience was not lost from the organisation. This also offered the retirees a period of working whereby there was more flexibility and accommodation for commitments/ conditions that prevented them from continuing in a patient facing role.

The trust had a recruitment and retention framework 2022-2027. They told us that the focus of this was to look after staff and help them to feel they belong in the NHS.

Maternity

Good ↑

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service did not always meet the trust target for mandatory and role specific training.

The mandatory training was comprehensive and met the needs of women and staff. We saw whiteboards in various managers offices displaying compliance levels for the completion of mandatory and core specific training courses. Mandatory training included infection control and equality and diversity and core specific training included conflict resolution, resuscitation and medicines management.

All staff we spoke with confirmed they had received, and kept up to date, with their mandatory and core specific training.

The overall compliance for mandatory training across the maternity service was 91.5% for April 2022. However, compliance rates against mental capacity act level 1, fire safety and information governance did not reach the trust target of 90% for April 2022.

The overall compliance for midwifery core specific training across the maternity service was 84.1% for April 2022. The compliance rates against consent, mental capacity act level 3 and patient safety did not meet the trust target of 85%.

In 2020 the trust paused the requirement for mandatory training due to the main priorities of patient safety during the pandemic responses and this impacted on compliance rates.

Midwifery and medical staff completed a range of multidisciplinary team (MDT) maternity skills and drills training. This included cardiotocography CTG monitoring, situational awareness, human factors, practical obstetric multidisciplinary training (PROMPT) and maternal acute illness management (MAIMs).

There were two clinical educators who delivered MDT simulation training for medical emergencies such as eclampsia and fetal bradycardia. They told us this was based on feedback from skills and drills, incidents, audits or complaints.

Medical staff attended weekly departmental training which was protected time. However, they did not always have protected time to complete mandatory or role specific training due to staff shortages. For example, the compliance for fetal monitoring training was 80% which was below the trust target of 90%. We reviewed the 2021 results of the General Medical Council National Trainee Survey (GMC NTS) which showed the trust scored significantly worse than the national aggregate for study leave.

Managers told us they monitored mandatory training compliance on a monthly basis and alerted staff when they needed to update their training by email.

Maternity

Safeguarding

The service did not always meet the trust target for level 3 adults safeguarding training. However, staff understood how to recognise, report and protect women from abuse and the service worked well with other agencies to do so.

All staff we spoke with confirmed they had received, and kept up to date, their safeguarding training.

We saw whiteboards in various managers offices. These displayed high levels of compliance with children and adult safeguarding training (levels 2 and 3) for triage and labour ward for April 2022.

Midwives undertook refresher safeguarding supervision training four times each year and compliance rate was 96%.

For May 2022, the overall compliance for adult and children safeguarding level 1 and 2 training was above the trust target. However, the compliance against the level 3 core specific adult safeguarding training was below the trust target.

The service had plans to deliver a new training program to all staff which was based on domestic abuse, stalking and honour-based violence (DASH 2009).

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They had access to safeguarding relating guidance including female genital mutilation (FGM) which referenced appropriate legislation and evidenced based practice.

All midwifery staff and most medical staff knew how to make referrals to the named safeguarding lead or manager.

The service ensured maternity areas were safe and every door was securely locked. We observed staff being compliant with ward security by using security passes and asking women and visitors to use the CCTV/intercom system.

Staff had a clear guidance to follow in the event of child abduction. The service completed a child abduction simulation exercise in April 2022 in which learning points were identified, immediate actions completed and shared with staff as part of the MDT safety brief.

The service displayed safeguarding posters with local safeguarding contact numbers for anyone concerned about the welfare of any individual.

We reviewed electronic records and patient whiteboards which included a symbol to notify staff if women and / or families were subject to a child protection or child in need plan.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Maternity

The service performed well for cleanliness. We reviewed cleaning schedules which outlined when, what and how areas were cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, and monthly audits showed high compliance rates. The domestic supervisor also carried out audit checks of cleaning standards and cleaning record completion.

We reviewed hand hygiene audit results which showed the compliance had improved in the last six months and showed high compliance against the trust target of 98%.

Staff followed infection control principles including the use of personal protective equipment (PPE) and being compliant with bare arms below elbows. There were hand gel sanitisers on the entrance to all areas and hand washing facilities. We saw hand hygiene posters above sinks to provide a visual guide to hand washing.

Staff cleaned equipment after patient contact and labelled equipment with an “I am clean sticker” to show when it was last cleaned.

We received information from five women who said that the cleanliness was “very clean” and “outstanding”.

Environment and equipment

The service did not always maintain, service or replace equipment. Software licences had expired on cardiotocography (CTG) machines which had also exceeded their lifespan. However, the design and use of facilities and premises kept people safe. Staff were trained to use equipment and managed clinical waste well.

Women could reach call bells and staff responded quickly when called.

We observed a theatre alarm being activated with an appropriate response from available staff.

The design of the environment followed national guidance.

For example, there was a triage service available to assess women before transfer to the antenatal ward or birthing rooms to reduce unnecessary admission. We saw direct access ‘emergency only’ routes from the wards and triage area to three obstetric theatres for emergencies. There was a four bedded recovery area next to the labour ward.

The service had suitable facilities to meet the needs of women's families. For example, one ward was split into antenatal and postnatal areas. All women in confirmed labour were admitted to a single birthing room with en-suite facilities and birthing pools were available. We saw gasses were piped into these rooms. All rooms had emergency pull cords. There were side rooms for women whose babies were on the nearby neonatal ward.

Women, and families could utilise quiet rooms in outpatients and a bereavement suite on the labour ward in the event of a bereavement. However, this ward did not have a separate exit.

There were accessible toilets for people with limited mobility.

We observed that staff were assigned to complete equipment checks at daily meetings / safety huddles. Staff completed appropriate daily safety checks of emergency adult and neonatal resuscitation equipment.

Most electrical equipment had been safety tested within the last 12 months.

However, we found a Mindray machine which had expired the service date of March 2022 and a cardiotocography (CTG) machine had expired the service date of July 2021. This meant there was a risk of staff not being able to accurately monitor the fetal heart rate pattern to assess the wellbeing of the baby and identify any signs of deterioration.

We escalated this immediately to managers who explained the CTG machines had reached the end of their 7 to 8 year lifespan. This meant there was also an increased risk of equipment failure.

The service had CTG machines waiting to be dispatched. However, we heard varying reasons for this delay from managers such as no electronically interface screens or laptops or trolleys were available. The risk register provided more information that the software license used to analyse the CTG data remotely had expired. This meant the service was not meeting the national guidance recommendations. There was an increased risk of women being transferred or admitted unnecessarily and an increased risk of human error when reviewing fetal heart rates.

The trust used an equipment management system to monitor the maintenance and service history for all medical devices. We reviewed an audit of three months compliance for high, medium and low risk maintenance completion. The trust did not meet the trust IPEM standard target of 80% for December 2021 or January 2022 for medium and low risk maintenance completion. This was due to absence and operational pressures from the Omicron COVID-19 variant. In February 2022 we saw that these rates had improved and were over the trust target.

We reviewed the risk register information which contained the risk for CTG machines.

Community midwives had access to emergency equipment at the hospital. The service had a lone working policy.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. They identified and quickly acted upon women at risk of deterioration

Staff used a modified early obstetric warning score (MEOWS) and Newborn Early Warning Trigger & Track (NEWTT) to identify women and babies at risk of deterioration.

The service had appropriate escalation policies in relation to a deteriorating patient, such as emergency evacuation from a birthing pool and sepsis management. Staff had access to the A&E department and cardiac arrest team.

The sepsis pathway was embedded in maternity care and staff were reminded of the guidance and appropriate escalation, at daily / safety huddle meetings.

Staff completed regular risk assessments in line with local, system wide and best practice guidelines. We saw assessments completed for high BMI, gestational diabetes, eclampsia and venous thromboembolism (VTE). We saw an example of when a referral was made to the antenatal hospital clinic for a woman who had a raised BMI and was an ex-smoker, which was line with National Institute for Health & Care Excellence (NICE) guidelines.

Women were asked about their general health and emotional wellbeing at every appointment and this information was updated onto their maternity personalised plan.

Maternity

Staff would follow guidance to discuss the risks and benefits for perinatal care including preferred birthing location. Perinatal care is the period of time from pregnancy to up to a year after giving birth.

Women who were considered as low risk were offered to be reviewed in community and / or hospital antenatal clinics. They had a provisional plan to give birth at home, or at the Bronte birth centre (which is a standalone service) at Dewsbury or Pinderfields birth centres (which is an alongside unit).

Women who were considered as high risk were reviewed at the consultant led antenatal clinics at Pinderfields and cared for by the continuity teams with a plan to deliver at Pinderfields hospital.

There was a screening clinic which was used to complete antenatal screening checks such as blood pressure, pain or for reduced baby movements. We observed two members of staff demonstrating the best practice of 'fresh eyes' approach when reviewing fetal heart tracings at an antenatal screening clinic.

Women were instructed to call the birth centre or midwife when they commenced labour and were told where to attend depending on their personalised plan and the current staffing and acuity situation.

The service had 24-hour access to mental health liaison and specialist mental health support if there were any concerns about a woman's mental health.

We observed staff using the situation, background, action and result (SBAR) framework to complete appropriate handovers. This meant all necessary key information was shared to keep women and babies safe when handing over their care to others.

We requested but, did not receive the audit results relating to Maternity at the time of writing this report. However, following the inspection the trust provided results from recent audits and these showed mixed results when compared to the previous audit results in 2020. For example;

- There was a significant improvement in the documentation of risk assessments on admission "Intrapartum/ Antepartum Fetal Heart Monitoring and Fresh Eyes". However, standards had deteriorated for documenting the 30 minute reviews and two hourly coordinator reviews.
- There were significant reductions for woman waiting less than 24 hours for artificial rupture of membranes however, there was unclear evidence of consistent communication regarding the risks associated with induction of labour. There were also delays in starting the induction process and the trust were auditing these reasons and had put appropriate recommendations in place.

However, the trust did not submit audits for the world health organisation (WHO) surgical safety checklists.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

We reviewed data for planned versus actual staffing information for each ward / unit and this showed regular staffing gaps within the rota's for both registered nurses and healthcare assistants. The service did not display the data in meaningful way. It was not RAG colour rated to show when the actual matched the planned number of staffing.

Maternity

Managers told us they reviewed and planned midwifery staffing to meet a midwife to birth ratio of 1:24. This was based on the most recent Birth rate plus (BR+) acuity assessment in May 2020 and national guidance recommendations. The Trust made significant investments in the midwifery workforce in summer 2020 to meet the Birthrate Plus recommended planned staffing models.

At the time of the inspection the service was following the staffing escalation policy. We observed the manager of the day holding multiple daily staffing meetings to assess midwife staffing levels across all three hospital sites using the BR+ tool. They were focused on providing safe care ensuring a ratio of one midwife to one woman in established labour and discussed the numbers of women in labour and numbers waiting for artificial rupture of the membranes (ARM).

We reviewed the average midwife to birth ratio which was 1:26 for the last six months for the maternity service.

Managers adjusted staffing levels accordingly to manage the risk. They redeployed staff from the community, continuity and birth centres to support the Pinderfields labour ward and antenatal and postnatal ward. This meant that the Dewsbury birth centre was regularly closed.

Managers told us they would plan the rota one month in advance and checked weekend staffing establishments in advance.

We reviewed the maternity dashboard. This showed the planned versus actual midwifery staffing levels for only the antenatal and labour wards with an 81.8% fill rate for the year to date. However, the maternity data contained an error and we do not know if this rate was correct. We did not know if these unfilled shifts were filled with bank or agency staff or redeployed staff.

The service had two continuity teams who provided antenatal, intrapartum and postnatal care to women identified as low risk wishing to birth at Bronte Birth Centre. This service was under monthly review following the recommendations of the Ockenden report and had recently been reduced from three to two teams.

The Community Matron and Managers reviewed community midwifery caseloads per quarter; making adjustment as necessary to maintain caseload size to approximately one RM to 98 per year. In 2022 the caseloads were slightly less that the nationally recommended average per year to facilitate the planned sessional rotation. In March 2022 the community midwives had a caseload of 1:56.

Community midwives told us that when they were on-call they could be supporting births at home, in birth centres, or at maternity units depending upon staffing escalation. They reported this was impacting their time to deliver community care for woman.

We were informed the service had a high vacancy rate of approximately 16 whole time equivalent (WTE). The service had an active running recruitment advert for midwifery staff.

The average turnover rate was 1.5% for registered nursing and midwifery staff and 1.6% for unregistered support workers. This calculated as 1.5% average turnover rate for the maternity service. We were told the turnover rate was higher compared to previous years. The main reasons given by midwifery staff for leaving was retirement, reduced hours, further education and training and relocation to smaller units.

We saw current sickness levels displayed on governance and learning boards. For example, 11% on the antenatal and postnatal ward and 13% on the labour ward. In April 2022 the average sickness rate was 12.5% for registered nursing and midwifery staff and 8.5% for unregistered support workers. This calculated as average sickness rate of 10.5% across the midwifery service. We heard that the January 2022 sickness rate was more than double the rate in January 2021 (5%).

Managers told us they would request bank and agency staffing from NHS Professionals (NHSP) or PULSE a leading recruitment agency for the UK healthcare sector. They preferred to use staff who were already known to the service and who had already completed their full induction.

In March 2022, 7,198 hours were covered by bank and agency staff with 91% of shifts were covered by NHSSP and 9% were covered with agency.

Medical staffing

The service did not always have enough junior medical staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We saw medical staff working on the antenatal and postnatal wards, labour wards and on the triage unit. There was consultant led antenatal and postnatal clinics in the women's health outpatient's department. Medical staff could support the birth centre which was a midwifery led unit (an alongside unit).

Managers told us they would request bank and agency locums when they needed additional medical staff. We reviewed locum use data submitted for locum Obstetrics and Gynaecology medical staff March 2021 to April 2022. This showed the grand total of 8105.53 hours were covered by locum staff. For March 2022 locum consultants covered 342 hours, locum senior registrars covered 128 hours and junior doctors covered 274.91 hours.

We reviewed the percentage of junior doctors allocated to each paediatric rota. In March 2022 there was only 82% of SHO's and 62% of registrars available to cover these rotas.

We saw a good skill mix of medical staff on each shift which included a consultant, senior register and senior house officer (SHO). They attended medical handovers, safety huddles and completed ward rounds. We heard that during staffing escalation periods consultants would step down to work as registrars.

Junior doctors felt supported by consultants who were available at all times and were visible on wards. They told us there was always a consultant on call during evenings and weekends. In addition, there were consultant and trainee anaesthetists available 24 hours a day.

The service informed us the Head of Clinical Service and Deputy Director of Operations were working on the new medical staffing model. They were aware of the challenges of medical cover on the triage ward especially if the labour ward was busy and this could lead to medical review delays and have a poor impact on patient and staff experience.

Following the inspection, the trust submitted additional information. This showed the average fill rate between January and June 2022 was 100% for consultant staff, 98% of specialist medical doctors and 84% for junior doctors. They reported that gaps were filled using substantive and locum staff. However, In June 2022 the trust achieved 90% fill rate for junior doctors which meant that not all shifts were covered.

Maternity

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

We reviewed eight electronic medical records which accurately recorded women's choices and risk assessments. All entries were electronically dated and timed. We reviewed an appropriate referral to an antenatal clinic based on risk.

Women could access, and contribute to, their online personalised maternity care plan. This included birth plan discussions, summaries of clinic visits, screening and other test results, contact numbers and details of future appointments.

All staff involved in the women's perinatal care could access women's medical records. The service shared discharge information in a timely way with women and GP's.

Electronic records were stored securely. We saw paper medical records in outpatient departments which staff said were tracked in and out electronically.

We observed staff maintaining the confidentiality of women. They locked computer screens when unattended, ensured printed confidential information was not left unattended and ensured conversations were discreet.

Staff told us health visitors issued the personalised child health record (red book) to each child.

The service's risk register identified a risk that community safeguarding information recorded before 2019 was not easily accessible if needed for any serious case reviews or litigation cases. This was partly due to the migration of paper records onto the trust's electronic record system however, the service was looking into possible solutions.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We saw two members of staff checking the dosage of a prescribed medicine on the postnatal ward.

The service displayed posters to remind staff about the process of; ordering medicines to take out (TTO) and prescribing medicines with approved patient group directions (PGDs). PGD's allow appropriately trained, nominated healthcare professionals to supply and administer specified medicines to pre-defined groups of patients without a prescription.

Staff reviewed women's medicines regularly and provided advice to women and carers about their medicines. We observed a medicine round on the antenatal and postnatal ward. This was one of four scheduled rounds to review medicines.

Staff completed medicines records accurately and kept them up to date. We reviewed three completed prescription charts in the service, two were completed accurately and one was missing the recordings of weight, allergy and venous thromboembolism (VTE) assessments.

Staff appropriately stored all medicines, including controlled drugs (CD) and medical gasses with restricted access to authorised staff. The manager of the day holds the key to the controlled drugs (CD) cupboard.

All medicines stock were in date.

The service had made improvements to the dispensing 'to take out' (TTO) medicines based on feedback from audits, patient feedback and CQC survey results with an aim to reduce discharge delays and poor patient experience.

We reviewed data for staff within the Family and Clinical Support Services Division which showed 94% of staff were compliant with level 2 mandatory training on medicines and was within trust target.

Incidents

Staff recognised and reported incidents and near misses. Managers shared lessons learned from incidents with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The service had a comprehensive incident reporting policy. Staff were aware of the importance of reporting incidents and raising concerns with managers. They knew what incidents to report such as maternity red flags and how to report them on the electronic incident reporting system. There were 31 datix raised in the last six months relating to staffing at the triage unit, however, we heard staff did not always report staffing issues on datix.

In the last six months, the service had two never events which were serious patient safety incidents. On the same day in January 2022 there were two incidents of retained swabs. In February 2022 there was a maternal death relating to obstetric haemorrhage and this was reported to the healthcare safety investigation branch (HSIB).

Managers shared safety incident information and lessons learned on ward / unit governance learning boards. The top three incident reported themes displayed were delayed induction of labour, blood loss of more than 1500mls and 3rd and 4th degree tears.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Staff met at monthly departmental team meetings to discuss the feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff. There were folders on ward/unit with weekly newsletters. However, we heard of two examples when managers had not received feedback from incidents their ward / unit staff had raised.

Managers reviewed, and discussed, incidents which were graded as moderate and severe harm discussed at the perinatal mortality review tool (PMRT) meetings.

We spoke with staff and reviewed 12 months of datix incidents which showed that staff were not always debriefed or supported following serious incidents such as an obstetric emergency. This was recognised by leaders as an area for improvement following clinical incidents and complaints.

Between 01 May 2021 to 26 April 2022, the service had submitted 14 cases to the healthcare safety investigation branch (HSIB), four were declined, six were ongoing and four were completed.

Maternity

We reviewed the safety recommendations following three HSIB investigations and the associated actions plans for the service. One of the recommendations was to ensure recognition of an abnormal antenatal cardiotocography (CTG). This was concerning particularly when we have still found during our inspection concerns about the equipment which could impact on staff's ability to detect deterioration of the baby.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We saw national guidance posters and flowcharts on wards/ units.

The safeguarding guidance including female genital mutilation (FGM) which referenced appropriate legislation and evidenced based practice. The emergency escalation policy was in line with national guidance and Ockenden report recommendations (2020).

The service would update policies and deliver training when best practice and new guidance was released. For example, the preterm labour birth guidelines and maternity skills training were both in line with the Saving Babies' Lives Care Bundle version 2 (SBLCB v2) and National Institute for Health & Care Excellence (NICE) guidance.

We reviewed eight medical notes and received information from three women which demonstrated the service was managed in accordance with best practice and national guidance. Women were asked about their general health and wellbeing at every antenatal appointment, and they were given a named midwife throughout their pregnancy.

The trust had an operational plan for the Bronte and Pinderfields birth centres which complied with the "safer childbirth; minimum standards for the organisation and delivery of care in labour" guidelines from The Royal College of Obstetricians and Gynaecologists (RCOG).

We observed managers sharing safety alerts, the guideline of the week (safe administration of Oxytocin) and message of the month (sepsis) at safety huddle MDT meetings.

Staff told us the transitional care policy had recently been rewritten to include new escalation protocols for women needing medical input at the antenatal clinic at Dewsbury. The current version had a review date of March 2021.

Most staff we spoke with knew how to access policies for guidance. However, one midwife was unaware of the escalation policy and would just contact the on-call team if medical assistance was required.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. Staff we spoke with had completed role specific training on the mental capacity act however, the compliance rate for mental capacity act training did not meet the trust target.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers.

The service demonstrated full compliance with all elements of the saving babies lives care bundle (version 2) and submitted their final local maternity system (LMS) survey in June 2021. The standards had been successfully implemented for;

- reducing smoking in pregnancy
- risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
- raising awareness of reduced fetal movement
- effective fetal monitoring during labour
- reducing preterm births.

The service had self-assessed its position in response to the final Ockenden report (2022) against all 93 recommendations across 15 immediate and essential actions. They had 55 actions which were RAG rated green; 25 actions which were RAG rated amber and 7 actions which were RAG rated red. The service provided a monthly report to the Maternity Surveillance Group which detailed progress, gaps and challenges in achieving, and embedding, all essential and immediate actions.

The service had also recruited a clinical educator to implement cardiotocography CTG training for medical and midwifery staff.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women's religious, cultural and other needs.

Staff completed regular comfort rounds to make sure women had enough to eat and drink.

The antenatal and postnatal ward provided a schedule of the times when breakfast, lunch and tea would be served to women. If women had missed a meal due to being transferred, they were offered food and a warm drink.

We received information from three women who confirmed they could access water at all times. However, one woman said they did not always access water because "staff seemed busy".

There was a range of menu options available which included special dietary requirements. The service also displayed information where food and drink was available to purchase.

We saw posters displayed on the antenatal and postnatal ward which were dedicated to breastfeeding and including best feeding position, nine steps to a successful feed and available support.

Staff told us women were provided with breastfeeding guidance prior to discharge. The service had a breastfeeding specialised midwife and a peer supporter programme. We spoke to one woman who said they were supported by staff with breastfeeding /bottle feeding their baby.

Community midwives visited the women's home on the first day and then it depended on whether they were breastfeeding or bottle feeding as to when they arranged their second visit.

The success rate for women commencing breastfeeding was 69.9% across the maternity system in the last 12 months. This did not meet the national target of 76%.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

We received information from three women who had requested pain relief during labour, two said it was managed well and one said there was a delay receiving it.

Staff told us that women in birth centres could use the birthing pool to help them manage their pain. There was a consultant anaesthetist available 24 hours seven days for women who required epidurals.

The service had a task and finish group to improve the delays in prescribing pain relief medication. As a result there is a new process which is being embedded and the last audit showed 97% of medicines were given on time.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women. The service had been accredited under relevant clinical accreditation schemes.

The service carried out a comprehensive programme of audits however, due to system pressures audits was suspended for two months in January and February 2022 and recommenced in March 2022.

Managers told us they completed regular environmental which were all satisfactory with no themes. They audited all aspects of care and the results showed staff did not always complete risk assessments or document discussions on the antenatal and postnatal and labour ward.

The service auditing the use of the new Birmingham Symptom-specific Obstetric Triage System (BSOT) on the triage unit. The results for December 2021 showed that 98% of women were seen within 30 minutes.

We obtained information from national clinical audits which demonstrated the service complied with all ten safety actions in the NHS Resolution Maternity Incentive Scheme.

The service achieved 100% compliance for the last four pain management audits. This was based on pain management recorded discussions, if pain relief was received within 30 minutes of request and if an epidural was received within 30 minutes of request.

The service had completed an audit in 2021 to measure response times to maternal epidural requests between July and November 2020 for the labour ward. This showed anaesthetists attended 80% or over within 30 minutes (results: 98%) and 90% and over within 60 minutes (results: 100% by 60 minutes inclusive).

Maternity

We reviewed the National Neonatal Audit Programme (NNAP) for this hospital which was published in 2020. The results showed a 96.9% compliance for giving at least one dose results of antenatal steroids to babies born between 23 and 33 weeks against 92.7% for a similar sized unit.

The service carried out an audit to show the postnatal readmission rate was 0.4% for the number of postnatal women who attended the triage unit between January and March 2022. However, the trust was unable to make comparisons with similar sized services.

We also saw examples of how the trust bench marked against the healthcare safety investigation branch (HSIB) national learning reports and across the local maternity system (LMS).

The service had maternity dashboard to monitor clinical performance and governance and displayed a visual chart to monitor performance over the previous six months. It showed multiple activity indicators for every month such as the number of babies born before arrival.

The dashboard did not always show the comparison data for the trust, regional or similar sized services for all metrics. For example, managers were unable to compare the metrics for woman who required 3rd or 4th degree tears following vaginal births.

In addition, there was no visual traffic colour code system to use for benchmarking performance and this did not follow national guidance from Royal College of Obstetricians and Gynaecologists (RCOG).

Following the inspection, the trust informed us they used the data from a regional maternity dashboard data to measure the progress against national and regional trend data and discussed this at the maternity quality surveillance group meetings.

In the CQC maternity services survey 2021 the service scored better than expected for “Did a midwife or health visitor ask you about your mental health”. Women we received information from told us they were asked about their mental health at every appointment.

In the same survey the trust scored worse than expected for all five questions “whether the women had the opportunity to ask questions about their labour and their birth”, “whether they had skin to skin contact shortly after the birth”, “if concerns were taken seriously”, “if staff were able to help when they needed it” and “if their discharge was delayed”.

The CQIMS (Clinical Quality Improvement Metrics) data up until October 2021 identified areas of clinical quality improvement for the service which included reducing the number of women having a caesarean section with no previous births and women who had a postpartum haemorrhage (PPH) of 1500mls or more.

The number of women who had a post-partum haemorrhage of more than 1500mls was 4% which was worse than the Yorkshire and Humber region average of 3.4%.

Managers shared and made sure staff understood information from the audits using team meetings, safety huddles and weekly newsletters.

The service was accredited by UNICEF a baby friendly initiative and had completed stages 1 and 2 and were working towards stage 3.

Maternity

Competent staff

Managers did not always appraise midwifery staff's work performance to make sure they were competent for their roles. However, they held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. The service could develop individual plans for new starters if necessary.

On inspection we saw every qualified member of staff had a newly qualified midwife or trainee student working alongside them. Student midwives felt well supported in their role. All newly qualified midwives had 18 months to complete a competency booklet which had been created within local maternity system (LMS).

The trust employed specialist midwives for preceptorship and students. They managed a programme of continuous recruitment and provided support to new starters such as students, return to practice midwives and developed individual learning programs.

Managers supported staff to develop through yearly, constructive appraisals of their work. The professional midwifery advocates (PMA) wrote directly to every midwife to offer restorative clinical supervision if required.

The appraisal rates for midwifery staff was 68.9% and below the trust target of 85%. Management explained this was reflective of the high number of absences in the workforce.

Consultants and clinical supervisors supported junior medical staff to develop through regular, constructive clinical supervision of their work. The appraisal rates for medical staff were above the trust target of 95% consultants (including locums) and non-consultant grade and senior grade medical staff.

We spoke with two medical staff who said they had received great supervision.

Medical staff said there was little time for educational activities or study leave due to staff shortages.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

We heard positive examples of when staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge such as the new-born infant physical examination (NIPE). The trust had employed a specialist retention midwife to support career development and monitor staff experience.

There were high levels of staff redeployment, especially community midwives, onto wards / units with higher acuity women. We received varying information, some staff used this as an opportunity to keep up-skilled whilst other staff lacked confidence and skills in these high-risk areas. We heard the service had implemented a planned sessional rotation of community midwives, so they spend timing working on the labour ward rather than block periods of rotation.

Midwives were trained to worked in specialist roles for example, vulnerable women, young people, domestic violence, bereavement, safeguarding, perinatal mental health and breastfeeding.

Multidisciplinary working (MDT)

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Maternity

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed both the medical and midwifery night to morning handovers which had good MDT presence. They had clear, structured and detailed MDT communications in situation, background, action and result (SBAR) style. They discussed maternity personalised plans and high-risk patients.

We observed managers attending staffing escalation team meetings.

We observed safety daily huddle meetings at different times of the day. Staff in attendance discussed staffing updates and redeployment plans, the numbers of artificial rupture of the membranes (ARM's) and any safety briefings. These were minuted by the midwife of the day and anything of concern was escalated to the senior management team.

Staff we spoke with worked well together. However, we heard there was no MDT working between the birth centre and the antenatal day unit.

Managers had regular monthly meetings with GP's, health visitors and specialist midwives and the safeguarding team to discuss care for women and any safeguarding concerns.

Staff referred women for mental health assessments by the perinatal mental health (PNMH) team when they showed signs of mental ill health, depression.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards. There was always a consultant obstetrician and consultant anaesthetist on call for any obstetric emergencies.

Staff were supported by other hospital services such as mental health services, diagnostic screening and pharmaceutical help and advice 24 hours a day, seven days a week.

The service had a midwife on call who could provide support to women 24 hours a day.

Women were advised to call their chosen birth location at the onset of labour. If the birth centre was closed the calls would be diverted to the triage unit.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service displayed easy to read posters.

We saw information promoting healthy lifestyles and a list of support organisations. For example, we saw a poster encouraging physical activity for pregnant women and the importance of checking emotional wellbeing.

The majority of the posters had a website address or QR code links for people to obtain further information using their smart phones.

Maternity

The service had various initiatives to promote healthy lifestyles. Staff would assess women's health at every appointment and support any individual needs. There were specialist midwives to support women about smoking cessation, obesity and those dependent on alcohol or drugs.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty. However, not all staff had completed mandatory training on the mental capacity act.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available at every appointment. We reviewed two electronic records which showed a clear record of consent discussions such as place of delivery, method of delivery and any risks explained.

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004. When women could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff we spoke with said there had been a significant rise in mental health referrals since 2020. Perinatal specialist midwives supported women to ensure they have access to the right perinatal mental health support. We heard an example when additional support was given to women who had birth anxiety.

Staff we spoke with had completed role specific training on the mental capacity act. However, the compliance data for mental capacity training completion was below the trust target for levels 1, 2 and 3. This meant not all staff had completed mental capacity act training.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. They were welcoming and introduced themselves to women and their visitors.

Women said staff treated them well and with kindness. We received information from six women who all gave positive feedback "My midwife was amazing from start to finish", "Great overall care and treatment" and "felt very safe and in trustworthy hands".

Feedback from social media and friends and family tests (FFT) were all positive and confirmed that staff to be very caring.

We observed staff delivering personalised care to women and their family. They completed comfort well-being checks for women staying on the antenatal and postnatal wards. This had been introduced following feedback (FFT) and reported that positive feedback had increased by 50%.

We heard positive ways staff helped create a comfortable atmosphere during labour. For example, the birthing pools had mood lighting.

We received information from four women who confirmed staff respected their privacy and dignity "with complete respect". Staff demonstrated attention to detail when ensuring privacy and dignity of women and those accompanying them. For example, staff used privacy curtains for women in bays or kept doors closed and carried out conversations in private.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgemental attitude when caring for or discussing women with mental health needs.

Staff shared positive examples of how they understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. We received information from two women whose emotional wellbeing was checked and re-assessed by staff at every antenatal and postnatal appointment.

The service displayed many posters providing positive ways of supporting emotional health and wellbeing for example to new dads, partners and non-birthing partners and the birth mother in the babies first year.

Staff provided positive examples of when they provided emotional support and care to women and their families.

We saw examples of when staff discussed the emotional care of women during handovers and safety briefs.

Specialist bereavement midwives were available to provide additional support and bereavement follow up support to family members.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. The service was able to use areas on the ward which women and their families could use in the event of unexpected news. The labour ward had a dedicated bereavement suite situated behind closed doors at the end of the ward which had appropriate facilities.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Maternity

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service had a care pathway for women who were expecting twins or multiple births.

They demonstrated the need for sensitivity, individualised communication and good listening skills. Community midwives would continue to care for bereaved women and families at postnatal home appointments. Staff were able to signpost them to various charities and support groups.

We saw a poster which stated "we would like to remember the babies that are not here with us today that were lost in pregnancy, born sleeping or passed away in their first few weeks of life. We send their loved ones our deepest sympathies".

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their pregnancy care and treatment with clear information at every appointment.

Women could access their own Maternity electronic notes via a PC, tablet device or mobile phone and one woman had quoted it "contained details of each appointment, easier than keeping lots of paperwork".

We received positive feedback from five women who said they were able to ask questions at appointments, "they (staff) are great at listening" and two women who raised concerns during labour said they were taken seriously.

Staff provided examples which demonstrated an awareness of how they used different communication aids to speak with women, families and carers.

Women and their families could give feedback on the service and staff supported them to do this. The service displayed friends and family test posters and feedback cards and submission boxes were present on all the areas visited. There was also an option to leave feedback online or by QR code. All community laptops displayed accessible QR codes.

Women were supported to make informed decisions about their own care and treatment depending on the stage of their pregnancy. Staff recorded women's wishes and preferences as part of care planning processes.

We received positive feedback from four women who said they had enough information to decide their own pregnancy birth plan based on discussed risks and benefits "I felt included". Three women said that additional support was offered when needed but one woman said, "not always as staff who were looking after me looked overworked".

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Maternity

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care

Managers planned and organised services across all three maternity sites to meet the needs of the local population.

Staff made sure women were aware of alternative low risk birthing locations if their chosen birth centre was not open or if the community team were not available to attend a home birth. This was recorded as part of their care plan and women were advised to telephone the unit or their midwife when in labour.

Staff were able to plan home births, and postnatal appointment home visits, as part of the routine assessment. They also visited women in prison. We heard positive reviews about the continuity and community teams for example three women who said had a named midwife, but two women described it had not been easy to contact them.

This service had an operational plan which described the arrangements to ensure that antenatal, intrapartum and immediate postnatal care was safe and accessible for women who live within the Mid Yorkshire geographical areas.

The service displayed posters proving information and a list of support organisations, for women who felt isolated and had no support, were homeless or seeing asylum, were from an ethnic minority background and families who had children in care.

The facilities and premises were appropriate for the services being delivered. The service provided a free bus service for women and families which operated hourly between each hospital site from 8am to 8pm weekdays and 1pm to 8pm on the weekend and bank holidays.

There were beds available for the women's birthing partner to stay on the ward / unit.

There was a two bedded bereavement suite available on the labour ward.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems, learning disabilities and dementia. There were clear guidelines for referrals to the perinatal mental health team.

Specialist midwives provided additional care and support to women. For example, there were clinics for diabetes, fetal medicine, perinatal mental health, multiple pregnancy, pregnancy loss, infant feeling and birth matters. They review also women who were being cared for on non-maternity wards/ units.

In addition, the trust collected data which showed that there was a significantly high number of women using the service who were current smokers compared to the national average. In response to this the service had implemented a smoking cessation clinic.

Managers monitored and took action to minimise missed appointments. We heard of a recent quality improvement project where the service amended the content of the appointment letters to improve the 'did not attend' (DNA) rate.

Managers ensured that women who did not attend appointments were contacted by community midwives who would be able to re-book an appointment.

Maternity

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

The service had a complex needs team who provided the necessary care and support for women living with mental health problems, learning disabilities and dementia, received the to meet all their needs.

The trust collected data which showed that there was a significantly low number of women using the service whose babies had their first feed with breast milk. The service had positive examples to show this was being addressed such as employing a specialist breastfeeding midwife and an infant feeding clinic.

All women, and staff involved their perinatal care, had access to an online personalised wellbeing care plan "My Maternity notes". It detailed all pregnancy conversations such as preferred location of birth, test results and appointments and a weekly summary of what to expect.

Women were able to record the practical ways staff could provide additional support, for example declaring any known triggers which may exacerbate birth anxieties.

The service had a standard colour scheme for the patient whiteboards to identify different stages of pregnancy. There were symbols to identify women who required bereavement or breastfeeding support and anyone with a child protection or child in need plan.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. The service displayed easy read posters in accessible formats to meet the needs of women with sight conditions, learning difficulties or dyslexia. Most posters had a QR code for smart phone access for further information.

Information was available in all languages spoken by women and local community for example posters and discharge videos.

Managers made sure staff, women, loved ones and carers could get help from translation service interpreters or British sign language (BSL) when needed.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids, such as a white board and a pen and clear transparent masks, to help women become partners in their care and treatment.

Access and flow

Women could access the service when they needed it and received the right care promptly.

Woman we received information from had been offered a choice appointment dates and times for their perinatal appointments.

The continuity service ensured women were seen regularly throughout their pregnancy. The maternity dashboard showed an average of 7.3% of women were booked onto a continuity pathway over the last six months.

Managers were supported by delivery suite coordinators to manage the access and flow into the maternity service effectively. There were daily MDT meetings held to discuss the numbers and acuity for women who were planned for artificial rupture of membranes (ARM) or caesarean sections, unplanned and emergencies.

Managers worked to keep the number of birth centre closures to a minimum, and there were 138 closures between September 2021 and March 2022. During periods of staffing escalation these centres would close to allow staff to be redeployed to fill staffing gaps (and / or provide 1:1 labour

care). This was to ensure there was 1:1 care on the theatres, labour ward, antenatal and postnatal ward at Pinderfields hospital. From April 2021 to March 2022 99% of women experienced 1:1 care in established labour at Pinderfields hospital.

The Bronte birth centre would also close if the local ambulance service could not guarantee safe transfer to Pinderfields hospital which was a 15-minute journey.

The service had an escalation policy to deal with the management of an obstetric emergency and staff knew to phone 2222 and state obstetric emergency and location. Staff told us they received skills and drills training for birthing pool evacuation and neonatal transfers.

There was a triage unit at Pinderfields hospital for women who could be reassessed and medical reviews if they had any concerns. We saw a poster explaining how the triage system worked.

We heard that women, particularly those who did not have English as their first language, regularly turned up to the Bronte birth centre when it was closed. Managers told us there were signs on birth centre doors with the triage telephone numbers. We saw this new phone service at the triage unit which took all diverted calls from the closed birth centres.

In December 2021 the unit implemented the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This was a RAG rated tool used to improve patient flow and ensure all women were triaged and appropriate plans of care made. The aim was to achieve 15 minutes as required by the BSOTS triage model. In March 2022, 98.4% of 764 women were triaged by a midwife within 30 minutes which is in line with National Institute for Health & Care Excellence NICE guidance.

We were informed by staff that there were delays for medical reviews at the triage unit. We were made aware of an incident where two women had waited two hours to be reviewed in November 2021. The service completed a quality improvement project to improve patient experience and implemented a buzzer waiting system. In addition, a third midwife has been added to the rota.

At times when the service was full or in staffing escalation women were given the opportunity to be transferred to a local hospital however, there were similar challenges reported across the local maternity system (LMS) and region. The trust submitted daily ‘sit rep’s’ to the regional maternity team to ensure the regional team are briefed on the service’s position.

We reviewed three months of audit data collected for delayed induction of labour (IOL). The results showed a good success rate with a prostaglandin pessary which aimed to be effective within 24 hours of admission. This meant the labour ward was able to plan and support women suitable for artificial rupture of the membranes (ARM).

Maternity

We reviewed information which showed that over the last six months the service had significantly improved the length of time which woman waited to be transferred to the labour ward. The average times between admission and administration was consistently below the 2 hour threshold.

We reviewed the action plan following the action plan following the last inspection in 2018. The service had made significant changes to improve access and flow across the service. The service were planning rotas four weeks in advance as opposed to one week. There was a reduction in triage delays and artificial rupture of the membranes ARM delays. The service reported red flag incidents in line with NICE safe midwifery staffing guidelines.

Women were normally discharged from the birth centres, antenatal day units and labour ward the same day. Women who required further observations were moved onto the postnatal ward at Pinderfields hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information in different languages about how to raise a concern in patient areas. We saw posters stating “we are listening” with contact information and a QR code for smartphone users to leave online feedback. The trust offered a drop-in session to allow women and their families to talk to the patient advise liaison service (PALS) team face to face.

Staff understood the policy on complaints and knew how to handle them.

Managers responded appropriately to online complaints. They investigated all complaints promptly which involved speaking to identified staff.

Managers shared feedback from complaints in various formats such as at meetings and newsletters and on whiteboards.

We heard positive ways of how learning was used to improve the service to minimise the risk of repeat issues.

There were ‘you said’ ‘we did’ posters on the antenatal and postnatal wards demonstrating how the service had made improvements following complaints. For example, women were provided with an estimated discharge date and time when admitted to the ward/unit.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The midwifery and women's health service was managed by a well-defined leadership team. It was led by a Director of midwifery (DOM) with support from a head of clinical services.

The leadership structure chart was clear and comprehensive.

The service had five maternity safety champions which included executive and non-executive directors.

The service had a non-executive director who reported to the board and who was also a safety champion.

Staff spoke highly of the director of midwifery (DOM).

The leadership team were visible and approachable. They attended daily handovers and safety huddles. The matrons visited each site every week. However, some staff said they would appreciate a more visible presence from the matrons and leadership team.

Staff we spoke with told us how management had supported them to take on more senior roles and develop their careers, with a view to succession planning. We heard examples of staff completing their RCN leadership skills course.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However not all staff were aware of the vision and strategy for the future of the service.

The head of clinical services delivered a presentation to staff on the strategy, priorities and risks for their services in February 2022. This aligned with the trust strategic objectives.

The first priority focused on quality and safety to improve patient and staff experience;

- keeping patients safe at all times
- providing excellent patient experience
- delivering expected outcomes
- being an excellent employer.

The second priority focused on performance;

- being well led and governed with sound finances
- having an effective partnership that better supports patient care
- providing excellent research, development and innovation opportunities.

Maternity

The service were working extensively with the maternity voice partnership (MVP) and also the safety recommendations from the Ockenden report to develop the next strategy due for release 2023.

Although leaders had shared the plans for the new strategy in various team meetings not all staff understood the work being done to improve staff experience. We heard many examples from staff who did not know the future plans for the Bronte birth centre and what this meant for the birth centre staff, community and continuity midwives.

Culture

Staff felt respected, supported and valued by colleagues. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women and their families could raise concerns without fear.

We heard positive examples of how staff felt working within their local team such as “good”, “friendly” and “kind culture”.

There were supportive working relationships between the hospital, community and medical staff across all three sites.

The service displayed a number of posters for the Mid Yorkshire (MY) Maternity phone line and contact emails for staff to access if they required confidential support from professional midwifery advocate team.

We saw positive ways managers and coordinators supported staff’s wellbeing such as checking to see that everyone had time to have a break. However, most staff we spoke with were unable to take a break due to workload.

The 2021 NHS staff survey results for women’s services directorate showed that staff scored less than the organisation for “we each have a voice that counts” and “morale”.

This was a similar theme found on inspection and from intelligence. Many staff we had contact with did not feel supported or valued within the wider team. They felt their voice had not been heard by leaders who were also reported to “lack insight”.

Leaders were aware of this cultural theme from issues raised via the Freedom to Speak Up Guardian. The service had implemented a number of actions as a result of these findings such as recruiting Freedom to Speak Up Ambassadors by the end of May 2022. We heard that matrons would be working alongside staff to understand the pressures they experience and learn how to be more supportive and visible at times of need.

Following our inspection visit the service sent a survey to staff asking for their communication and engagement preferences and had set up an email address for staff to raise concerns.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. They were given opportunities to meet, discuss and learn from the performance of the service.

Maternity service is part of the Family and Clinical Support Services Division.

The service had a formalised governance framework and processes to support the safe and effective delivery of care.

Leaders had monthly MDT meetings to discuss quality and safety issues.

We reviewed three clinical governance meeting minutes which were held monthly within the Division of Families and Clinical Services and chaired by the Divisional Clinical Director. They had regular attendance by senior leaders and clinical governance. There was a standard agenda which covered quality, safety and performance issues.

We saw examples of an effective governance structure for communicating quality, safety and performance issues. We saw how issues could be escalated up to the clinical governance meetings and divisional management team and also how information was shared back to sub committees and all staff.

Each area/ unit had a governance learning board which were updated every month. These were used to share the top three; things that have gone well, risks, datix themes and things to improve. They also displayed patient feedback, the number of complaints and compliments, learning from incidents and staff achievements. At the bottom it highlighted the compliance of mandatory and role specific training completion, appraisals, and sickness rates.

Managers held regular ward / unit face to face and virtual meetings with their staff including community staff. Staff discussed quality and safety issues and learning from recent incidents, audit outcomes or feedback from complaints.

Medical staff attended a half day governance session once a month which was focused on different topics each month and included a case study presentation. Trainee medical staff met regularly and there is a process where any issues are raised at the consultant meeting under the education agenda item.

Management of risk, issues and performance

Leaders used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, leaders did not always identify actions to reduce the impact of risks in a timely way.

Leaders demonstrated they had the knowledge and oversight of the service's main risks and understood the challenge of risks in terms of quality, improvements, and performance.

The service had an embedded perinatal clinical quality surveillance model and the Maternity Quality Surveillance Group met on a monthly basis. This group was able to corroborate the information from different sources and discuss a range of issues such as risks, Ockenden updates and learning from serious incidents and HSIB recommendations.

The service had a comprehensive electronic risk register and risks were reviewed monthly and escalated appropriately through divisional meetings. Managers used a RAG rated system to monitor the ongoing risks and each had an associated action plan with a named manager. This confirmed known risks and issues found on this inspection such as short delays in time from admission to triage and delayed induction of labour. They used both balloon catheter dilators and prostaglandin pessaries to help with labour admission planning.

We acknowledged the service had experienced some extremely challenging periods with high levels of activity and acuity at the same time as reduced staffing levels due to vacancy and sickness.

The manager of the day had good oversight of what was happening across each site to maintain and ensure a safe and effective delivery of care and treatment. The focus of safe staffing activities was to meet the provision of 1:1 care for women in established labour and reduce any delays of induction of labour.The leaders were aware the unsustainability of the current staffing models.

Leaders and senior staff met daily when the service was in staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff in an attempt to meet the planned staffing levels and they would close low acuity birthing centres. All non-essential study leave was cancelled, and specialist non-clinical midwives and managers were deployed to support clinical activity.

The overall staffing position and impact such as delays in induction and red flags were reported on a monthly basis to the trust Board via the monthly executive led Maternity Quality Surveillance Group (MQSG).

Leaders were aware of the negative impacts across the service in terms of staff experience such as low morale and satisfaction, and inability to take rest breaks for drink and food.

They had identified common themes and trends over the last six months for staff working at the triage unit. These included the service not meeting the agreed staffing levels to successfully implement Birmingham Symptom Specific Obstetric Triage System (BSOTS). We heard of recent improvements with the BOSTS system such as the addition of a third midwife.

Leaders were aware of the significant use of locum medical staff because the consultant obstetricians were covering the acute service. This negatively impacted the service because junior medical staff did not have the clinical training time and there were longer waits for medical reviews especially on the triage unit.

The service demonstrated appropriate actions taken to mitigate the risks. They completed a comprehensive review of midwifery staffing to determine the future workforce model and national maternity standards and guidelines. The service required investment for an additional 15.71 WTE midwives with a further 3.30 WTE to make some interim roles substantive (DOM, maternity support workers and 24/7 ward clerk cover) to ensure safe service. The next Birthrate Plus review assessment was booked for quarter 4 in 2023.

We reviewed the most up to date action plan following the last inspection in 2018 and the service was on track with the recommendations.

The service participated in a national staffing survey which bench-marked staff satisfaction with other trusts.

The trust commissioned an external company to look into staffing issues and some areas have been identified to prioritise improvement actions for staff experience.

The service had identified the delay in receiving the new cardiotocography (CTG) machines and interfaced screens on the risk register. They were aware that the equipment had expired their lifespan and had not been safety tested within the last 12 months. Managers acknowledged the communication with the medical physics department could have been improved. However the service had not addressed this risk within suitable timeframes as the software license had expired in December 2019 but actually stopped working in February 2021. This meant there was no oversight of license expiry dates or forward planning to mitigate the ongoing risk. This was of particular concern as there had been incidents and HSIB recommendations that related to CTG monitoring; equipment that may not be functioning properly would impact on staff's ability to detect deterioration during labour.

Information Management

The service collected reliable data and analysed it. Most staff could find the data they needed. Staff could use data to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Important information such as policies and minutes of meetings were easily accessible to staff. Data management systems were integrated and secure.

Information governance was included in mandatory training.

Staff could easily access the electronic patient record systems and care records.

The community team had access to SystmOne to aid the sharing of information between the hospital and community with GP's and other health professionals.

Notifications were submitted to external organisations as required. For example, the service submitted staffing positions for the previous 24 hours to the Local Maternity System (LMS) and NHS England and Improvement (NHSE/I).

However, we saw a limited number of computers. It was difficult for staff to print out information such as handover sheets on the antenatal and postnatal ward. This was because the printer was only linked up to one computer and was not linked to their hand-held device.

Engagement

Leaders actively and openly engaged with patients, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, leaders were not always effective in their communication or engagement with staff.

Leaders we spoke with acknowledged the impact of system wide issues such as recruitment, retention, sickness and shift fill on staff experience.

They were aware of themes and trends escalating from datix raised, the Freedom to Speak up Guardian, and anonymous whistle-blowers to the CQC. The main themes emerging were that staff felt unhappy being asked to move to work on an area or unit they don't feel comfortable or skilled to be working on. Staff were worried and anxious about the quality of the care and treatment provided to women and their families. In addition, there were a lot of newly qualified staff.

Leaders offered engagement opportunities for staff to discuss the reasons for planned community rotations and redeployment such as open meetings, 1:1 meeting, HR meetings and union meetings. The service set up a specialised concerns email address and well led surgeries and time out events.

However, staff continued to feel unsupported and unable to understand the decisions made at senior level.

We heard of positive examples of constructive staff engagement on other operational issues.

The director of midwifery engaged with staff when they raised concerned about the Birmingham Symptom Specific Obstetric Triage System (BSOTS). As a result of these discussions there was an improved process and simpler signage and staff reported back that "we found it to flow really well today".

Staff had been asked to provide feedback on the best time for them to be informed of any redeployment decision. They had also been asked about their preferred route of leadership engagement.

There was a monthly staff quiz with prizes and weekly newsletters for each area.

Maternity

We reviewed the 2021 staff survey for the women's services division. The directorate scored lower than the organisation in all nine questions and most significantly lower for "we are safe and healthy", "we work flexibly" and "morale". This was a representation of the concerns raised by staff during this inspection. In response to this the service set up a culture and workforce group and created a staff engagement and culture improvement action plan 2022-2023. We saw many actions had been completed.

The service gathered views from women who used their maternity services from family and friends' tests (FFT), QR codes, complaints and compliments. Managers would build improvements into their individual ward action plans.

We reviewed the patient experience highlight report from March 2022 which feeds into the patient experience sub-committee. It summarised how the service made improvements to the planning and delivery from feedback.

The service successfully collaborated and met with the local Maternity Voices Partnership (MVP) in Calderdale, Kirklees and Wakefield who connect with women who represent the local population. The MVP group held focus groups with women to discuss induction of labour and also discharge expectations. This resulted in positive changes made to the service such as a discharge video and the feedback has been very positive.

The service ensured the voices of women from Black, Asian and ethnic minority backgrounds (BAME) were heard and their opinions addressed. The maternity dashboard showed that BAME women made up 28% of births in the last year up to March 2022. In response to maternity survey results from 2020 the service made sure information could be easily translated into various languages and ensured face to face bookings.

Managers shared the 2021 CQC maternity survey results with all staff. Managers had updated ward action plans to focus on patient experience and areas for improvement.

We heard of positive ways the service had made significant improvements. They had increased the number of skilled midwives to complete new-born examinations. They added the five questions which were significantly lower than the national average onto the friend and family test and will review these responses against complaints every month.

The service completed a maternity survey (March 2020 – August 2020) and feedback combined with local and national intelligence helped the service improve in several ways.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service shared positive examples of continually learning and commitment to professional development.

Women who had reached full term or whose waters had broken were encouraged to attend the antenatal induction clinic to have a balloon catheter dilator fitted. This was to promote labour contractions with an expected delivery within 24 hours. This meant the delivery coordinator could plan admissions and deliveries more effectively and improve patient experience.

There was a strong record of collaboration work with local Maternity Voices Partnership (MVP) Calderdale, Kirklees and Wakefield who connect with women who represent the local population.

Maternity

We heard of many ways staff were recognised for their achievements such as the trust's GRATix scheme which is an initiative for staff to say thank you to each other and make their colleagues feel valued and appreciated.

We saw many posters displaying service achievements including recognition awards such as a recognition award in May 2021 and certificate of commendation as part of the celebrating excellence annual awards in 2019.

One member of staff had been nominated for BAME national midwife of the year.

Staff participated in a fundraising event for the sick children's trust a local charity.

Services for children and young people

Good ➔➔

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff. However; not all staff had completed training in line with trust guidance.

The mandatory training was comprehensive and met the needs of children, young people and staff.

The trust target for core mandatory and statutory training (MAST) was 90% and 85% for role specific. Overall mandatory compliance was 90.6% and 81.4% for role specific for children and young people services. Mandatory topics included fire safety, mental capacity act, health, safety and welfare, infection prevention and control, information governance, moving and handling and safeguarding.

Data provided from the trust showed that children's services were meeting the trust target of 90% in most training apart from information governance, mental capacity, and fire safety. The trust recognises it is in a recovery phase from a mandatory and core specific training compliance perspective. There is a service recovery plan in place, which is monitored through the divisional senior management team. This includes planned protected for staff to complete relevant training.in addition, periodically throughout the year, Organisational Development team select specific MAST subjects and contact non-compliance staff directly prompting them to complete and how to access the training.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

Clinical staff received and completed training on recognising and responding to children and young people with mental health, learning disabilities and autism. Additional training is delivered around the 'Complex Child' from the Children's Learning Disability team (CTLD) to staff. These sessions run at least twice a year; however, session availability was increased pending demand and new starters. The content includes ASD/ADHD, learning disability/ difficulty. This was a nursing education package and was offered to all registered nursing staff, new starters or people wanting a refresher

Nursing managers monitored mandatory training and alerted staff when they needed to update their training by their work email. Staff we spoke with told us they were given protected time to complete training.

Staff knew how to access the sepsis policy on the trust intranet.

As part of the trust induction, junior doctors completed spotting the sick child program. Nursing staff completed sepsis training which was part of the deteriorating patient/ High dependency Unit (HDU) training days. The current compliance

rates for clinical and non-clinical for sepsis was 54% and 51% deterioration child below the trust target. A recovery plan is in place, involving additional capacity on training courses. This would aim to provide a first step in compliance improvement, planned to give rates of 76% for Sepsis and 80% for the deteriorating patient by November 2022. Further courses will continue to be planned to move compliance up to and above trust target.

The trust had chosen European Paediatric Advanced Life Support (EPALS) course for staff which meets the same requirements in advanced resuscitation qualifications as an Advanced Paediatric Life Support (APLS) course. Data provided from the trust showed a drop in compliance for the EPALS training. The compliance rate was 62% with the trust target at 85%. The trust explained that this drop in compliance was due to the national pause of these training courses during the Covid 19 pandemic. This was identified as a risk on the service risk register at this time. The risk has now been closed as the training has been restarted.

The RCN guidance was to have two APLS/EPALS trained nurses on every shift. This was monitored via the eRoster. If rosters highlight that a shift did not have two trained nurses this will be escalated to the matron/ associate Director of Nursing who will arrange shift swaps/moves for the necessary, cover.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, however not all staff had completed the training in line with trust

Nursing staff received training specific for their role on how to recognise and report abuse. Staff we spoke with told us they had received face to face training and completed level 1, 2 and 3. Medical staff received training specific for their role on how to recognise and report abuse.

We reviewed role specific safeguarding training level 2 compliance was 84.3% adults and 90.6% children. Level 3 compliance for children was 77.9% which was below the trusts target. The drop in compliance was due to the pause in availability during the COVID 19 pandemic. The division has included planned protected time to complete relevant training and to mitigate risk until all relevant staff are retrained, the Safeguarding and Complex needs teams are available to provide advice and support at ward level for safeguarding concerns. This includes the daily presence of a team member on site, to help review patients who have identified additional needs or safeguarding concerns, support risk assessment processes and facilitate escalation if required.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff were aware of female genital mutilation (FGM) and Child sexual exploitation (CSE) and told us these subjects were covered in their safeguarding training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

All staff had received training and knew how to recognise an adult or child at risk. Nursing managers told us staff received safeguarding supervision sessions and any specific cases learning would be discussed and disseminated throughout the department.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Services for children and young people

Staff we spoke with knew the name of both the named safeguarding children's nurses. Staff knew how to report concerns and were able to tell us the procedure they would follow. For example, one member of staff gives us an example when they had suspected abuse and how they referred the child to the local authority. Information was visible throughout the department for staff, patients, and visitors to see. This included the details of who to contact.

The service displayed safeguarding posters with local safeguarding contact numbers for anyone concerned about the welfare of any individual.

We reviewed patient electronic records which included a symbol to notify staff if children and or families were subjected to a child protection plan or at risk.

Staff followed safe procedures for children visiting the ward. Access to all children's areas was via intercom system. Gate 46 was the only area that was not always secure. We observed on more than one occasion access to this area given without checking who they were**.**

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were clean and tidy. There were suitable furnishings which were clean and well-maintained. The service performed well for cleanliness and displayed March 2022 audit results which showed high compliance rates. Patients told us they thought the areas were cleaned to a high standard and saw domestic staff cleaning throughout the day.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed the data from the hand hygiene audits for the last twelve months results were not always recorded. March 2022 results showed high level of compliance across the service.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were compliant with bare below the elbows. At the entrance to the unit hand sanitisers were available. Hand washing facilities were available with hand hygiene posters nearby for guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All areas we visited were visibly clean and equipment had I am clean stickers in place to indicate cleaning had taken place. Disposable curtains were clean and labelled to show dates of their last change. Curtains were routinely changed every three months as a minimum or earlier if dirty. This was in line with the trust's infection prevention and control policy.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Children, young people and their families could reach call bells and staff responded quickly when called. We observed patients pressing their call bells and staff responding quickly. We spoke with five patients, and they told us that staff were quick to respond.

Services for children and young people

The design of the environment followed national guidance. Gate 46 was a large ward spilt into four care clusters. Each cluster had a nurse's station and emergency buzzers could be heard in all clusters so that staff could respond to an emergency. The children's burns unit was located next to Gate 46. It had facilities for 5 inpatients beds and a separate outpatient's area within the burn's unit. Theatre had a separate recovery area for children. The anaesthetic room and recovery area were child friendly.

Entrances to all the children's department were kept locked and access was by intercom access. Gate 46 was the only area that allow us entry without checking who we were. We also observed a family gaining access when somebody was exiting Gate 46.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was available in all areas. Daily records checks were documented, and tamper proof tags were used correctly in line with local policy. Electrical equipment all had Portable Appliance Testing (PAT) testing stickers and dates present.

The service had suitable facilities to meet the needs of children and young people's families. Gate 46 and burns unit provided family friendly rooms for children and facilities for a parent or guardian to stay overnight. Gate 46 also featured a playroom, dining room, therapy room, parent's room, and a dedicated adolescent facility with separate lounge for older children.

There were accessible toilets for people and nappy changing facilities for parents with children within the department.

The service had enough suitable equipment to help them to safely care for children and young people. We checked a range of consumables items including syringes and dressings. All were within their expiry date. All sharp boxes that we looked at were signed, dated, and stored appropriately.

Staff disposed of clinical waste safely. We saw different coloured waste bins and sharp boxes for different types of waste such as general waste, clinical waste swabs and dressings.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The service used a paediatric advanced warning score (PAWS) to assess, detect and respond to any child deterioration. We reviewed patients notes where they had a PAWS score of 10 and above, staff had taken appropriate action and escalated in line with trust policy. Staff told us they participated in simulation training to reinforced learning and embed safe PAWS practices.

We reviewed the November 21 PAWS audit data, which included data from March to September 2021. This showed overall compliance with target, but below average compliance in three of the seven standards. The Trust explained that cancellation of 'Deteriorating Child' study days during the pandemic had impacted on PAWs compliance, however they had introduced several measures to improve compliance.

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. The sepsis 6 care bundle was embedded in paediatric care. Staff were reminded of the appropriate escalation at daily safety huddle meetings.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Staff completed nursing care plans and risk assessment. We saw evidence of hydration and nutrition, skin assessments, bedside safety checks, self-harm and enhanced care risk assessments completed appropriately and reviewed throughout their length of stay.

Staff shared key information to keep children, young people, and their families safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep children and young people safe. Staff completed situation, background, action, and result (SBAR) framework to complete handovers.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep children and young people safe. The service was staffed by qualified paediatric nurses and healthcare support staff. There was always a Band 6 nurse on each shift this ensured that more junior members of staff had the support of a more experienced nurse. This was in line with Royal College of Nursing (RCN) 2013 guidance.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. The service used a clinical judgement review and the children's Shelford Safer Nursing Care tool for defining staffing levels. Managers told us that the reviewed and planned nursing staffing to meet the 70:30 ratio of registered to unregistered staff.

The ward manager could adjust staffing levels daily according to the needs of children and young people. We observed a bed meeting where matrons and senior staff discussed staffing and acuity levels twice daily, staff were moved around the department to support the increase in demand and acuity. The service accesses additional healthcare assistants to support with one-to-one support when required.

At the time of the inspection staffing for nurses and healthcare matched the planned numbers for children's and young people division.

We reviewed the raw data for turnover and sickness rates for April 2021 to March 2022. The average turnover rate was 1.24% for registered nursing and midwifery staff and 0.73% for unregistered support workers.

The average sickness rate was 5.32% for registered nursing and midwifery staff and 9.1% for unregistered support workers. This calculated as average vacancy rate of 8.16 % for the child and young people services.

In March 2022, 5720 hours were covered by bank and agency staff. 91% of shifts were covered by NHSSP and 9% were covered with agency.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff said when they needed extra staff, bank staff were preferred with these being the staff that already worked in the children's service. Managers and staff told us they did often use agency staff.

Managers made sure all bank and agency staff had a full induction and understood the service. All bank staff and agency received a full induction to the trust and children's and young people service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep children and young people safe. There were separate rotas for medical cover Gate 46, CAU and the neonatal unit. The children's department had 16 Whole Time Equivalent (WTE) consultants in post that worked across both sites. Nursing staff told us that there was always a doctor available when needed.

Every child admitted with an acute medical problem was seen by a middle grade doctor within 14 hours of admission. We saw evidence of this when we reviewed patient notes.

The medical staff matched the planned number on the day of inspection. We received the percentage of junior doctors allocated to each paediatric rota. In March 2022 there was only 82% of Senior House Officer's (SHO's) and 62% of registrars available to cover these rotas.

The trust provided consultant vacancy rates. Data for March 2022 showed a vacancy rate of 0.60%.

The trust provided data to evidence medical sickness from April 2021 to March 2022, however this was not site specific. Sickness rates for March 2022 were 3.12%.

Managers told us they would request bank and agency locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We saw evidence of a good skill mix on each shift which included consultants, SHO's and registers.

The neonatal unit consultant cover was separate to Gate 46.

The service always had a consultant on call during evenings and weekends.

The service had two consultants per day during the week. At the weekend there was a consultant for admissions and another providing cover on the wards. Consultant rotas showed there was cover 24 hours a day. Consultants led handovers took place at 08:30 am, 16:00 pm and 20:30 pm We attended a handover and found it to be comprehensive and organised.

Managers told us that there were some gaps in Tier 2 rotas, currently does not have 10 WTE doctors, due to gaps in the allocation from the deanery.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used paper and a new electronic health records system. Each member of staff had individual login details to access electronic records. All nursing and medical staff had received training in using the electronic record and ongoing support was available. We reviewed 15 sets of records. All were comprehensive and completed appropriately. For example, all records contained details of presenting conditions, medical history, current treatment, and plan. Records were signed and dated by the clinician making the notes, diagnoses and management plans were documented. We reviewed sets of nursing care plans for gate 46 these were pre-populated. We reviewed three sets of notes on the children's burn unit and found the care plans to be person centred to each child and reviewed regularly. This is in line with best practice.

When children and young people transferred to a new team, there were no delays in staff accessing their records. Records were accessible to all staff. The system alerts staff to a child at risk or under a child protection plan.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. There was appropriate, secure, storage facilities for medicines. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked in line with the providers policy. Controlled drugs were kept in separate locked cupboards and appropriate checks recorded. We saw records for electronic fridge temperatures, and all were within acceptable limits.

All medicines we checked were within their expiry date. Oxygen cylinders were full and within expiry date.

We observed nursing staff wearing red aprons when making up and administering medication in line with best practise.

We reviewed the data for all staff required to administer medication within the family and clinical service division which showed 94% of staff were compliant with level 2 mandatory training on medicines and was within trust target

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. We saw nursing staff checking their names, date of birth, any allergies, and the charts to confirm the right medicines were given to the correct child or young person.

Staff completed medicines records accurately and kept them up to date. We reviewed 10 prescription charts. Allergies were recorded correctly. All charts had the weight of the child recorded which allowed for correct prescribing of medication based on weight.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services.

Services for children and young people

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff that we spoke with knew what incidents to report and how to report them using the electronic reporting system.

The trust provided data of seven serious incidents (SIs) declared in 2021/22. The trust used a serious incident tracker to monitor timeliness for investigations. This included the date for a root cause analysis (RCA) was due and when the incident had been discussed at the patient safety panel.

A patient safety bulletin was disseminated to all staff which detailed shared learning from incidents or other concerns. Staff confirmed that they did receive these by email and were available on the staff intranet.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. The service had a comprehensive incident reporting policy and staff were aware of the importance of reporting incidents.

The service had not had any never events.

Managers shared learning with their staff about never events that happened elsewhere. We observed that incidents were discussed at handovers and safety huddles. Managers displayed on my quality boards learning from recent incidents/ datix.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to children and young people's care.

Staff met at monthly meetings to discuss feedback and look at improvements to patient care. The meeting minutes were shared afterwards with all appropriate staff. Patient safety learning bulletins were disseminated and available on the staff intranet.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Children, young people, and their families were involved in these investigations. Incidents were investigated thoroughly and discussed at the Paediatric Significant Events meeting. Actions and learning points were identified and followed up at the next meeting.

Managers debriefed and supported staff after any serious incident. Staff told us that they were debrief by the consultants after any serious incidents.

Services for children and young people

Managers acted in response to patient safety alerts within the deadline and monitored changes.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies, procedures, and guidelines on the intranet. Policies and procedures were evidence based on national guidance including National Institute for Health and Care Excellence (NICE) guidance.

The service had gained the United Nations International Children's Emergency Fund (UNICEF) baby friendly accreditation stage one and two and were striving to achieve UNICEF accreditation stage 3.

The neonatal unit participated in the BLISS family- friendly framework accreditation scheme for neonatal units to self-assess the quality of family centred care they deliver against a set of seven core principles.

Burns unit staff followed guidance from the Northern burn care network. The sister on the burn's unit attended the lead nurse meeting for the Burn Care network every three months.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. All staff had received core training in consent, mental capacity and deprivation of liberty safeguards as part of mandatory and statutory training.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people, and their families.

We attended a handover meeting and staff discussed all aspects of the wellbeing of children and young people and their families.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

Gate 46 had a dining room where the catering team served the meals. We saw a board in the dining room that informed staff of any child or young person with specific dietary requirements and/or allergies. The menu did contain child friendly meals. Patients that we spoke with had varying opinions about the food. Some said it was okay, whilst others said that they did not think there was a lot of choice.

We spoke with the kitchen staff they said they could arrange for alternatives if any food was not suitable or extras like ice cream if requested

Water jugs were in reach, and we saw that they were replenished frequently.

Milk kitchens were available on Gate 46 and neonatal unit for storage of breastmilk and formula feeds. Breastfeeding mothers were offered meals during their stay in hospital.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. We reviewed fluid and nutrition charts on the electronic patient record system and in the nursing notes all were documented and updated correctly.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. Staff used the Paediatric York hill Malnutrition Score (PYMS) for children and young people who were at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists* was available for children and young people who needed it. Specialist support from staff such as dietitian and speech and language therapist are available staff must refer a patient

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it and we saw evidence that this was frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Children's services used a paediatric pain scoring tool. It was used alongside the PAWS chart. We saw evidence of this tool being used and completed to monitor pain of children and young people.

Children and young people received pain relief soon after requesting it. We discussed pain relief with five families, and they told us that their child's pain had been assessed with the use of a tool and they had not waited long for pain relief to be administered. Staff frequently checked with the parents as to whether their child was settled and comfortable.

Play specialists were available for distraction during painful procedures and reassurance for the child and parents.

The children burn unit has an allocated play specialist and a 3D television to distract children when undergoing painful dressing changes.

Staff prescribed, administered, and recorded pain relief accurately.

Services for children and young people

Patient outcomes

Staff monitored the effectiveness of care and treatment. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The trust took part in several audits, including National Paediatric Diabetes Audit, National neonatal audit programme (NNAP), seizures and Epilepsies in children and young people, Asthma national audit and neonatal infection.

Data showed that in the 2020/21 Paediatric diabetes audit showed lower performance than previous years. Results were affected due to non-face to face contact with patients due to the pandemic.

As the data reported covered the previous year and with the understanding that face-to-face clinics were back up and running, it was agreed to await the next report and review. At the time the summary was completed the National report had not been published therefore no comparisons to national data were possible.

In the 2020 National Neonatal Audit Programme (NNAP) data showed lower than national and slight reduction on previous years. It is to note that the data reported was from 2020 (published late 2021) and a lot of work had already been undertaken to address areas of poor performance as the team had access to their local data before National reports were published which they acted upon.

Managers and staff used the results to improve children and young people's outcomes. The trust had a paediatric audit lead within the consultant body who worked with the audit department. Audits were presented to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) meetings. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The service was accredited by UNICEF a baby friendly initiative and had completed stages 1 and 2 and were working towards stage 3.

Managers used information from the audits to improve care and treatment. Managers told us that audits were used to identify areas of learning and improvements.

Managers shared and made sure staff understood information from the audits using team meetings, safety huddles and newsletters.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraised staff's work performance however they held supervision meetings with them to provide support and development.

The clinical educators supported the learning and development needs of staff. The service had two clinical educators that supported the development and learning of staff. Staff told us that the clinical educators had a strong presence across the department and were supportive.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of children, young people and their families. All staff had received training in paediatric basic life support trained (PBLS).

The lead clinical educator for Paediatrics developed an online training package recognising a deteriorating child for staff working with children in adult areas. Additionally, a competency matrix was completed depending on practitioner role and area of care.

Staff from neonates and paediatrics had completed bereavement training that had been delivered by an external hospice. Staff told us that they found this training useful and give them the skills to deal with specific situations.

Managers gave all new staff a full induction tailored to their role before they started work. All staff completed the three-day trust induction and then a further two days specific for paediatrics and or neonates. All new Band 5 staff were rotated across all areas of paediatrics for the first six months to gain experience and confidence and to mitigate risks if any area was below safe staffing levels.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers and staff told us that some staff appraisals were overdue to organisational pressures. Due to both the availability of appraiser and appraisee with staff having to work clinically. The trust target was 85% compliance for nursing appraisal. Data received for April 2022 was significantly below the expected level. A recovery plan which included scheduling all outstanding appraisals and cleansing data had begun and the improvement was seen in the change from the April to May data.

Medical staff compliance rates were above the trusts target.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers were supportive and encourage staff to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist core competencies were available dependant on your role. Staff were supported to complete and given protected time to achieve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Different teams of healthcare professionals worked together as a multidisciplinary team (MDT). We observed an MDT meeting which was consultant led and included nurses, physiotherapist, occupational therapists, and community teams.

We observed a daily safety huddle which was nurse led. Discussions included incidents investigations and learning.

The school room on Gate 46 was staffed by a team and teaching assistant from the local authority who worked closely with the ward staff.

Staff worked closely with complex care team and mental health services.

Services for children and young people

Staff on the burn's unit worked effectively using a team approach to patient care which was led by a Consultant Burn surgeon and a consultant anaesthetist. The team included paediatric burns nurses, paediatric clinical psychologists, occupational therapist, physiotherapists, outreach nurses and play specialist. Daily MDT meetings reviewed inpatients treatment plans and ongoing care.

The service had a children's community team for learning disability (LD). The team included specialist nurses that support children and young people and families up to the age of 18 years with LD. Services offered included helping to understand and manage children's behaviours.

Seven-day services

Key services were available seven days a week to support timely patient care. The children's service was available 24 hours a day seven days per week

Consultants led daily ward rounds on all wards, including weekends. Children and young people were reviewed by consultants depending on the care pathway. Consultants led daily ward rounds seven days per week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Children services had access to other services such as diagnostic, laboratory and mental health seven days a week.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Gate 46 had a wall of information to promote healthy eating and infection control.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw that when a child or young person was admitted a full assessment was completed on admission and if needed referrals to dietitians or speech or language therapy were requested.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care.

Staff made sure children, young people and their families consented to treatment based on all the information available. Parents we spoke with said they have been fully involved in the consent process.

When children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture, and traditions.

Staff clearly recorded consent in the children and young people's records. We saw evidence of consent forms appropriately completed

Services for children and young people

Staff understood Gillick Competence and Fraser Guidelines and how to support children who wished to make decisions about their treatment. 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 implications of those decisions.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust's target.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards Staff told us that they could access policies on the intranet.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people, and their families. Staff took time to interact with children, young people, and their families in a respectful and considerate way. Families we spoke with said staff were friendly, caring, and helpful. They felt safe leaving their child in their care. We spoke with a patient on the burns unit who had used the service over several years. They told us staff had always been caring, supportive and felt comfortable in the ward.

Services for children and young people

We saw staff respected privacy and dignity and talked to children, young people, and their families in an appropriate manner. We observed staff introducing themselves to the parents and the child.

The service had a cold cot for parents to spend more time with their deceased baby. Staff in the unit told us about several initiatives they had in place for the families of babies who were receiving end of life care. This included providing boxes with moulds or hand and footprints, locks of hair. In addition, the unit had memory boxes for children which included trinkets and a teddy.

Staff followed policy to keep care and treatment confidential.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgemental attitude when caring for or discussing those with mental health needs.

Emotional support

Staff provided emotional support to children, young people, and their families to minimise their distress. They understood children and young people's personal, cultural, and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Children and young people on the burn's unit had the support from the burns psychology service which provided specialist psychological assessment and intervention to children, young people with burns injuries and their families.

Play specialists were able to provide support to children to alleviate their anxieties.

Parents we spoke with told us staff had supported them emotionally. On the neonatal unit parents told us that staff looked after them as well as their babies.

The service benefited from a complex care team that supports children and young people with mental health, learning disabilities and autism.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff on the neonatal unit work closely with the specialist bereavement midwives who provide additional support and bereavement follow up to family members.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people, and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Parents told us they were fully informed in their child's care; they were kept informed and up to date on what was happening.

Services for children and young people

Parents told us that staff listened to children's and parents' concerns and requests and would work with them to provide the best care for that child. They were encouraged to ask questions.

Staff talked with children, young people, and their families in a way they could understand, using communication aids where necessary. Staff provided examples which demonstrated an awareness of how they used different communication aids to speak to children and their families.

Children, young people, and their families could give feedback on the service and their treatment and staff supported them to do this. The service displayed friends and family posters and we saw family and friend's cards and submission boxes on all areas we visited. There was an option for people to leave feedback online or by QR code.

Staff supported children, young people, and their families to make advanced decisions about their care.

Staff supported children, young people, and their families to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service ensured children and young people's privacy and dignity were maintained during their stay in hospital.

Facilities and premises were appropriate for the services being delivered.

Gate 46 admitted young people under 18 years old. 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, CAU and the burns unit could stay with their child on a bed next to them.

The neonatal had two separate parent flats located next to the unit for parents to stay over at a time of need or when preparing for home.

Gate 46 had two anti-ligature rooms for young people who were at risk of harm.

Services for children and young people

Gate 46 had a separate parent room which had a fridge and facilities to make drinks and warm food. This room also contained a shower and toilet facilities.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. The service had appointed an inpatient transitioning nurse that liaise between paediatrics and adult services for children transitioning. They provided support to the young person and their families.

Managers monitored and took action to minimise missed appointments.

Managers ensured that children, young people and their families who did not attend appointments were contacted. The service followed up on those who did not attend.

The service relieved pressure on other departments when they could treat children and young people in a day.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. The service had a complex care team who provided the necessary care and support for children and young people to meet their needs

Wards were designed to meet the needs of children, young people and their families.

Staff used transition plans to support young people moving on to adult services.

Staff supported children and young people living with complex health care needs by using 'This is me*' documents and passports. The service used health passports which supported young people, aged 14 plus who had a learning disability, and their parents to have confidence in sharing important information with medical staff such as communication needs, support needs, understanding behaviour, baseline health information, how to take your medication, keeping safe, and if they had e any fears for example having a blood test. We did see these in use where applicable.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

The service did not physically have information leaflets available on the ward in languages spoken by children, young people, their families and local communities. It would be challenging for the trust to store leaflets in every language. However, a number printed on the back of every leaflet to phone, if parents and carers would like the leaflet in another language. This is verbally told to families and carers when they are given a leaflet and staff can assist them to acquire, they leaflet if they are having difficulties.

Services for children and young people

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff told us that they could circulate a message on the computer system to ask for any staff member that could speak a required language to support with patient communication. Staff told us that this was usually responded to quickly if someone could speak the desired language. They could also access a specific translation service if required.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. We observed different dietary requirements being met to meet the needs of cultural preferences.

Staff had access to communication aids to help children, young people and their families' become partners in their care and treatment. Staff told us they used whiteboards to help patients communicate. Staff could also access writing aids so that parents could write things down if English was not their first language.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Managers and staff worked to make sure children and young people did not stay longer than they needed to.

Pinderfields children's assessment unit accepted referrals from primary and emergency care. Paediatrics consultants take phone calls from GPs to determine whether the child needed to be seen. The neonatal service had a clear admission criteria.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

The service moved children and young people only when there was a clear medical reason or in their best interest.

Staff did not move children and young people between wards at night.

Managers and staff started planning each child and young person's discharge as early as possible. Discharge planning was commenced from the start of admission.

Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of children and young people whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported children, young people and their families when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards. We reviewed three inter hospital transfers from Dewsbury CAU to Pinderfields site for children who were acutely unwell. There was a clear transfer documentation which included the use of Safer Transfer of Paediatric Patient (STOPP). PAWS observations had been completed before, during and after transfer.

Services for children and young people

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. The trust shared with us data for complaints received between April 2020 and March 2021. There were 22 complaints which included themes identified included clinical treatment, communication and staff attitudes and behaviours.

The service clearly displayed information about how to raise a concern in patient areas. We saw posters in all areas on how to raise a compliant.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. They investigated all complaints promptly and spoke with identified staff.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff in various formats such as meetings, newsletter and on whiteboards.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The Children's Services at the Trust was managed by a well-defined leadership team which sits within the wider Division of Families and Clinical Support Services (FACSS) The leadership structure chart was clear and comprehensive. Leaders were visible, supportive, and approachable. The matrons visited each site every week and attended team meetings. Staff told us they knew who they were and how to contact them.

Leaders supported staff to develop their skills and more senior roles. Band 7s completed the RCN leadership programme and Band 6 clinical educator development programme.

Services for children and young people

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision and a quality strategy which focused on always keeping patients safe, providing excellent patient experiences that deliver expected outcomes, being an excellent employer, being a well led service with sound finances, have effective partnerships that support better care and provide excellent research, development, and innovation opportunities. Children's services had clear priorities and operational plan which focused on staffing, safety, and costs. Key objectives across the trust were to maintain effective relationships and good working with external partners. Staff were aware of the vision and strategy

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt respected and valued. They were encouraged to be open and honest and believed their views were listened to.

Ward leaders spoke highly of their teams and praised them for the work they had done during pandemic and continued to do so afterwards.

The trust's patient safety team completed quarterly audits of compliance against the duty of candour regulatory requirements. We reviewed the data provided to us and found that the trust was successful in achieving 100% compliance providing patients with verbal and written notification of duty of care within ten working days of an incident being reported.

During the pandemic, the trust recognised that they needed to ensure the wellbeing and safety of their staff and developed a range of initiatives. Wobble room/ areas were set up. These safe spaces were set up for staff to go to for time out, have a cry, sit quietly, recuperate and reflection. The number of rooms had now reduced, but staff can still access them if needed.

The Trust appointed a clinical psychologist to work on staff services before the pandemic which meant the Trust were in a strong position to support staff during the pandemic. The team was increased and expanded during the pandemic, but the service is still at capacity. The Trust had the MY Wellbeing Matters Service in place which allowed staff to access rapid intervention from trained psychologists. Recently a Staff Wellbeing Hub has been set up through the upcoming ICS which was centrally funded and would allow staff to access training packages as well as support.

The Trust had a comprehensive Bullying and Harassment Policy which was up to date and accessible to all staff on the Trust Intranet. The policy set out a clear commitment to eliminate all forms of bullying and harassment.

The service had recently recruited a freedom to speak up guardian.

Services for children and young people

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Children and young people services was part of the Family and Clinical Support Services Division. The divisional clinical director was the divisional governance lead.

The trust shared with us the last three clinical governance meetings for January, February and March 2022. These occurred monthly and showed good attendance. There was a standard agenda which covered quality, safety issues and performance data.

Service leads identified their top three risks. These were reflected on the risk register; measures put in place to mitigate the risks and were regularly reviewed.

Managers held regular ward face to face and virtual meetings with their staff including community staff. Staff told us they discussed quality and safety issues and any learning from recent incidents, audit outcomes or feedback from complaints.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Ward level leaders had good oversight of their team's risks, issues and performance through on going ward level audits, improvement plans and top three risks. The trust had implemented the display of 'My Quality' Boards on the wards which included performance metrics, top risks, things to improve, positive theme and improvements.

We spoke with senior managers and consultants who were aware of the individual ward risks which was based around PAWS, staff wellbeing and staffing.

Monthly risk meetings looked at identified risks, and themes were fed up into governance meetings.

The service had faced some extremely challenging times with high levels of acuity at the same time as reduced staffing due to the pandemic and sickness.

Daily managers had good oversight of what was happening across the children's and young people service to ensure a safe delivery of care and treatment.

Senior leaders met daily to discuss any staffing escalation to mitigate staffing risks and manage unexpected events. They redeployed staff across the service to meet the planned staffing levels.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to policies and guidance on the trust intranet. Staff could easily access the electronic patient record system and care records.

The community team had access to electronic records to aid the sharing between the hospital and community.

Data management systems were integrated and secure.

Mandatory training covered information governance and data security that all staff completed.

Discharge summaries and medication letters were routinely sent to GPs and other relevant professionals within 24 hours of discharge.

The service works closely with System Partners. Unplanned care ED (Emergency Departments), 111 referrals and discusses with commissions to how to improve access and demand on services.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Wards displayed staff engagement boards that included general information about ward performance in various areas.

We saw celebrating success boards across all areas and thank you cards showing appreciation to staff.

Family and friends test boxes and posters were displayed across children and young people services, this gives patients and their families the chance to give open and honest feedback about their care.

Staff told us there was a freedom to speak up guardian available in the trust and were encouraged to speak about any concerns.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service shared many positive examples of continually learning and commitment to professional development. For example, the introduction of shared care pathways with GPs. This e-consultation based process enabled primary care clinicians to seek advice from specialists in primary care by sending an electronic message through the electronic computer system. This allowed for faster responses and for the less complex cases e-consultation ensured that patients were managed within primary care setting.The system also ensured that patients that needed a referral into the service were triaged to the right specialist clinics so that they got the support and treatment that they needed with minimal delay. The service had seen a 60% reduction in outpatients' referrals since the introduction of this service.

The children's burns service had made the following service changes which had improved patient care and experience;

- Nurse-led assessments in children’s burns clinic for children presenting with minor to moderate scalds and burns.

Services for children and young people

- The service has implemented the Medical Data Solutions and Services (MDSAS) Information Technology (IT) system, which supports virtual non-face-to-face outpatient appointments. It enables parents/carers of children with minor burns/scalds to bathe their child at home and upload photos for assessment, support and advice. The outcome was that parents/carers are empowered to provide the care for their child at home, reducing the need for hospital attendances.
- Medical and nursing staff had completed competencies in laser doppler imaging.
- The service had moved the children's plastic dressing clinic to the children's burns unit previously in adults' outpatients. This enables children to be seen in a child friendly environment.

We saw posters displaying service achievements including recognition across the service.

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