The Mid Yorkshire Hospitals NHS Trust

Pontefract Hospital

Quality Report

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Date of inspection visit: 23-25 June 2015, 3 July 2015
Date of publication: 03/12/2015

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Maternity and gynaecology	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Mid Yorkshire Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust serves two local populations; Wakefield which has a population of 355,000 people and North Kirklees with a population of 185,000 people. The trust operates acute services from three main hospitals – Pinderfields Hospital, Dewsbury and District Hospital and Pontefract Hospital. In total, the trust had approximately 1,116 beds and 6,698 staff.

We carried out a follow up inspection of the trust between 23-25 June 2015 in response to a previous inspection as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust in July 2014. In addition, an unannounced inspection was carried out on 3 July 2015. The purpose of the unannounced inspection was to look at the emergency department at Pontefract General Infirmary out of hours.

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

Following the announced inspection in June 2015 CQC received a number of concerns and on further analysis of additional evidence an unannounced focussed inspection took place on the 25 August 2015 on Gates 20, 41, 42 and 43 at Pinderfields Hospital. The focus of the inspection was to look at staffing levels, missed patient care and poor experiences of care. At the inspection we had serious concerns regarding the nurse staffing levels on Gates 20, 41, 42 and 43 which had impacted on the care patients received. We also had concerns regarding the management and escalation of risk and where actions had been implemented these had not always been monitored or sustained.

After the unannounced inspection on 25 August 2015 we wrote to the trust and asked them to provide information on how the trust intended to protect patients at risk of harm both immediately and going forward. The trust provided information to CQC which highlighted what immediate actions they had taken to support nurse staffing on the wards.

We visited Gates 20, 41, 42 and 43 on the evening of 22 September 2015 to check that improvements had been made. We found additional support staff had been put in place to support registered nurses on the ward and measures had been put in place to ensure patients received the care they needed.

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

Our key findings from the follow up inspection in July 2015 were as follows:

- We found within the trust there had been improvements in some of the services and this had meant a positive change in the ratings from the previous CQC inspection notably within outpatients and diagnostic services. In some domains in key services we noted improvements from our previous inspection findings but other factors had impacted on the rating so the rating had stayed the same. However we found in medical care, end of life services and community inpatients they either had not improved or had deteriorated since our last inspection.
- The trust had responded to previous staffing concerns and was actively recruiting to fill posts. Staffing levels throughout the trust were planned and monitored. However there were areas where there were significant nurse staffing shortages and these were impacting on patient care and treatment particularly on the medical care wards, community inpatient services and in the specialist palliative care team. There was also shortage of medical staff within end of life services.

Summary of findings

- We found that most areas we visited were clean however there were areas in accident and emergency departments at Pinderfields and Dewsbury District Hospital and in the mortuary at Dewsbury and District Hospital that were not clean and infection control procedures had not been followed.
- Patients nutritional and hydration needs were not always assessed using the Malnutrition Universal Screening Tool (MUST). At our inspections we found that not all fluid balance and nutrition charts were fully completed which meant staff could not always assess the hydration and nutritional status of patients and respond appropriately where patients needed additional support.
- The trust had consistently not achieved the national standard for percentage of patients discharged, admitted or transferred within four hours of arrival to A&E. Pinderfields had not met the 95% standard for the previous 12 months and Dewsbury District Hospital had not met the 95% target for the previous 6 months.
- There was a governance structure which informed the board of directors. This was developed and implemented in 2014.
- The trust had a vision for the future called “meeting the challenge”. This was detailed in the trust’s five year strategic plan 2014/15- 2018/19. The trust had developed an overarching strategy called “striving for excellence” which was detailed in the five year strategy. Underpinning the strategy there were five breakthrough aims which had key metrics against them so the trust could measure their performance against these.

We saw areas of good practice including:

- There had been a turnaround of the outpatient service which had included the standardisation of processes, following up of the backlog of outpatients, compliance with performance targets and a restructuring across the other services. As a result the 9,501 backlog of overdue outpatient appointments we found at our inspection in July 2014 had reduced to three patients in June 2015.
- Across services in the trust 'listening into action' events had been held to support staff to transform their services by removing barriers that get in the way of providing the best care to patients and their families. Overall in the NHS staff survey 2014 the trust had improved scores on 59 questions compared to the results in the 2013 survey.
- Most of the staff we spoke with told us they felt the culture within the organisation had changed and that there was a desire to improve from the senior management team, management was better, communication had improved and there was more clinical engagement.

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

Importantly, the trust must:

- Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels.
- The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board.
- The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed.
- The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.
- The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented.
- The trust must ensure there are improvements in the monitoring and assessment of patient’s nutrition and hydration needs to ensure patients’ needs are adequately met.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must continue to strengthen staff knowledge and training in relation to the mental capacity act and deprivation of liberty safeguards.

Summary of findings

- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines, and that oxygen is prescribed in line with national guidance.
- The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment.
- The trust must ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.
- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users.
- The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.

In addition the trust should:

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.
- The trust should ensure staff are involved and informed of service changes and re-design.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	There were concerns over interdepartmental ED learning and sharing of lessons learned from incidents, incidents were shared internally on the hospital site and with Pinderfields hospital; however sharing did not occur between Pontefract to Dewsbury. Toys were found in the department that were unable to cleaned thoroughly, the recording of fridge temperatures were intermittent, safeguarding information was not always completed accurately whilst children were in the department Mandatory training rates for medical staff were poor with low levels of compliance. Receptionist cover in the main department had been intermittent in the previous months due to receptionist sickness rates. Staff had awareness and knowledge over when an incident had occurred and when to record this on the centralised system. There had been no recorded never events. Safety thermometer data was collected with the emergency department. The risk register had no specific items recording specifically for Pontefract ED, despite staff highlighting to us that items had been escalated. Personal protective equipment were available and bare below elbows policies were maintained. Infection prevention control (IPC) audits were undertaken and had mixed results. The environment was well maintained. Manager environment checklists and visual inspection of the environment were completed daily and recorded. The emergency department used a centralised computer records system. Patient records were completed. Two relatives' areas were well organised and well maintained. A designated consultant lead for major incidents was identified.
Medical care	Requires improvement 	We had concerns regarding the registered nurse staffing levels on the unit. Mandatory and statutory training compliance was variable on the unit. There was 100% compliance in manual handling (practical training) however there was low compliance in patient safety training, resuscitation, infection

Summary of findings

prevention and control. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these.

We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. However appraisal rates for nursing staff was 60%. We found malnutrition universal screening tool (MUST) was completed fully. We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking.

Staff were able to demonstrate their knowledge of mental capacity assessments and deprivation of liberty safeguards and we saw examples in practice on the unit.

Although patients were concerned that nurses had too much to do they were generally happy with their care and the way they were treated by staff on the unit. In May 2015 we saw the results of the friends and family test which indicated 100% of patients who would recommend the service they had received to friends and family who need similar treatment or care. Patients we spoke to felt that they were listened to by staff. Patients were aware of what treatment they were having and said that this had been explained to them properly.

We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014. We found the service had specialist roles to support people's individual needs which included a learning disability nurse. There was a ward based action group which aimed to enhance the environment for patients. This had resulted in upgrading the day room and sourcing higher chairs for tall patients. Visiting times have also been extended to allow relatives to be involved in supporting patients at mealtimes.

There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Summary of findings

There had been a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site which meant they were not always visible at the hospital site. Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Therapy staff told us that although they do not have much contact with more senior managers they feel confident that their line managers take their concerns and messages further up the organisational chain. We were told that there was no specific nurse or medical lead for Pontefract Hospital.
Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.

Surgery

Good

At the last CQC inspection in July 2014 we rated surgical services as good for caring, but improvements were required for safety, effectiveness, responsive and being well led. During this inspection overall we rated Pontefract General Infirmary as good with responsive requiring improvement.
Staff were responsive to people's individual needs; however there remained concerns over waiting times, such as the 18-week referral to treatment times.
There were systems for the reporting of incidents and evidence of learning. Staffing levels were in line with the staffing establishment and skill mix. Infection prevention and control and medicines were managed effectively. The checking of equipment had improved. There was good adherence in theatres with the 'five steps to safer surgery' checklist.
There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care

Summary of findings

needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. The majority of outcomes were within expected ranges.
There was effective ward level leadership however engagement and visibility of the Chief Executive and the Board of Directors on the site could be improved.
Surgical services were caring. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The service took account of patient concerns and complaints.

Maternity and gynaecology

Good

Overall at this inspection we rated the service as good. We found in the birthing unit, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. Although steps had been taken to try to address this in 2014 and in the week prior to our inspection, it was too early to show any changes had taken place. Across the trust the birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014, and women at the midwife led unit received 1:1 care during labour. Escallation guidelines were in place and staff knew the procedures to follow should there be insufficient staff to safely care for the needs of patients. Staff told us they were kept up to date with information about what was happening within the trust; senior managers were approachable and they knew who they were.

Outpatients and diagnostic imaging

Good

There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented. The level of care and treatment delivered by the outpatient and diagnostic imaging services was good. We found there were sufficient numbers of staff to make sure that care was delivered to meet patient needs and sickness rates were below the trust target of 4%. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed. New equipment had now been purchased for pathology

and would be in the trust from July 2015. There were planned dates for going implementation on 5 November 2015 for biochemistry and January 2016 for haematology.

The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site. We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. Data showed that 64%-100% of staff in outpatients had completed training specific for their role appraisal rates ranged from 41% for nursing staff to 100% for estates and ancillary staff. Within radiology services we were shown on the computer system that appraisal rates across the 340 staff was 88%. We found staff understood about consent and data showed that 64%-100% of staff had completed training specific for their role which included mental capacity training levels two and three.

There continued to be capacity issues within some specialities particularly ophthalmology and cardiology. Some patients expressed concerned regarding cancellation of appointments. Analysis of data showed that since August 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for admitted and non-admitted pathways. The trust had implemented an action plan and completed the first two phases; the next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. The trust provided information on the outpatient backlog we saw in June 2015 this number was down to three patients from 9,501 when we inspected in July 2014.

Management teams had a vision for the future of the departments and were aware of the risks and challenges they faced. There were monthly governance meetings where trends from incidents and risks within the division were discussed. Staff

Summary of findings

reported they now had a secure management structure and staff were positive about the changes the management team had brought to the service. Staff throughout the service told us they felt the culture within the organisation had changed.

Pontefract Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Maternity and Gynaecology; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Pontefract Hospital

Pontefract Hospital is part of the The Mid-Yorkshire NHS Trust. It is situated in Pontefract and serves a population of approximately 355,000 people in the local Wakefield and Pontefract area. The hospital has approximately 28 inpatient beds and a number of day case facilities.

The trust employs around 8,060 members of staff including 755 medical & dental staff.

Pontefract Hospital provided a range of services including: accident and emergency, rehabilitation unit, surgical short stay unit, outpatient services for adults and children, day surgery for adults and a midwife-led maternity unit.

The health of people in Wakefield is generally worse than the England average. Deprivation is higher than average and about 20.6% (12,500) children live in poverty. Life expectancy for both men and women is lower than the England average. The population had a similar age group breakdown to the England average. In Wakefield there was a much lower proportion of black, Asian and minority ethnic (BAME) residents with 4.8% BAME residents compared to an England average of 14.6%. In the Kirklees area there was 20.8% BAME residents which was a higher proportion than the England average.

We carried out a follow up inspection of the trust between 23-25 June 2015 in response to a previous inspection as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust in July 2014.

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Head of Delivery: Adam Brown, Care Quality Commission

The team included CQC inspectors, including a pharmacist inspector, and a variety of specialists including a consultant surgeon, medical consultant, nurse specialists, executive directors, a safeguarding lead, and senior nurses. We were also supported by two experts by experience that had personal experience of using or caring for someone who used the type of services we were inspecting.

Detailed findings

How we carried out this inspection

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

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

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

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

We carried out the announced inspection visit between 23 and 25 June 2015. During the inspection we held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, allied health professionals (including physiotherapists and occupational therapists) and administration and support staff. We also spoke with staff individually as requested. We talked with patients and staff from ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Pontefract Hospital

Data showed across the trust there was approximately 1,116 including: General and acute 873, Maternity 192 and Critical care 51.

The trust had approximately 6,698 whole time equivalent staff which included 735 medical staff, 2,043 nursing staff and 3,920 other groups of staff.

The trust had a total revenue of over £520 million in 2014/15. Its full costs were over £533million and it had a deficit of over £12 million.

During 2014/15 there were 97,784 inpatient admissions, 492,072 outpatient (total attendances) and 214,189 accident & emergency attendances.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	N/A	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	N/A	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

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

Urgent and emergency services

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust is made up of three sites Pinderfields (PGH), Dewsbury (DDH) and Pontefract (PGI) each site has an emergency department with total attendances at 216,728 2014/2015, 18,000 attendances per month. Attendance on each site can be broken down to 250- 300 patients on the Dewsbury and Pinderfields site and 100 patients per day Pontefract site.

Attendance data showed that on the Pontefract emergency department (ED) site 36,573 patients attended July 2014 to May 2015. Attendance by children is approximately a third of cases attending the ED are children approximately 1000 per month/ 3428 total admissions May 2015. Attendances have risen for paediatrics per year from 10,881 in January 2013 to December 2013 to 11,170 in January 2014 to December 2014. Of the total number of patients attending the ED between July 2014 to May 15 of these 9% (3478 out of 36,573 patients) resulted in admission to hospital which is below the England average of 21.9%. The emergency department was open 24 hours a day, seven days a week. Paediatric admissions were accepted 24 hours a day.

The emergency department included a major's area consisting of three trolley cubicles, four closed door cubicles, two trolley cubicles for paediatric admissions, two trolley resuscitation areas, a triage room and two see and treat rooms.

During inspection we visited on two occasions one as part of the overall announced inspection and once as part of an unannounced inspection. We spoke to 3 patients and 8 members of staff including nurses, qualified and unqualified, and medical staff. We reviewed 21 sets of electronic records and documentation and reviewed information provided by the trust prior to our inspection.

Summary of findings

There were concerns over interdepartmental ED learning and sharing of lessons learned from incidents, incidents were shared internally on the hospital site and with Pinderfields hospital; however sharing did not occur between Pontefract to Dewsbury.

Toys were found in the department that were unable to cleaned thoroughly, the recording of fridge temperatures were intermittent, safeguarding information was not always completed accurately whilst children were in the department Mandatory training rates for medical staff were poor with low levels of compliance. Receptionist cover in the main department had been intermittent in the previous months due to receptionist sickness rates.

Staff had awareness and knowledge over when an incident had occurred and when to record this on the centralised system. There had been no recorded never events. Safety thermometer data was collected with the emergency department. The risk register had no specific items recording specifically for Pontefract ED, despite staff highlighting to us that items had been escalated.

Personal protective equipment were available and bare below elbows policies were maintained. Infection prevention control (IPC) audits were undertaken and had mixed results. The environment was well maintained. Manager environment checklists and visual inspection of the environment were completed daily and recorded.

Urgent and emergency services

The emergency department used a centralised computer records system. Patient records were completed. Two relatives' areas were well organised and well maintained. A designated consultant lead for major incidents was identified.

Are urgent and emergency services safe?

Requires improvement

Mandatory training rates for medical staff and nursing staff were poor with low levels of compliance; medical staff averaged 80% and nursing staff 80.5% compliance.

Receptionist cover in the main department had been intermittent in the previous months due to ED receptionist sickness rates, this resulted in the main reception area been staffed by inadequately trained staff.

Triage was not always recorded as occurring during the 15 minutes when a patient arrives. Staff were moved to different areas regularly and when this occurred concerns regarding the staffing establishment arose

Toys were found in the waiting area that were unable to be cleaned thoroughly. The recording of fridge temperature checks was intermittent.

Safeguarding information was not always completed accurately whilst children were in the department.

Staff had awareness and knowledge over when an incident had occurred and when to record this on the centralised system. There had been no recorded never events. Safety thermometer data was collected with the emergency department.

Personal protective equipment were available and bare below elbows policies were maintained. Infection prevention control (IPC) audits were undertaken and had good results. The environment had been recently decorated and the department was well maintained. Equipment observed was found to be clean and in good working order. Manager environment checklists and visual inspection of the environment were completed daily and recorded.

Medicines were all stored and stock recorded appropriately. Mandatory training rates for nursing staff were good and senior nursing staff had a good overview of compliance. The emergency department used a centralised computer records system. Patient records were completed. A designated consultant lead for major incidents was identified.

Incidents

Urgent and emergency services

- The trust had reported 21 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between February 2015 and May 2015. 319 incidents were being reported via the three ED's at the trust.
- The trust made incident data available, we reviewed incidents recorded since February 2015 Pontefract ED had reported 21 incidents, of which none were graded as severe and none were graded as moderate harm. 2 were graded as low harm and 19 no harm/near miss. One of the incidents that were graded as no harm/near miss one was a missed skull fracture and inappropriate spinal assessment, this patient then received conservative treatment.
- All incidents within the ED were reported through a centralised reporting system. Senior nursing and medical staff reviewed the incidents reported and analysed the data to identify any trends. The top three incidents adverse incidents that affect staffing 7 out of 21, laboratory investigations 4 out of 21 and possible delays and failure to monitor 2 out of 21 and problems with the referral from primary to secondary care 2 out of 21. Nursing staff we spoke to told us staffing was the top incident with violence and aggression being number two.
- Staff we spoke to could explain the process of incident reporting and knew when to report incidents. All incidents were reviewed by the matron and then disseminated to the are lead for ED. Staff were aware of their roles in relation to incidents and there need to report, provide evidence, take action, triage or investigate as required.
- Learning from incidents was shared internally through the onsite clinical governance meetings; these were attended by medical and senior nursing staff from the Pinderfields and Pontefract ED only. On site sisters meetings, communications book and email system and circulate memos were also used to share learning, departmental all site learning was unachieved as however no formal mechanism existed to disseminate lessons learned throughout the whole trust or the three ED's. Staff corroborated with us that incident feedback is not routinely shared throughout the three sites; staff told us that they do receive individual feedback if the incident was specific to them; however no mechanism exists to discuss themes from incident data from each site. Staff where aware of a recent paediatric incident that occurred in the department and were able to recognise this incident.
- Staff spoke to us about specific lessons learnt from incidents used to be shared via an ED newsletter however this had been recently discontinued.
- Senior nursing staff had an update of incidents via the leads meetings and they are shared on the nursing dashboard and these are reviewed at the lead nurse's one to one meetings with the matrons.
- The trust was signed up to the NHS England "Sign up to safety campaign" a national initiative to make the NHS the safest system in the world, the senior medical and nursing team did not make reference to this campaign when incidents were discussed.
- Serious Incidents (SI's) are incidents that require further investigation and reporting. Ten serious incidents had been reported on the STEIS (strategic executive information system) within the three EDs at the trust. We requested serious incident reports and no reports were supplied from Pontefract.
- Root cause analysis investigations were undertaken in the ED, staff told us the process for dissemination post review was a memo, email dissemination and documentation in the communications book.
- Never events are serious incidents, wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level. No never events had been recorded,
- The department did not hold specific mortality and morbidity meetings however there was evidence these were discussed as part of the governance meetings.

Duty of Candour

- Staff spoke to us about their knowledge of duty of candour and been able to tell patients if an incident or mistake had occurred and the need to be open and honest. They spoke about offering patients face to face meetings to discuss incidents.
- Staff were aware of the need to record this discussion and space was available on the reporting system for this recording.

- As part of the serious incident reports duty of candour was commented on and we were able to see that discussion had taken place with the family.

Safety Thermometer

- In the reporting period July 2014 to Dec 2014 overall in the three EDs, 20 harms had been reported under the safety thermometer reporting system. 4 pressure ulcers were recorded in Oct/Nov 2014, none recorded in the previous 9 months. 12 falls were recorded these peaked in February 2014 and reduced towards the end of the reporting system and four catheter related urinary tract infections were recorded.

Cleanliness, infection control and hygiene

- One of the must do's in the CQC 2014 report was to ensure that all equipment in the accident and emergency department is appropriately cleaned, labelled and stored in the correct environment. "I am clean" assurance stickers were in use during the inspection, however their use was not consistent and equipment was found in inappropriate conditions. In an internal infection prevention and control (IPC) audit in December 2014 care of equipment scored 80%, this same score was recorded again in February. During a more recent audit in May 2015 100% was scored.
- We observed that staff complied with the trusts policies for wearing the correct personnel protective equipment such as gloves and aprons. Stocks of personal protective equipment were readily available.
- We observed that alcohol gel dispensers were all in working order. Adherence to the "bare below elbows" policy was good with all staff observed as being "bare below elbows".
- There had been no cases of MRSA or Clostridium difficile acquisition within the ED noted in the previous year.
- IPC practice audits were displayed in the department to the public and cannula care, bare below elbows, hand washing and cleaning and decontamination was all noted to be 100%, care of catheters was left blank.
- The department had had a deep clean prior to our visit and had been redecorated. We observed that environment cleanliness check lists were available in cubicles.
- The NHS carries out audits against set standards to monitor the level of cleanliness, the national specifications for cleanliness in the NHS: a framework for settings and measuring performance outcomes April 2007 at the previous internal audit in May 2015 a score of 97.5% was noted, Emergency department are routinely classified very high risk departments (98% compliance) so a breach of cleanliness standards had occurred.
- The resuscitation area had two trolleys and we observed them both labelled as clean, during a second visit to the department mattresses were labelled and clean**.** Mattress inversion to indicated cleanliness as seen on the Dewsbury site was not a procedure undertaken on all the three EDs and none were seen in Pontefract, Staff told us that trolleys were not made up now following discussions with IPC .Clean linen was stored at the end, so patients know it is clean.
- Mattress inversion, tipping the trolley mattress on its side was used on the Dewsbury site to indicate cleanliness this was not a procedure undertaken on all the three EDs and no mattress were seen inverted on the Pontefract site.
- The children's ED was not a separate area and was inspected and found to be clean. The folding changing station in the baby care room was found to be unclean.
- On checking the trust guideline for the management and maintenance and safety of play equipment if was found to be a document that had not been through approval and trust sign off. Soft toys were found in the children's waiting area, these are unable to be cleaned.
- We observed that sinks within the department still had a drainage plastic separator in the plug hole- this can be used however in hospitals this is not used as can cause bacterial build up in the sink. Health Technical Memorandum 04-01: addendum Pseudomonas aeruginosa- advice for augmented care units and Legionnaires' disease. The control of legionella bacteria in water systems Approved code of practice and guidance.
- Staff showed us a book where ward manager assurance and cleanliness checklist were completed and stored. This included visualisation over cleanliness of rooms, cubicles and equipment.

Urgent and emergency services

Environment and equipment

- The department was divided into four minor's cubicles including an ear nose and throat room, an eye examination room and a gynaecology room. 3 major cubicles and 2 paediatric cubicles and a two bedded resuscitation area.
- Two trolley resuscitation department for adults and one bay could be adapted for use for paediatric admissions trolley cubicles were available for minor and major patients.
- The resuscitation room was clean and well maintained; this room was tidy and uncluttered.
- The relative's room was in use during our visit by a patient with mental health needs, staff told us they used this room when a patient required mental health assessment.
- The minor injury area was clean, tidy and well organised.
- During the inspection we spent time in the children's ED waiting area and the paediatric emergency department. The paediatric emergency department had opened curtained. It was decorated in bright and colourful child friendly designs on the walls. It was well equipped with children's toys and play facilities. A waiting area is present in the children's ED which is situated behind the nurse's station and is not in direct view, this leads down a separate route into the ED.
- In the Paediatric ED a mixture of cots and trolleys were available.
- No electronic equipment no electrical testing stickers were present, staff were not aware of the way to check this equipment had been tested the Inspection team queried this and saw evidence of testing and recording centrally.

Medicines

- There were processes in place for ensuring medications were kept securely. Medication fridges were found to be locked when we randomly checked them.Fridge temperatures were manually recorded and were within expected limits, on five occasions during the months of June temperature checks were not recorded.
- All medicines cupboards were found to be locked and when unlocked drugs were checked and were stored in order and date.
- Controlled Drugs were stored according to legal requirements. Controlled drug books were checked are completed with signatures and dates.
- Allergies were recorded on patient record cards and within the IT patient administration system.
- Patient Group Directives (PGD's) are written instructions which allow non-prescribing healthcare workers to supply and administer specific medications to patients who meet set criteria. The use of PGDs is underpinned by legislation (Human Medicines Regulation 2012, the Misuse of Drugs Act 1971 and the Misuse of Drugs regulations 2001). We reviewed Patient group directives within the department and found them all appropriate for drugs used within ED and we observed them to be fully signed individual by staff.

Records

- The emergency department used an electronic patient record system widely used within the NHS. Nursing and Medical documentation in the ED was stored electronically.
- All staff were provided with access to the system and provided with training on how to use the system. Locum staff also had access.
- Staff talked to us about information held on the system and staff also scanned further information into the system currently not available on the system such as observation sheets.
- We reviewed 21 sets of patient records who attended the department during the inspection. We found the notes to be recorded in a timely manner.
- Paper records were found to be handled and stored securely. The trust provided information governance training compliance data for ED which showed compliance at 78% for nursing staff and 76% for medical staff at Pontefract and Pinderfields.
- Staff had developed a board where each patient in each cubicles name was documented along with various issues about their care e.g. bed booked, ambulance booked and time of observations etc. This wasn't in a confidential area and did contain patient's names.

Urgent and emergency services

Safeguarding

- The department had systems in place to safeguard vulnerable adults. Nursing and Medical staff we spoke to were able to explain to us about safeguarding procedures for both adults and children and were aware of their responsibilities and appropriate safeguarding pathways to use to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.
- Safeguarding training was incorporated into the induction process for junior medical staff; the trust provided safeguarding compliance data for ED which showed compliance at 100% for nursing staff and 84% for medical staff safeguarding level 2 and 3 training at Pinderfields and Pontefract.
- Staff were able to discuss issues around sexual exploitation and female genital mutilation. These issues were contained within the level 3 safeguarding programme.
- A symbol was present on the computer system for children at risk.
- Staff were aware of the key individuals for safeguarding for maternity service, children's and adults.
- On reviewing incident forms we noted one incident where safeguarding and bruising in non-mobile children policies where not adhered too as safeguarding information and discussions with senior medical staff had not occurred prior to the discharge of the child. This resulted in discussions and visits by the health visiting team.

Mandatory training

- One of the must do's in the CQC 2014 report was to ensure that all staff attend and complete mandatory training and role specific training particularly for safeguarding and resuscitation. Information about levels of compliance with statutory and mandatory training was supplied to us by the trust pre the inspection, compliance for medical staff ranged between 44% and 100% and nursing staff 100%. Resuscitation training compliance data supplied by the trust 95% nursing staff and 68% medical staff completing training. We discussed compliance with senior staff within the department and they told us compliance was low due to the current staff vacancies within the department.
- Statutory and mandatory training was delivered by a mixture of face to face and e-learning training sessions. Staff we spoke to told us about new e-learning training programmes they accessed, they also spoke to us about difficulties they have accessing the system at work as the programmes freeze and crash and so they have now arranged for remote access at home to complete their e-learning.
- Medical staff new into the ED spoke to us about attending a 3 day induction programme containing the training required for mandatory training.
- The senior sister was aware of the mandatory training compliance levels for the department and had an up to date training records which showed 100% compliance for most mandatory training.

Assessing and responding to patient risk

- Patients arriving by ambulances were not brought in through a dedicated entrance, approximately six ambulances a day arrived at Pontefract. Staff told us that they used national early warning scores (EWS) to assess adults.
- Children arriving by ambulance were transferred into the paediatric area or the paediatric resuscitation area. Paediatric early warning scores were used to assess children.
- Patients arriving on foot initially checked in, in the reception area. Year to date figures showed the median time patients could expect to first be seen for initial assessment is CEM standard of 15 minutes, On the day visited waiting times were about 20 minutes and they told us the normal wait was between 15 to 1 hour, during a visit to another site and reviewing the computer system, triage was not recorded within the 15 minute timescale, with 10 patients waiting 17 to 58 minutes for triage.
- Sickness rates for receptionist staff throughout the trust was 2.27% (March) lower than the England average for administration and estates staff (3.50% July to September 2015). Sickness within the administrative group had been as high as 15.81% in previous 6 months,

higher than England average. On reviewing incident forms lack of receptionist cover was noted on four occasions during February 2015 to May 2015. The impact on this was that at times no one was available to observe the waiting room, and inform nursing staff of admissions of patients requiring immediate care. On another occasion the reception was observed by a domestic and a security guard. During the times of no reception cover patients had to be booked in over the telephone.

- Nurse practitioner route are allocated by the receptionists via a set criteria on the computer this shows on the computer system as a blue chair.
- The ED co-coordinator completes a breach report at the handover of each shift.
- Escalation route was clear and we reviewed the standard operating procedure for managing emergency demand. Resource escalation action plans (REAP) are used from level 1 to level 6 demand.
- Staff reported to us concerns about lack of service support, they told us that this often leads to delays in discharge of patients and leads to breaches as they are tested off site. We noted three incidents form completed where a delay in treatment had occurred due to a delay in blood test results due to broken equipment on the Pontefract site and bloods having to be transferred off site for testing. On one occasion a patient breached the four hour target due to the delay in obtaining blood results.
- On the day of inspection triage was being provided and was being delivered within national recognised limits of 15 minutes, staff told us that staff were allocated to triage for 3 hour time slots during their shifts during a visit to another hospital in subsequent days it was noted that the triage time was as long as one hour. Prior to the inspection, initial assessment (triage) times were not supplied by the trust as a new dashboard was been finalised and these weren't available.
- Patients were able to see the Emergency nurse practitioner (ENP) with extended training and skills. The ENP patient stream could only take minor injury patients and not illness. Following the inspection the trust confirmed that some of the practioners are also non-medical prescriber.
- Staff told us that since the midwifery department had become nurse led they had had an increase in births in the department. However they weren't aware of any incidents resulting from these births. We did not see any incident forms in relation to birth within the department.
- Staff reported that they had recently asked for the issues surrounding the priority decision tree, to be escalated onto the risk register. On reviewing the risk register this hadn't been placed on to the register.

Nursing staffing

- One of the must do's from the Care quality commission 2014 reports was to ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner. Staff told us that recruitment at Pinderfields ED had not encountered any problems.
- No best practice tool is currently available for EDs. The trust had recently undertaken a staffing establishment exercise in relation to staffing ED, as the trust Director of Nursing had been a member on the NICE national working group establishing the staffing ratios for ED's. The trust had scoped staffing requirements at Pontefract in line with one nurse to four patients, and one to one nurse or two to one patient in resuscitation areas as described in the draft NICE safer staffing in ED guidelines however at the point of inspection this document had not been published, so the staffing establishments had not been implemented.
- Current established staffing levels are agreed as 4 nursing staff to be on duty in the morning (3 qualified and 1 HCA), 4 nursing staff to be on duty for the afternoon shift (3 qualified and 1 HCA) and 2 nursing staff for the night shift (2 qualified). In addition 2 emergency nurse practitioners were on duty during the day, with one on duty overnight, an additional twilight nursing shift had recently been funded.
- No registered sick children's qualified nurses (RSCN) were employed at Pontefract, however registered nurses had attended a local university and undertaken a children's nursing module.
- Band 5 staff nurses are rotational posts between Pinderfields and Dewsbury sites and in the urgent care

improvement programme this is noted to be extending to other grades of staff. The rotation was developed to increase and maintain nursing staff core skills, but also to help with recruitment.

- Recently the trust has commenced agency bookings through a different agency and staff said that this has increased the competency of staff as they are often staff who work in the trust, or work in another ED department often at a senior level.
- The use of overtime for staff has just been recently agreed in the weeks leading up to inspection.
- On the day of inspection we observed the department to be fully staffed with as 4 nursing staff to be on duty in the morning (3 qualified and 1 HCA), 4 nursing staff were planned to be on duty for the pm shift (3 qualified and 1 HCA)and 2 nursing staff for the night shift (2 qualified).On speaking to staff and reviewing rotas we found that the department has been staff at the established levels, changes to these levels occur when ED staff were moved to other departments as recorded in the incidents forms on these occasions staffing fell below establishment for specific periods of time due to staff movement.
- Sickness rates for nursing staff were 1.82% (April 2015) lower than the England average of 4.81% (July to September 2014). It had been as high as 8.01% in previous 6 month period.
- Nursing staff shifts are staggered throughout the day to ensure that there are sufficient numbers at the times of peak demand. Handover are arranged formally twice a day, and informal handovers are held when required.
- We reviewed information supplied by the trust that gave details of the number of diverts 7 diverts included patients from Pontefract being admitted to Dewsbury rather than Pinderfields. Pinderfields is the nearest ED to Pontefract.
- Staff were aware of their usage of agency staff and they told us that recently agency staffing has improved as a different agency is being used, staff used by this agency were ED nurses from the Yorkshire region, and staff had developed an agency checklist for nurses who it is their first time in the ED department.
- Staff also reported to us that staff were very often moved from the department to cover shifts at Pinderfields hospitals, an agreement had recently been reached where staff were moved from the ED to the rehabilitation ward at Pontefract and staff were moved from the rehabilitation ward to cover the ED shift at Pinderfields. Staff felt that this agreement was better as it allowed the ED flexibility to return the staff to ED from the rehab ward should capacity increase. On reviewing incident forms we noted that incident forms were completed where staff were moved off site to community units, on one occasion, staff were moved when another member of staff was on sick leave, staff reported the impact of this as being three members of staff left on site. Two members of staff were required to apply a plaster of paris which left one member of staff to look after 8 patients in main department.
- Staff expressed a worry over the future of the department and whether it will remain as an ED or developed into a minor injury unit.
- Staff did report that occasionally on shifts they don't feel like they are satisfying patient needs due to staffing issues and frustrations about the difficulties around ambulance transfers.

Medical staffing

- Consultants cover both the Pinderfields and Pontefract sites with 12 WTE consultants employed to support the ED department. 11 of these posts were substantive posts and there were 1 vacancy at Pinderfields site.The vacancy had been recruited to, with one of the current registrars starting this role in August 2015.
- Consultant recruitment had been difficult and a clinical fellow role had been developed which allowed middle grade doctors to work at Pinderfields ED but have a day a week for specialist interests for example pre-hospital medicine with the ambulance service or medical education, currently five medical staff were undertaking this role.
- Occasionally when a divert is in place the diverting hospital can send a member of medical staff with a patient.
- Registrars and Junior doctors rotated round the different ED's in the trust. The junior doctors worked on a 19 person rota funded by the Deanery.

Urgent and emergency services

- Consultant cover was available 24 hours a day seven days a week..Consultants were available 8.30am until 5pm; middle grade medical staff were present from 5pm to 12 midnight. From 10pm the department is GP led with medical staff from an external provider.
- Sickness rates for medical staff 0.52% (April) previous lower than the England average for medical staff of 1.12%.
- Handover are arranged formally twice a day, and informal handovers are held when required.

Major incident awareness and training

- There was a designated major incident store within the department. A designated lead consultant covered all three EDs. A designated lead nurse was available in Pontefract.
- A major incident policy was in place, this was reviewed and found to be detailed and in date, last reviewed in May 2015. A lead for major incidents in ED is identified and on the Pinderfields site two nurses were identified as responsible for checking the major incident equipment.
- Staff we spoke to had a clear understanding of their roles and responsibilities with regards to major incidents, Although staff told an exercise had not been rehearsed for some years the trust confirmed that there was a full live exercise in 2013 and a table top exercise in 2014. Staff told us about incident training in preparedness for infectious disease patients.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The department used National Institute of Clinical excellence (NICE) and college of Emergency Medicine guidelines to support the treatment provided to patients. Arrangements were in place for patients to be provided with food and nutrition as required, patients who had been at home prior to admission without adequate nutrition were offered food and pain relief was offered. Pathways and admissions criteria existed which identifies patients that require direct admission to Pinderfields.

The emergency department was open 24 hours a day. Patients were requested for their consent. Staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs) in the previous 12 months. Staff had received appraisal, staff spoke to us about feeling confident about working within departmental competencies.

We observed good relationships between medical and nursing staff within the department.

CEM audits were not undertaken at Pontefract hospital.

Evidence-based care and treatment

- Departmental policies, procedures and guidelines were based on nationally recognised best practice guidance, for example National Institute for health and care Excellence (NICE) and the College of Emergency Medicine (CEM) standards. Current pathways were examined for sepsis, stroke, COPD, Asthma, chest pain and fractured neck of femurs and were in line with recommended guidance
- In line with national best practice tariffs, the pathway in Mid Yorkshire trusts is to admit patients who have sustained a fractured neck of femur (NOF) and stroke patients to Pinderfields ED. Patients with these illnesses or injuries were admitted directly via ambulance into ED Pinderfields. If a patient attends the other two EDs with family or carers these were transferred to Pinderfields on diagnosis for further treatment. On reviewing incident data one patient was admitted to Dewsbury following a stroke via an ambulance; however staff within the ED correctly diagnosed the condition and transferred to Pinderfields promptly.
- The CEM has a range of evidence based clinical standards which all ED's should aspire to achieve to ensure that patients receive the best possible care to ensure clinical outcomes. The CEM recommends that 100% of patients who present to an ED with signs of sepsis or severe shock should receive a dose of antibiotics prior to leaving the department (ideally within 4 hours). This audit was not performed at Pontefract.

Urgent and emergency services

- A must do in the CQC 2014 report was to ensure there were improvements in the numbers of fractured neck of femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours. Overall in the trust during July 2014 to March 2015, 377 patients were admitted with a fractured neck of femur and went on to have surgery.
- Overall in the trust local audit data is arranged by the consultant with a specialist interest in that area. The department had good level of participation in audits of the college of Emergency Medicine (CEM) standards, although staff told us these audits were not carried out on the Pontefract site.
- We were supplied with the presentations from national data vs. Pinderfields we were assured that this covered all sites; however on further discussion it was evident that Pontefract were not involved in the collection of audit data. Recommendations had been made in the conclusions of the national audits however we were unsure whether these are national recommendations and conclusions or trust specific, there was no evidence of how these had been acting upon internally within the trust.
- Staff told us about nursing cross divisional audits which were carried out in record keeping, prescription charts, consent, venous thrombolic events (VTE), cardiac arrests, crash trolleys, controlled drugs and non-medical prescribing and nursing documentation, we asked for evidence of audits undertaken but we didn't receive this data.
- Within the 3 sites a specific non-invasive ventilation (NIV) audit was in progress for completion in August. 2015, this audit was based on the NIV guidelines from the British thoracic society 2008. Blood test requesting for patients with abdominal pain is also in progress.
- We were told that the audits are presented at the clinical governance meetings. We also reviewed the minutes of the medical divisional group and noted reference to ED; however no specific audit data was presented. The triumvate for ED were also not noted in the attendance for three meetings we reviewed.
- On checking the trust guideline for the management, maintenance and safety of play equipment if was found to be a document that had not been through approval and trust sign off.

Pain relief

- In the 2014 survey of emergency department, the trust performed about the same as other trusts for the question "how many minutes after you requested pain relief medication did it take before you got it? Similarly the trust performed about the same as other trusts for the question, "Do you think the hospital staff did everything they could to help you control your pain?"
- In EDs audits of effective pain relief administration are often carried out in accordance with the CEM standards for the management of moderate of severe pain, severe pain caused by renal colic, the management of fractured NOF and pain in children however no audits were supplied by the trust to be able to assess compliance with administration of pain relief.
- Patients we talked to told us about being offered pain relief if they required. We witnessed patients being asked about levels of pain and pain relief being offered to patients.

Nutrition and hydration

- In the 2014 survey of emergency departments, the trust performed about the same as other trusts for the question, "Were you able to get suitable food or drinks when you were in the A&E department?
- We observed a member of staff offering hot drinks and snacks to patients. Sandwiches were available on the department with various options. Packet soup was also available; staff spoke to us about assessing the patient's journey into ED when requiring food not just the time spent within the department. They were mindful that a patient having ED attendance may have been at home without food for some time prior to admission.
- Patients told us during their admission into the ED department they had been offered drinks and snacks.
- Vulnerable patients over 60 years checklist had been developed and offering food and drinks were highlighted for checking in this population group.
- A drinks vending machine was available in the waiting room.

Patient outcomes

- We were supplied with evidence that the trust participated in six of the 16 national audits undertaken by the College of Emergency medicine, during discussion with staff they told us that because of the client groups Pontefract were not involved in the CEM audits.

- The CEM recommends that unplanned re-attendance rates within seven days for EDs should be between 1% and 5% Pontefract hospitals was higher than the England average on re-attendance rates to A&E July 2014 to May 2015 with a re-attendance rate of 9%.
- On reviewing clinical governance meeting minutes audit results, transfers to ITU, deaths in department, incidents, claims, complaints the minutes had little narrative to them so we are unaware of any actions taken by Pinderfields hospital as a result of the evidence discussed.
- Staff were aware of the current protocols and pathways that exist including sepsis, non-invasive ventilation pathways, stroke and neck of femur pathways.
- Staff told us that the recent sepsis audit had been discussed at the consultant meeting; Pontefract site was not included in the collection of data.

Competent staff

- Appraisals of both medical and nursing staff were undertaken. The trust reported that 100% of nursing staff on the Pontefract site had received their appraisals; staff we spoke to confirmed this data.
- Nursing staff we spoke with felt well inducted into the department and well supported, staff felt able to raise concerns when they need to.
- Nurse practitioners were trained to treat injury and not illness and were not nurse prescribers.
- Staff explained to us the new band 5 rotation programme between the three EDs which ensure competencies are maintained in the different pathways. As a result of the band 5 rotation scheme plans are currently been made to rotate the band 6 and 7 roles.
- We spoke to junior doctors who told us they received regular supervision from the emergency department consultants.
- Nursing staff were aware of the need to revalidate in the coming year, however staff told us that no specific issues had been discussed with them from the management team in regards to revalidation.
- Staff we spoke with, told us they felt confident and competent working in their own protocols. They did express concern to us that the length of stay of some patients in the ED meant that different competencies were required.
- Staff were not trained on the advanced trauma nursing course, as Pinderfields is not a major trauma centre, extra in house training was available for arterial line and chest drain management.

Multidisciplinary working

- There were examples of internal multi-disciplinary team (MDT) working.
- During our attendance at a bed management meeting we noted a very organised pace and system to the meeting, with key decisions been made in an effective manner. The current REAP level was discussed, the amount of patient in the ED department, the current wait time and number of breaches were discussed. Whether a hospital divert was in place was discussed and what beds were available and what extra capacity was open.
- Staff spoke to us very clearly and positively about the relationship with the newly formed mental health liaison team, this new service was provided mental health advice and guidance 24 hours, seven days a week. Staff felt this improvement in care services for mental health patients.
- Staff spoke about their positive relationships with the safeguarding team, community physiotherapy teams and medical consultant teams. Staff also spoke to us about their links into specialist nurse services in relation to stroke, respiratory and cardiac conditions.
- Staff spoke to us about the admissions avoidance team, a team for access to GP and community matron where the aim is to get patients home safely. They also told us about the hospital avoidance team for when issues where more social in nature. Staff spoke to us about their relationships with the drug and alcohol liaison services and a specific teenage section of this team and the children and adolescent mental health service (CAMHS) team. All patients who alcohol related issues are referred to the alcohol service.
- Access to radiology services is available 24 hours a day 7 days a week, specialist scanning is only available in hours.
- Access to pathology services are available until 4.30pm/ 5.30pm Monday to Friday, out of hours staff have access in the department to a point of care blood testing machine which can test simple blood tests. Blood tests used in testing for cardiac conditions are provided off site and this is where delays can occur.

- Staff told us that at times the service felt unsafe with the lack of backup support. They told us about three patients all needing CT scanning, patient one had a scan as was in hours, patient two and three needed scanning but had to go to Pinderfields as was out of hours, they requested a paramedic crew to attend, however on arrival the crew was an unqualified crew and were unable to transfer the patient alone, due to patient having opiate pain relief. A nurse accompanied this patient.

Staff were aware that unqualified crews are available even if they request qualified crew they would prefer if they were communicated with prior to transfer as they would be able to plan for escorts. When this lack of communication occurs staff don't always complete incident forms. Staff reported that they have called meetings with the management team to discuss these issues.

- Security is provided onsite 24 hours a day and a closed circuit television (CCTV) system is installed and monitored at the Pinderfields site.
- There is access to onsite access 24 hours a day to anaesthetic support.

Seven-day services

- The emergency department was open 24 hours a day, seven days a week. The Children's ED is internal to the main department it also remains open 24 hours a day
- The department remains a 24 hour doctor led ED, with medical cover provided until 5pm daily by the consultant rota. After 5pm until 12 midnight there is a senior middle grade doctor on duty and from 10pmcover is provided by a private medical contract staffed by senior doctors and GPs. Staff told us that the level of night cover led them to feel it was unsafe, however they couldn't recall any specific incidents.
- Approximately 10-12 patients attend ED overnight.

Access to information

- Medical and nursing staff could access current information for each patient in the department. This information was displayed on computer screens in the main nurse base area and touch down areas in the department.
- The computer information system had been recently introduced into the department and was widely used in the NHS.
- Staff reported to us frequent breakdowns of the national ED recording systems, no incident forms were completed.
- Staff had access to patient information that they required through the computer system and were able to provide GP letters through this system.
- Staff were unsure as to whether consultants in Pinderfields view the records of the patient prior to transfer, but this facility exists.
- The computer programme allows for records storage of observations, during the inspection staff were using printed observations chart and then scanning them in to system, they told us this was because the system only allows for three sets of observations to be recorded.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patient's consent being obtained before care was delivered.
- Staff spoke to us about their knowledge and experience of the mental capacity act (MCA) and declaration of liberty (DoLS), staff were aware of procedures for gaining consent and the need for referrals where required.
- Staff had accessed training on MCA level 1, 2 and 3 compliance data supplied to us by the trust showed low levels of training compliance 47.5% for nursing staff and medical staff at 44%.staff showed us a pocket guide to MCA and DoLS.
- We spoke with staff about obtaining consent from children and young people "Gillick Competency", staff were clear about the need for assessment of children and young people under 16 to decide whether they are old enough to consent to medical treatment.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Concerns were raised about access to out of hours support service such as radiology scanning and clinical blood testing, but these were delivered onsite in core hours, out

of hours they are provided on Pinderfields site, we saw evidence patients experiencing delays in treatments, and testing due to blood samples not arriving in the testing facility and testing equipment on site failing.

Staff were concerned about recent changes in the booking of ambulances and recent delays in transfers due to this changing to the booking system from priority one ambulance (life threatening illness or injury); these are often downgraded to a priority two booking systems and concerns around patient deterioration.

Access for specialist treatment was not provided on site and a strict admissions criteria existed. Pathways were all developed to reflect national guidance. CEM audits were not always undertaken on the Pontefract site despite appropriate patients being identified. A good system of answering complaints within the 3 departments was identified.

Service planning and delivery to meet the needs of local people

- The number of patients attending Pontefract ED had remained relatively static with on average 3324 patient attendances per month, July 2014 to May 2015. Peak attendance was seen in March 2015 with 3495 attendances and lowest attendance of 2973 in January 2015.
- Staff were aware of the population they serve and the ethnically diverse needs that they require.
- Medical service was provided onsite by a GP cooperative scheme.

Meeting people's individual needs

- A dedicated Paediatric area was available to Paediatric admissions
- Access to radiology service was available 24 hours a day.
- On the ED computer system a symbol was available to request direct to admitted ward staff that patients needed an air mattress, this system ensured that patients received on prior to admission onto the ward. Staff spoke to us about pressure area packs.
- Staff showed us stickers that were used to identify patients with dementia.
- Nursing and medical staff spoke to us about a programme called documented care, comfort, toileting and verbalising (CCTV) this programme clearly demonstrates the comfort rounds given to patients, during the inspection we saw evidence of the CCTV round.
- A listening to you board had been developed as a result of the information from the friends and family test results, patients had told the trust that not enough staff were present, long waiting times, no explanations of treatment and discharge and staff not introducing themselves. Actions taken were listed as extra staff being provided, new information boards, clear explanations, and reminding staff to introduce them and wearing ID badges.
- Translation services were available, two separate displays of leaflets were reviewed and Patient information was only available in English. Staff also had access to a patient picture board which they used to translate. Family and friends cards were also found to be available in other languages. Staff were aware that during the time of the visit it was Ramadan and the need to support cultural needs.
- Information for patients regards to domestic violence was available in a staff area, not in a public area.
- Cubicles exist for speciality conditions such as gynaecology, mental health interview room and decontamination following a chemical/ biological exposure.
- A children's waiting area had been developed following feedback about paediatrics waiting with adults from a member of staff. This area was in the middle of the department and three cubicles used for paediatrics were on the bottom left side of the department which segregated children from adults as much as possible.

Access and flow

- The Mid Yorkshire hospitals NHS trust had not achieved the national target of seeing 95% of patients within four hours consistently each quarter for the previous six months ranging from 82.6% to 92.1% January 2015-June 2015.Pinderfields had met the 95% target for the previous 12 months.
- Staff told us that attendance has recently increased by 1000 patients and compared with January to May 2014 however we are unable to corroborate this as data was not supplied by the trust pre April 2014.

- The CEM recommends that the time patients should wait from arrival to receiving treatment is no more than one hour we noticed during the two visits that patients were waiting up to 58 minutes; one patient waited over two hours from the sample reviewed.
- The median amount of time people could expect to spend in ED before being discharges, admitted or transferred between July 2014 and September 2014, all three sites was on average around 125 minutes which was lower than the England average of 136 minutes.
- On average against the England comparison the percentage of people leaving the ED on all three sites was higher than the England average. Overall in England this data is recognised by the department of health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait.
- There have been no reported breaches of patients waiting for more than 12 hours in the ED once a decision had been made to admit.
- The target for Ambulance handover times to be achieved within 15 minutes, data supplied by the trust indicated that in the previous two months Pontefract had achieved this 92.31% and 94.83% with the overall trust position being 78.74% and 72.24%.Self handover is used within the Yorkshire ambulance service and the clinical lead spoke to us about the lack of self-handover from ambulance patients in throughout the three EDs, we spoke to ambulance crews about this and they told us it was underutilised and confusion over its use and some staff not being engaged in the process.
- Ambulance crews we spoke to talked about a complex and complicated handover process and this not being consistent over the 3 sites in the trust.
- GP medical referrals go directly to the allocated ward, however is the patient is clinically unwell they attend ED. GP surgical referrals still attend the ED. If patients are allocated to the medical team they can attend the ambulatory care ward run by consultant medical teams, this approach was not consistent as one GP admission occurred and staff reported this has been inappropriate for Pontefract as they needed Pinderfields care.
- Staff spoke to us about clear plans for escalation and where aware of how to ask for help when the department was busy this including asking paediatricians to attend the department, referrals directly to speciality areas.
- Criteria existed about what admissions Pontefract could take, they do not take patients who have had a take cardiac arrest, stroke, or fractured neck of femur from the ambulance service. However staff needed to be prepared for these patients being admitted as they can often come in alone or with relatives as walk in patients.
- On the day of inspection despite set criteria as Pinderfields site was on a blue light divert so couldn't take any emergency admissions from ambulances or GPs, the ambulance crews contacted the department to ask whether they would take two patients, we witnessed the Sister in charge refuse to take both patients as they didn't fit the admission criteria.
- Staff told us about recent changes in the booking of ambulances and they had had recent delays in transfers due to this changing to the booking system. They told us that when they booked priority one ambulance (life threatening illness or injury), these are often downgraded to a priority two booking systems. Staff talked to us about recent incidents where they felt this downgrading caused patient harm, however on further questioning they hadn't completed and incident forms on these issues. On further discussion with the HOC it became apparent that this downgrading was a decision discussed with the trust and had now brought them in line with other organisations.
- Staff told us that a bed with very strict criteria attached for admission was available on the rehabilitation ward and they used this bed for patients that were going to breach their ED waiting time.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). All complaints were overseen and allocated by the matron, and investigated by four medical consultants and the three ED lead nurse.
- Complaints were submitted and processed using the trusts computer centralised recoding tool. Learning from complaints was disseminated via the combined clinical governance meeting for Pinderfields and Pontefract and the Dewsbury clinical governance meeting for Dewsbury.No formal route of learning was shared over the three sites.

Urgent and emergency services

- Senior nursing and medical staff spoke clearly to us about how complaints information is gained, responded too and used within the department. Complaints are investigated by four medical consultants and the lead nurses.
- Staff spoke to us about complaints and a recent piece of work that had been carried out in regards to staff attitude, and seating in the waiting room. They also spoke to us about a child with complex care needs and due to the family complaining the child now has a plan for direct entry to the paediatric ward, where staff are knowledgeable about the child's needs.
- We reviewed 10 recent complaints for the trust and their responses, none were supplied for Pontefract; we saw that apologies where offered and clear routes of the investigation and clear timelines were documented and plans to prevent complaint happening again were noted. In the second of the three complaints duty of candour was commented on this wasn't present in none of the other three. We also reviewed minutes of the senior nurses meeting and governance minutes where complaints where discussed. Staff told us that at Pontefract they don't receive many complaints; most of the ones that they did receive were medical about missed diagnosis and staff attitudes.

Are urgent and emergency services well-led?

Requires improvement

During the inspection it was clear that staff did not understand the 2017 vision for the three emergency departments, they were worried for the future of the Pontefract department and whether it would become a minor injury unit.

No robust clinical governance structure occurred through the three EDs, Pontefract and Pinderfields held meetings together and Dewsbury held a separate meeting, these meetings were not well attended or documented so if apologies were given in was difficult to see what actions were required. There were concerns over trust wide and departmental learning and sharing of lessons learned from incidents. Incidents were shared internally in the hospital, however sharing did not occur between sites especially Pontefract to Dewsbury.

The risk register was not updated when staff escalated issues for Pontefract to be placed on the risk register. Visibility of the senior management team on the Pontefract site was poor.

Nursing staff from the three sites meet regularly to discuss issues and concerns. All staff spoke highly of their colleagues.

Vision and strategy for this service

- The Mid Yorkshire NHS trust had introduced a set of core values during our discussions with staff; staff did not make reference to the values.
- Senior staff told us the vision for the department was to streamline services within ED at Pinderfields and to enable admission of the patient into the correct place. However not all staff could share the vision for the department with us.
- We reviewed the Urgent care improvement programme which has specific detailed work for the future development of the ED and the relaunch of rapid assessment strategies, ambulance handover paths. Key actions and performance requirements to be completed within that quarter were identified, however some status of these actions were indicated with red and amber indicating that not all actions had been completed within the timescale.
- Staff spoke to us about their uncertainness for the future of services on the Pontefract site, they told us they were unsure as to what services would exist and whether the department would remain an ED or become a minor injuries unit.
- They were aware that no further overnight closures were planned for the department and night time attendance had increased.
- When we asked the senior management team about the vision and strategy for the future they were very clear that Pontefract is remaining as an ED, however some discrepancies occurred about the type of admissions it would take as some spoke about less ambulance admissions and some spoke about remaining the same.

Governance, risk management and quality measurement

- A clinical governance structure was in place on the Pontefract ED site, as ED was part of the division of medicine and their governance meetings fed into the division of medicine governance meeting.

Urgent and emergency services

- The ED held multi-disciplinary group governance meetings, incidents, complaints, clinical audit data clinical issues, transfers, deaths and claims were reported. Little narrative was available about discussions or actions. Issues related to Pontefract and Pinderfields site were discussed.
- We reviewed two sets of minutes attendance was low. Minutes from the Dewsbury site Governance meetings were not discussed.
- No robust governance structure existed for the three EDs at the trust. A computer programme was shared to store their governance minutes, but no formal mechanism existed for shared governance on all three sites.
- Senior nursing staff meet regularly from all three sites to discuss issues and concerns.
- A departmental covering all 3 sites risk register was available this had 8 cross site risks on it; no specific risks were shown for Pontefract. On review incident forms and during discussion with staff two issues had been escalated for placement on the risk register. On reviewing the risk register neither of these risks had been added. These were the risks of patients deteriorating whilst awaiting transfer to tertiary care.

Leadership of service

- The three ED sites in Mid Yorkshire Hospitals was headed by a Head of Service (HoC), a matron and a patient services manager, these staff were all based on the Pinderfields site the HoC role is 50% clinical and 50% non-clinical.
- The Matron for the service attends Dewsbury site one week in four, Pontefract twice a month, the matron was aware of visibility being an issue when covering a three site ED. Each of the three sites had a lead nurse and a lead paediatric nurse was available for all three sites, the paediatric lead nurse visits every ED once a week.
- Staff spoke highly about their colleagues and senior leaders.

Culture within the service

- We found there was an open culture in the ED and staff were not afraid to express concerns informally or formally.
- Staff spoke to us about the ED team a general feeling of a positive moral in nursing staff with a good support network; however the same was not discussed in relation to medical staff.
- Staff reported to us good working relationship with Pinderfields and Dewsbury sites.
- Staff spoke about their worries in the department and about the length of stay of patients and patient safety concerns, and it being normal now to run with 4- 12 hour breaches and patients in beds.
- Staff spoke about their proudness in the team to work in difficult environments in relation to the flexing of beds.

Medical care (including older people's care)

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides medical care (including older people's care) across three sites. Pontefract Hospital had one medical ward, the rehabilitation unit. The Rehabilitation Unit had 30 beds although 29 beds were open during the inspection, 20 for stroke patients, eight for medical patients and one cubicle for patients who had attended the emergency department.

During the inspection we spoke with five patients and seven staff, including doctors, therapists, nursing staff and a pharmacist. We looked at medical records and prescription charts. Before the inspection, we reviewed performance information from and about the Trust.

In July 2014 CQC carried out an announced comprehensive inspection and overall we rated medical care at Pontefract Hospital as requires improvement. We rated safety, effectiveness, responsiveness and being well led as requiring improvement and caring as good.

Summary of findings

Overall we rated the safety domain as requires improvement. We had concerns regarding the registered nurse staffing levels on the unit. Mandatory and statutory training compliance was variable on the unit. There was 100% compliance in manual handling (practical training) however there was low compliance in patient safety training, resuscitation, infection prevention and control.

There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these.

Overall we rated medical care services as requires improvement for being effective. We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. However appraisal rates for nursing staff was 60%.

We found malnutrition universal screening tool (MUST) was completed fully. We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking

Staff were able to demonstrate their knowledge of mental capacity assessments and deprivation of liberty safeguards and we saw examples in practice on the unit.

Medical care (including older people's care)

Overall we rated medical care services as good for caring. Although patients were concerned that nurses had too much to do they were generally happy with their care and the way they were treated by staff on the unit. In May 2015 we saw the results of the friends and family test which indicated 100% of patients who would recommend the service they had received to friends and family who need similar treatment or care. Patients we spoke to felt that they were listened to by staff. Patients were aware of what treatment they were having and said that this had been explained to them properly.

Overall we rated medical services as being good for the responsive domain. We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014.

We found the service had specialist roles to support people's individual needs which included a learning disability nurse. There was a ward based action group which aimed to enhance the environment for patients. This had resulted in upgrading the day room and sourcing higher chairs for tall patients. Visiting times have also been extended to allow relatives to be involved in supporting patients at mealtimes.

There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Overall we rated medical care serves as requires improvement for being well-led. There had been a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site which meant they were not always visible at the hospital site. Throughout the inspections we found nurse staffing levels on wards continued to be a problem. Therapy staff told us that although they do not have much contact with more senior managers they feel confident that their line managers take their concerns and messages further up the organisational chain. We were told that there was no specific nurse or medical lead for Pontefract Hospital.

Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall we rated the safety domain as requires improvement. We had concerns regarding the registered nurse staffing levels on the unit.

Mandatory and statutory training compliance was variable on the unit. There was 100% compliance in manual handling (practical training) however there was low compliance in patient safety training, resuscitation, infection prevention and control.

There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these.

Incidents

- We found there was a policy was in place for the reporting and investigation of incidents: Incidents were reported electronically using an online reporting system (datix). Between January 2015 and May 2015 there had been a total of 3,773 incidents reported across the division of medicine.
- In the same time period we saw the majority of these incidents were graded as low or no harm (93%) with the remaining 7% graded as moderate and above.
- During this period the top themes for incident reporting were slips, trips and falls, pressure ulcers and staffing levels. These accounted for 2,386 incidents out of a total of 3,730 which equated to 64%.
- The division of medicine reported 71 serious investigations between January and March 2015. These included incidents raised due to care and treatment, slips trips and falls incidents and pressure ulcers. In April 2015 the division reported 19 serious incidents of which 63% were pressure ulcer related and in May 2015 there was a further 19 serious incidents due to pressure ulcers, slips, trips and falls and administration of assessment.
- There had been one never event within the division which related to a medication incident in September 2014. We saw an investigation had been completed and an action plan developed.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. All the medical wards recorded the safety thermometer information monthly. This included information about the last time a patient had fallen on the ward, developed a grade 3 or 4 pressure ulcer, if patients had been assessed for or developed venous thromboembolism (VTE) and the number of urinary infections including those for patients with catheters.
- Overall the Trust percentage of harm free care for the period June 2014 to June 2015 (inclusive) was 91.79% which was worse than the England average.
- We observed safety thermometer information displayed at the entrance to the unit. The last fall with harm was 32 days ago, there had been one category 3 pressure ulcer reported in both April and May 2015, VTE assessment compliance was 100% and it had been 14 months since the last urinary tract infection.

Cleanliness, infection control and hygiene

- We found the unit was clean and well maintained. There were policies and procedures in place to ensure that any patients with an infection were managed appropriately, including barrier nursing procedures where applicable.
- Personal protective equipment and alcohol hand gel was available at the entrance to the unit.
- There had been no cases of Methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) on the unit in the last 14 months. One patient was being cared for with Methicillin-resistant staphylococcus aureus (MRSA) however this was not acquired in the hospital.

Environment and equipment

- We reviewed information on the unit and found the resuscitation trolley had not been checked on 2 days from the beginning of June but had been checked the rest of the time.

Medicines

- Staff told us that a pharmacist visited the unit daily. One of the pharmacist informed us that an optimum/ minimum level of visits was planned taking into account clinical need of patients on the unit. On this unit the

minimum was for a pharmacist to visit at least three times a week with a pharmacy technician visiting twice a week. The optimum was for daily visits from a pharmacist.
- Pharmacy staff told us that the rehabilitation unit was using an electronic system to test and monitor the temperature of the fridge and storage room in which medicines were kept. This system measured the temperature every 10 minutes and was monitored centrally in pharmacy. Alerts were sent to the unit when incorrect temperatures were detected in order that corrective action could be taken. We saw a printed report for the fridge temperatures on the day of inspection which showed that the correct fridge temperature had been maintained in the last 24 hours.
- One pharmacist told us the controlled drugs were checked in line with trust policy; once daily balance check by the nurses, monthly check by the ward manager and three monthly checks by the pharmacy team. We observed that these checks had been completed and recorded in the controlled drugs log book.
- We found medicines were all stored securely.

Records

- We looked at 16 medication charts on the unit all of which had been fully completed. When patients had refused medication the reason for missing the dose had been documented on the chart.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- We saw information for June 2015 which showed 100% of staff had received level one safeguarding adult training and 80% had undertaken level two training.
- For the same month we saw 100% had completed level one children's safeguarding training and 81% had completed level two.
- Therapy staff we spoke to had completed their safeguarding training and were aware of whom to contact regarding safeguarding concerns.
- Nursing staff on the unit were able to give an example of when they had consulted with the Head of safeguarding for advice regarding an issue with a patient.

Mandatory training

- The trust provided information on training which showed compliance rates within the division of medicine. We saw there was 88% compliance with core mandatory training this included training on health and safety, fire safety, infection control and manual handling.
- Therapy staff reported that they were up to date with their mandatory training and that this was checked weekly.
- Nursing staff reported that it was difficult to complete mandatory and statutory during the day due to staffing pressures and shortages, they said they could find time on the night shift to do online training. One nurse told us they had booked onto resuscitation training but was unable to attend due to staff shortages.
- Mandatory and statutory training compliance was variable on the unit. There was 100% compliance in manual handling (practical training) however there was low compliance in patient safety training, resuscitation, infection prevention and control.
- We were told that a patient safety training session was booked for staff on the ward in July 2015.

Assessing and responding to patient risk

- The trust followed the National Institute for Health and Care Excellence (NICE) guidance to identify deteriorating patients. Electronic monitoring systems helped staff to recognise when patients were deteriorating. The system included prompts and advice to staff on what actions were needed.
- The trust used an electronic observation recording tool (Vital Pac). This allowed staff to improve the monitoring of whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating. We saw this in use on the unit.
- We were told that deteriorating patients were reviewed Monday to Friday by the unit medical staff, during out of hours by the on-call anaesthetist and if necessary a call to 999 was made.

Nursing staffing

- We reviewed information the Safe Nurse and Midwifery Staffing: public board paper for May and July 2015. We saw within the Division of Medicine the vacancy position in October 2014 was 37.60 WTE and had steadily

increased month on month to 16% or 74.95 WTE in April 2015. In July 2015 the vacancy rate across the division was 81.52 wte (18.3%) this had increased from the April 2015 position.

- We were told that there was a template for agreed staffing based on a ratio of one nurse to eight patients. The current establishment was four registered nurses (RN's) and three health care assistants (HCA) during the day and three RN's and two HCA's at night. The minimum staffing levels were three RN's and two HCA's during the day and two RN's and two HCA's at night.
- On the day of inspection there were four RN's and three HCA's on duty during the day and three RN's and two HCA's planned for the night shift. We were told the day prior to inspection the staffing levels were below the minimum with and three RN's and one HCA on duty for most of the day. This was due to staff sickness.
- The fill rates for the previous month were displayed. The fill rate for registered nurses on days was 74.6% and 93.4% on nights. The fill rate for health care assistants on days was 104.9% and 112.1% on nights.
- We were informed that the Chief Nurse sets the establishment and this was agreed across the Hospital 8-10 months ago. The ward manager was not aware of the use of an acuity tool.
- The unit had three registered nurses on maternity leave and two vacancies which were waiting to be filled.
- We were told that a nurse had been moved to Pinderfields Hospital to help out with pressure there. Another nurse told us that staff from the unit were regularly moved to Pinderfields and sometimes Monument House when they were short staffed.
- When staff were off sick the shifts were offered out to current staff. There was a central bleep holder who can be contacted to deal with staff shortages due to sickness.
- For longer term sickness absence the unit used bank and agency staff and these were usually regular staff who were familiar with the unit.
- Annual leave was booked through employee online which linked to the e-rostering system.

Medical staffing

- The trust provided information prior to the inspection which showed that in January 2015 there was a vacancy rate of 11.56% in diabetes and 14.81% in respiratory medicine
- The rehabilitation unit had an associate stroke specialist who visited during the week from Monday to Friday and saw all stroke patients.
- A stroke consultant visits the unit every Tuesday to carry out a ward round in the morning and a multidisciplinary team meeting in the afternoon.
- A medical registrar covered the unit Monday to Friday and saw all patients.
- Staff told us that there was no medical cover over the weekend; an on-call anaesthetist was available for cover weekends and overnight. We were also told that cover s not provided for medical staff when on holiday or off sick.
- We were informed that there are no foundation level doctors working on the Unit.

Are medical care services effective?

Requires improvement

We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. However appraisal rates for nursing staff was 60%.

We found malnutrition universal screening tool (MUST) was completed fully. We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking

Staff were able to demonstrate their knowledge of mental capacity assessments and deprivation of liberty safeguards and we saw examples in practice on the unit.

Evidence-based care and treatment

- We saw the division of medicine for 2014-15 were participating in 25 audits. We saw the trust wide annual audit priority programme identified when the audit was due to start and when the audit was due for completion.
- Staff informed us that several audits were carried out on wards which included a daily hand hygiene audit, antibiotic prescribing audit, safe care audit, care assurance audit, forget-me-not audit.
- We found monthly matron assurance frameworks audits for each clinical area the audits review included

medicine management, storage and management of equipment /crash trolleys, documentation, patient experience and a full review of nursing assessments and care planning.

Nutrition and hydration

- Patients we spoke with told us the food was good.
- We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking.
- We found malnutrition universal screening tool (MUST) was completed fully. The MUST identified patients at risk of malnutrition and dehydration.

Patient outcomes

- Therapy staff told us that there were not always enough nursing staff to support the therapy activity available. They thought that this limited the effectiveness of the therapy on patient outcomes.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and an annual appraisal.
- Therapy staff we spoke to had completed their appraisals and said they had regular supervision with their line manager.
- The ward manager told us staff appraisal rates were approximately 60% and that this was due to staff sickness and staffing shortages.

Multidisciplinary working

- Therapy staff reported good working relationships across the multidisciplinary team. They told us the stroke consultant was approachable and that they felt the service was joined together.
- Multidisciplinary team meetings were held weekly on Tuesday afternoons.
- We were told that speech and language therapy was available for patients on the unit and viewed evidence of speech and language therapy input for stroke patients in 2 patient's medical notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust provided information for the division of medicine which showed levels of training for MCA/ DOLS. We saw 83% of staff had completed level 1, 44% had completed level 2 and 59% had completed level 3 training.
- Therapy staff we spoke to had received training in the Mental Capacity Act 2005 and understood when it should be used and applied.
- We observed that 2 Deprivation of Liberty Safeguards applications and one extension had been made for patients on the unit.
- We observed in one patient's notes a best interest assessment had been carried in relation to their Deprivation of Liberty Safeguards application.
- A therapist informed us that they had been involved in the trust training programme for raising awareness of the Mental Capacity Act 2005 on the Unit and on other wards.

Are medical care services caring?

Good

Overall we rated medical care services as good for caring. Although patients were concerned that nurses had too much to do they were generally happy with their care and the way they were treated by staff on the unit. In May 2015 we saw the results of the friends and family test which indicated 100% of patients who would recommend the service they had received to friends and family who need similar treatment or care.

Patients we spoke to felt that they were listened to by staff. Patients were aware of what treatment they were having and said that this had been explained to them properly.

Compassionate care

- A notice board displayed the results of the Friends and Family test. In May there had been an 89.7% response rate with a score of 100% of patients who would recommend the service they had received to friends and family who need similar treatment or care.
- We spoke to five patients on the Unit. Although patients were concerned that nurses had too much to do they were generally happy with their care and the way they were treated by staff on the unit.

Medical care (including older people's care)

- One patient told us one day they hadn't been washed until 2.30pm due to staffing shortages. On another occasion they had a social work appointment at 11.00am but wasn't helped up until 10.55am.
- Another patient told us the treatment from the physiotherapist and occupational therapist had been excellent.
- One patient said the it was the best hospital they had been in and that all staff had a good bedside manner.
- We observed that patients on the Unit were treated with compassion and respect and their dignity was preserved.

Understanding and involvement of patients and those close to them

- Patients we spoke to felt that they were listened to by staff. Patients were aware of what treatment they were having and said that this had been explained to them properly.

Are medical care services responsive?

Good

Overall we rated medical services as being good for the responsive domain. We found the number of medical outliers had reduced on surgical wards since our last inspection in July 2014.

We found the service had specialist roles to support people's individual needs which included a learning disability nurse.

There was a ward based action group which aimed to enhance the environment for patients. This had resulted in upgrading the day room and sourcing higher chairs for tall patients. Visiting times have also been extended to allow relatives to be involved in supporting patients at mealtimes.

There were systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience

Access and flow

- At our inspection in July 2014 medical staff told us there were often 20 to 30 medical patients (outliers) on the surgical wards. At this inspection we reviewed data which showed from 1 June to 11 July 2015 indicated there were no medical outliers on any one day.
- We reviewed information the trust provided between February 2015 to May 2015 that was taken as a "snapshot" once a week on a Thursday. The data showed that at Pontefract there were no patients admitted under a medical specialty based on a surgical ward.
- We found a registered nurse co-ordinated patient discharges.
- We were told some patients who presented with a medical problem at Pontefract Accident and Emergency Department were generally sent to Dewsbury as there were no beds available at Pontefract and Pinderfields. Stroke patients were sent directly to Pinderfields.
- Staff expressed that for some patients and relatives Dewsbury District Hospital was too far away for patient's relatives to travel to from Pontefract.

Meeting people's individual needs

- Therapy staff were unsure if they had any leaflets for patients in other languages however they were aware of how to access interpretation services and how to request information to be translated.
- The ward sister told us that they were developing a booklet for patients to encourage them to use the dining room facilities more.
- There was a ward based action group which aimed to enhance the environment for patients. This had resulted in upgrading the day room and sourcing higher chairs for tall patients. Visiting times have also been extended to allow relatives to be involved in supporting patients at mealtimes.
- A notice board in the corridor displayed the contact details and a photograph of the Learning Disability Liaison nurse. The role of this nurse is to support staff to improve care for patients with a learning disability.

Learning from complaints and concerns

- We saw in the governance, patient harm and patient experience report across the division of medicine between January 2015 and March 2015 there was 132 formal complaints and 17 informal complaints. The top

key reasons for complaints was due to clinical treatment with the sub factors under this heading being poor nursing care, co-ordination of treatment and delay in diagnosis.

- In subsequent reports we saw the information for April and May 2015. There had been 40 complaints in April 2015 and 33 complaints in May 2015. The reasons for complaints were identified as clinical treatment, admissions/transfers/discharge procedure, communication and staff attitude/behaviour.
- We were told that the Unit had not received any complaints for over a year.
- Complaints data supplied by the Trust showed only one complaint for Elderly medicine between February and December 2014 which was partly upheld

Are medical care services well-led?

Requires improvement 

Overall we rated medical care serves as requires improvement for being well-led. There had been a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months. Some of the matrons continued to cover more than on hospital site which meant they were not always visible at the hospital site. Throughout the inspections we found nurse staffing levels on wards continued to be a problem.

Therapy staff told us that although they do not have much contact with more senior managers they feel confident that their line managers take their concerns and messages further up the organisational chain. We were told that there was no specific nurse or medical lead for Pontefract Hospital.

Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.

Governance, risk management and quality measurement

- We saw information in the governance, patient harm and patient experience report for the division of medicine which showed there had been 469 reported incidents related to staffing between January to March 2015. In the reports for June and July 2015 we found in April 2015 there had been 129 incidents and 181 incidents in May 2015 related to staffing levels.
- Within the division there was a monthly governance meeting at which all incidents were discussed with consultants and specialist nurses. We saw information in the meeting minutes which showed incidents, training and complaints were discussed. In addition to the governance meeting we saw the division of medicine produced a governance, patient harm and patient experience report.
- We found in the minutes of the governance meeting from February 2015 it was noted there was an overdue rate of clinical incidents which related to over 300 cases and this number had increased in the latter weeks of January 2015 mainly due to clinical pressures preventing staff from completing investigations in a timely manner. The trust reported at the time of inspection in June 2015 the division had recovered their position and the overdue rate was down to 66 incidents, which was within the accepted tolerance level by the Trust.

Leadership of service

- There had been a history of change at ward manager, matron and senior leadership within the division of medicine and we found at this inspection a number of ward managers and senior nurses had been in post less than six months.
- Some of the matrons continued to cover more than on hospital site which meant they were not always visible at the hospital site.
- Medical staff we spoke to told us they had approached the trust regarding the development of medical services at Pontefract and had been told that there was a plan to centralise services in 2017. They felt no-one was "arguing" the case for Pontefract Hospital.
- We were told that there was no specific nurse or medical lead for Pontefract Hospital.
- Therapy staff reported that they have regular meetings with their line manager and they received the Team

Brief. They told us that although they do not have much contact with more senior managers they feel confident that their line managers take their concerns and messages further up the organisational chain.

Culture within the service

- Therapists we spoke with felt well supported and said that services are moving forward. They thought that services were joined up which led to improved patient care.
- Senior nursing staff told us they felt things had changed and there was a culture of positive change.

Surgery

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

Information about the service

Pontefract General Infirmary provides elective (planned) surgery and day surgery. There are 20 acute surgical beds and four theatres. We inspected the day surgery unit, the operating theatres and the elective orthopaedic surgical ward.

We spoke with eight patients and 13 members of staff, including ward managers, nursing staff, medical staff (both senior and junior grades) and managers. We observed care and treatment. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust

Summary of findings

At the last CQC inspection in July 2014 we rated surgical services as good for caring, but improvements were required for safety, effectiveness, responsive and being well led. During this inspection overall we rated Pontefract General Infirmary as good with responsive requiring improvement.

Staff were responsive to people's individual needs; however there remained concerns over waiting times, such as the 18-week referral to treatment times.

There were systems for the reporting of incidents and evidence of learning. Staffing levels were in line with the staffing establishment and skill mix. Infection prevention and control and medicines were managed effectively. The checking of equipment had improved. There was good adherence in theatres with the 'five steps to safer surgery' checklist.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. The majority of outcomes were within expected ranges.

There was effective ward level leadership however engagement and visibility of the Chief Executive and the Board of Directors on the site could be improved.

Surgery

Surgical services were caring. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. The service took account of patient concerns and complaints.

Are surgery services safe?

Good

There were systems for the reporting of incidents and evidence of learning. Staffing levels were in line with the staffing establishment and skill mix. Infection prevention and control and medicines were managed effectively. The checking of equipment had improved. There was good adherence in theatres with the (World Health Organization) five steps to safer surgery checklist.

Staff received mandatory training; however, the number of staff that had completed mandatory training was below the trust's expected levels.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. We found staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system, and were encouraged to report them.
- The number of incidents reported for Pontefract between April 2014 and February 2015 was 24. The majority of these related to low or no harm and near misses. Staff gave examples of learning which included completion of a falls assessment for all patients with a learning disability.
- Information about trust wide incidents relating to surgery was shared with staff for leaning through e-mails, patient safety briefings and ward meetings. Staff were for example, able to inform us of the actions taken following a drug incident which had been shared across all hospital sites.
- There had been no never events reported at this hospital.
- Mortality and morbidity meetings were in place. All relevant staff participated in mortality case note reviews and reflective practice. Minutes of a meeting held in April 2015 for general surgery showed that learning included elderly patients to be carefully selected for invasive investigations, optimization of clinical condition and co-morbidities to achieve better outcomes and improved involvement of the teams for very sick and unwell patients.

- Staff were aware of the Duty of Candour Regulations. There was e-learning and written paperwork for staff to follow. The trust performance report showed there were no breaches against the Duty of Candour Regulations.

Safety thermometer

- The percentage of adult in-patients for April 2015 who had a VTE risk assessment on admission to the trust was 99.1%.
- The trust used the nationally recognised NHS safety thermometer as one of its improvement tools for measuring, monitoring and analysing care. Performance was measured against four possible harms: falls, pressure ulcers, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- Data for June 2015 showed 96% of patients in general surgery had received harm free care.

Cleanliness, infection control and hygiene

- Ward areas were clean and we saw staff regularly wash their hands between patients and between clinical interventions. Staff were bare below the elbows, in line

with trust policy and national guidelines. All patients spoken to were extremely happy with standards of cleanliness and the environment.

- There were no Methicillin-resistant Staphylococcus Aureus (MRSA) infections for surgery. There had been no reported cases of Clostridium difficile for surgical wards at Pontefract General Infirmary.
- The unit participated in the ongoing surgical site infection audits run by Public Health England. The Surgical Site Surveillance Report on knee replacements: October 2014 to December 2014 showed out of 84 patients operated on there was 1 surgical site infection (1.2%) which was better than the national surgical site infection target of 1.7%.
- We observed that in theatre two the instrument trolley was being set up at beginning of the list for all cases. We discussed this with the practice educator who agreed that this was not good practice and they would address this with theatre staff, discuss at the managers meeting and refer to the infection prevention control team to include within policy.
- Environmental audits for the day surgery unit showed 98% compliance and 100% compliance for the elective orthopaedic unit.

Environment and equipment

- At the last inspection we found that checks were not being consistently carried out on all emergency equipment. During this inspection records showed checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- The Resuscitation Committee received assurance of daily checks and reported these directly to the Quality Committee.
- There was an escalation process in place to report non-compliance with daily checks.

Medicines

- Medicines were stored correctly and securely on the wards and theatres.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Improvements had been made to ensure the minimum and maximum fridge temperatures were recorded to ensure medicines were stored safely. Ward and departmental check lists were in place and spot audits were carried out by the pharmacy department.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area.
- Compliance with training for adult and children's safeguarding level 1 across all surgical areas was 100%, 74% safeguarding adults level 2 training, 85% safeguarding children level 2 and 100% level 3 for safeguarding children.

Mandatory training

- The performance report for April to May 2015 showed that 92% of staff in the division of surgery was up to date with their mandatory training against a year end trust target of 95% and 77% with role specific mandatory training against a year end trust target of 85%.
- Data for June 2015 showed 71% of staff had completed resuscitation training. According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake

cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates. Records showed that 10 staff were scheduled for basic life support training.

Assessing and responding to patient risk

- At the last inspection we found that the Five Steps to Safer Surgery World Health

Organisation (WHO) checklist was not being fully completed. During this inspection we observed one surgical procedure and found all areas of the checklist were appropriately carried out.

- A WHO checklist standard operating procedure was in place which set out roles and responsibilities of the theatre team from sign in for the induction of anaesthesia, time out before the start of the surgical intervention, sign out and debrief.
- The surgical division had also redesigned the safer surgery form and rolled out training to staff.

Nursing staffing

- Staff described staffing levels as good. There were no vacancies on the day surgery unit. The unit had a stable workforce with low turnover rates. Staffing levels complied with the required establishment and skill mix.
- There were 12.8 registered nurses and 5.8 health care assistants on the elective orthopaedic unit. This was a nurse led unit with an advance nurse practitioner on each day and night shift.
- There was a safe staffing and escalation protocol to follow if staffing levels fell below the agreed roster.
- There was some rotation of staff across to the Pinderfields site but this had improved which meant staff were not regularly taken off shifts to cover other areas.
- Staffing in theatres and recovery was in line with established levels. There were five recovery staff.

Surgical staffing

- The orthopaedic ward at Pontefract was run by advanced nurse practitioners.
- Medical cover was provided by a resident medical doctor who looked after the whole hospital at night, including stroke, respiratory and renal patients.

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes.

Mortality indicators were within expected ranges. Pontefract General Infirmary was better than the national average in most elective and non-elective specialties with the exception of elective orthopaedics and non-elective urology which were higher (worse) than the national average. The trust participation rate and outcomes for the Patient Reported Outcomes (PROMS) measures were the same as, or better than the England average in all categories except hip replacement where measures implied it was worse. The average length of stay showed that all surgical specialties were lower (better) than the national average.

Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. There was effective collaborative working between teams. Staff had received training in the Mental Capacity Act and Deprivation of Liberty safeguards.

Evidence-based care and treatment

- Patients were treated based on guidance from the National Institute of Health and Care Excellence, the Association of Anaesthetists of Great Britain & Ireland and the Royal College of Surgeons.
- Staff were consulted on guidelines and procedures which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were ratified by the division of surgery governance group. The policies we reviewed (correct site surgery, preoperative pathway and the WHO 'five steps to surgery policy) were all in date and reflected best practice guidance.
- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.

Patient outcomes

Surgery

- There were no current CQC mortality outliers relevant to surgery. This indicated that there had been no more deaths than expected for patients undergoing surgery.
- The unplanned readmission rates within 28 days of being discharged for May 2013 and June 2014 showed Pontefract was better than the national average in most elective and non-elective specialties with the exception of elective orthopaedics and non-elective urology which were higher (worse) than the national average.
- The trust participation rate and outcomes for the Patient Reported Outcomes (PROMS) measures were the same as, or better than the England average in all categories except hip replacement where measures implied it was worse.
- The average length of stay between June 2013 and July 2014 showed that all surgical specialties were lower (better) than the national average.

Competent staff

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.
- We spoke to staff and observed from the training matrix that appraisals were undertaken annually and there were also informal one-to-one meetings for staff if requested.

Multidisciplinary working

- There was effective multidisciplinary working on the wards. Staff told us there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Trust wide training data for June 2015 showed 93% of staff in surgery had completed Mental Capacity Act and DOLS Level 1, 50% level 2 and 56% level 3. This showed an improvement since the last inspection.
- Staff had an awareness of MCA and DOLS and the requirement to undertake a best interest meeting when assessing patients who lacked capacity.

Are surgery services caring?

Good

Surgical services were caring. Patients told us they were well supported by staff.

We observed compassionate and caring interactions on the wards. Staff were aware of the emotional aspects of care for patients and ensured specialist support was provided for patients when needed. There results from the NHS Friends and Family test were positive.

Compassionate care

- The NHS Friends and Family Test inpatient data showed 100% of patients were 'extremely likely' or 'likely' to recommend the elective orthopaedic unit at Pontefract General Infirmary to their family and friends.
- Most patients spoke positively about the standard of care and treatment they had received. Patients said they were treated with dignity and respect and did not have to wait long for staff to answer call bells.
- We observed positive, kind and caring interactions on the wards between staff and patients.

Understanding and involvement of patients and those close to them

- Patients were kept informed and involved with decisions about their care and treatment when appropriate. An audit showed 100% compliance in the pre-operative assessment unit for providing patient and visitor information.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.
- Some patients did not understand why they had been admitted for minor operations in the morning for afternoon theatre lists. Staff said all patients for a surgery session were asked to arrive at the beginning of the session so that surgeons could go through consent with them before scrubbing in for theatre, rather than have to come out and scrub in again.

Emotional support

- There was information within the care plans to identify whether patients had emotional or mental health problems.

Surgery

- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.

Are surgery services responsive?

Requires improvement

Staff were responsive to people's individual needs; however there remained concerns over waiting times, such as the 18-week referral to treatment times.

The service took account of patient concerns and complaints. Improvements were made to the quality of care as a result of complaints and concerns.

Surgical specialities were aware of local priorities to meet the needs of the local population.

Service planning and delivery to meet the needs of local people

- The division have worked with commissioners of service and clinical leaders in primary care to agree a new service model which included the separation of elective and non-elective surgery with centralisation of elective surgery at Pontefract and Dewsbury.
- Each speciality had identified local priorities to meet the needs of the local population such as improving capacity and the patient pathway in breast surgery, changing hours to suit local community access to oral and maxillofacial surgery including evening and Saturday morning clinics and development of one stop general urology outpatient clinics.

Access and flow

- There continued to be issues in achieving the national targets for referral to treatment times (RTT) in five out of seven specialties in surgery. Data from the division of surgery performance report showed that 75.6% of the admitted pathways completed in May 2015 were completed within 18 weeks against the 90% target. At the end of June 2015 there was one incomplete RTT pathway waiting over 52 weeks in plastic surgery against a trust target of zero. The division had recovery plans in place to improve RTT targets. Performance was reviewed weekly with individual specialties and corporately at an executive level. Additional funding had been agreed for extra clinic lists as well as increased theatre capacity.
- The trust reported 72 last minute planned operations cancelled for non-clinical reasons between April and June 2015. The trust was better than the expected targets in these areas.
- The admission, transfer or discharge of patients from the surgical wards and theatres at Pontefract was effective. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Data for January 2015 showed theatre utilisation was 77% at Pontefract General Infirmary.
- There were 20 beds on the elective orthopaedic unit which staff said rarely ran at 100% capacity and generally there were five empty beds available at any time. Staff felt that with better organisation of theatre lists the unit could be fully utilised as patients were having joint replacements out of area or in the private sector when beds were available.

Meeting people's individual needs

- There was a dedicated dental list every two weeks for patients with learning disabilities. Pathways were in place to ensure vulnerable patients were not cancelled. Meetings were held with the patient and their carers before the date of surgery. There were learning disability champions on the wards who provided support and advice.
- Advanced nurse practitioners ran clinics for elective orthopaedic patients one week before admission as a stop gap between pre assessment and admission to address any concerns prior to surgery.

Learning from complaints and concerns

- Between January and December 2014, there were 40 complaints reported for surgery at Pontefract General Infirmary. The main themes related to staff attitude and communication, clinical management and delayed and cancelled appointments.
- Meetings from governance meetings showed complaints were discussed and action taken to make improvements.

Are surgery services well-led?

Surgery

Good

There was effective ward level leadership. The matron was visible on site however there was limited engagement and visibility of the Chief Executive and the Board of Directors. Staff felt senior managers did not appreciate the potential at Pontefract Hospital for elective surgery however; there was a vision and strategy which included the reconfiguration of services to centralise all non-complex elective surgery at Pontefract and Dewsbury Hospitals.

Governance structures were in place. Some staff felt decisions were made without prior consultation; the trust was developing approaches to improve staff engagement across all clinical areas. There were some examples of innovative practice.

Vision and strategy for this service

- The division of surgery had a two-year operating plan which translated the trust's strategies and five year integrated business plan. The two-year operating plan articulated what actions the division would take to ensure that the trust's strategic objectives were achieved.
- The service model included the reconfiguration of services to centralise acute and complex elective surgery requiring critical care support at Pinderfields Hospital and moving elective surgery from Pinderfields to Dewsbury and Pontefract Hospital. The timescale for changes was 2017 but this depended on services outside the division for example, development of emergency department service provision.
- During 2015/16 the division was establishing working groups to provide detail on service reconfiguration, patient pathways, ward layout and transition for the service model in 2017.

Governance, risk management and quality measurement

- The divisions integrated performance report was structured around the five Care Quality Commission (CQC) domains, safe, caring, responsive, effective and well-led. The purpose of the monthly report was to identify and assess the division's performance against the key measures of quality, safety and sustainability against national and local targets.
- Performance was reported using a scorecard; indicators were grouped into six domains based on finance and the five domains of quality identified by the CQC and Trust Development Authority. Each indicator was assigned a red, amber or green (RAG) status based on actual and forecast performance against pre-defined thresholds and reviewed on an exception basis where performance below the required standard was identified. If an indicator was rated as red in any given month or amber for two consecutive periods, a recovery plan was requested from the responsible officer for submission to the following Board meeting.
- The divisional risk register was reviewed and managed through departmental and speciality meetings and divisional governance meetings. Risks at division level were identified and captured. There was some alignment between the risks on the risk register and what staff said was on their worry list.
- There was monthly protected clinical governance half days, where no theatre or outpatient sessions were scheduled for these half-days so staff could attend.

Leadership of service

- We found there was effective ward level leadership at Pontefract General Infirmary.
- Staff told us matrons were visible however there was limited engagement and visibility of the Chief Executive and the Board of Directors at the Pontefract site which was the same comments we received at the last inspection.
- Some staff were not clear about the management structures and roles and responsibilities.

Culture within the service

- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Staff were proud of the services they provided however they felt that senior managers did not appreciate the potential at the Pontefract site particularly in relation to the utilisation of the elective orthopaedic unit
- The division of surgery performance report showed sickness levels between April and May 2015 was 3.82% which was better than the trust target of 4.4%.

Public and staff engagement

Surgery

- The use of 'Big Conversations' was starting to become a common approach to improve staff engagement and involvement. For example, theatres were looking at developing services and processes to work differently.
- The introduction of patient safety panels, the patient safety and 'risky business' newsletter had improved communications and shared learning.
- Some staff felt decisions were made without prior engagement with staff, for example changes and moves in staff to other specialties were not consulted with wards.

Innovation, improvement and sustainability

- The surgical team had won an award for the implementation of a learning disability pathway for dental patients.
- In response to patient feedback staff had set up a post-surgical review clinic which had been running for six months for patient's and received positively.

Maternity and gynaecology

Safe	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Mid Yorkshire Hospitals NHS Trust provided women's services over three sites: There are Obstetric led units at Dewsbury District Hospital and Pinderfields General Hospital (PGH) and a midwife led unit at Pontefract General Hospital. Community midwifery services were across all sites. The service included early pregnancy care, antenatal, intra partum and postnatal care.

Separate reports have been written for each site. However, the locations share the same service information relating to governance and management arrangements. Where information relates to an individual site, reference to that information will be made in the location report.

Between April 2014 and March 2015 the total number of births at Pontefract midwife led unit was 292 and 115 home births across Dewsbury, Pinderfields and Pontefract.

In July 2014 CQC carried out an announced comprehensive inspection and found across the trust the service was good for effectiveness, being responsive and caring. Improvements were required for safety relating to the checking of emergency equipment, and the midwife establishment was below the national recommendation. We also found although there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service, there were mixed messages about how open the culture was within the leadership team; staff felt senior managers were not always visible. The overall rating for the service was requires improvement.

This inspection took place on the 23, 24 and 25 June 2015 and was part of an announced focused inspection to follow up the outstanding requirement from the previous inspection. We inspected the antenatal clinic and the birthing unit (which had four en-suite rooms). There was no women available to talk with at the time of the inspection. We spoke with 17 staff, these included midwives and senior managers, and held meetings with midwives and community staff from across the site to hear their views of the service they provided. We also inspected two sets of post-natal care records and reviewed the trust's performance data.

Maternity and gynaecology

Summary of findings

Overall at this inspection we rated the service as good. We found in the birthing unit, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. Although steps had been taken to try to address this in 2014 and in the week prior to our inspection, it was too early to show any changes had taken place.

Across the trust the birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014, and women at the midwife led unit received 1:1 care during labour. Escallation guidelines were in place and staff knew the procedures to follow should there be insufficient staff to safely care for the needs of patients. Staff told us they were kept up to date with information about what was happening within the trust; senior managers were approachable and they knew who they were.

Are maternity and gynaecology services safe?

Requires improvement

Overall at this inspection we rated the service requires improvement. We found in the birthing unit, daily checks of essential equipment to ensure it was available in an emergency situation were not taking place. Although steps had been taken to try to address this in 2014 and in the week prior to our inspection, it was too early to show any changes had taken place.

The birth to midwife ratio across the trust had increased from 1:33 to 1:31 since our inspection in July 2014 and women at the midwife led unit received 1:1 care during labour. Escallation guidelines were in place and staff knew the procedures to follow should there be insufficient staff to safely care for the needs of patients.

Incidents:

- Between May 2014 and April 2015 there were two reported serious incidents across the trust in women's services. We saw these related to an intrapartum stillbirth (the death of a baby during birth after 24 or more weeks of pregnancy,) and a failure to obtain consent for medical termination of pregnancy.
- A root cause analysis (RCA) had taken place in both cases which highlighted lessons learnt and contributing factors. A RCA is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important lessons are learnedto prevent the same incident occurring again. An action plan and recommendations were shared with all staff. This was by e-mail, face-to-face communication, in team meetings and via the trust 'Maternity Measured' newsletter, which we saw was displayed within each ward and unit (issues 4, June 2015).
- Midwives and staff we spoke with told us they were encouraged to report incidents and were able to explain the procedure. They reported having received patient safety briefs; designed to rapidly disseminate learning from incidents or other concerns which had occurred within the trust.
- Within the Maternity Measured newsletter we saw one of the safety brief was about, 'Maternal obesity in pregnancy.' We were told the objectives of the guideline

was to make health care professionals aware of the risks associated with obesity; therefore help women to receive the appropriate level of care thereby reducing the risks to both mother and baby.
- We also saw a copy of a weekly email, sent to staff and dated, 30 April 2015, from the Head of Midwifery/ Supervisor of Midwives. It included information about serious incident and mentioned how feedback to staff about the outcome of an incident they had reported, had improved. Staff we spoke with at the unit confirmed feedback from incidents they had reported had taken place.

Environment and equipment:

- We found between January and June 2015, there were 10 occasions when the adult resuscitation trolley equipment in the birthing unit, had not been checked. We found there were 14 occasions when the paediatric resuscitaire had not been checked and this included the emergency drugs. This meant the equipment might not have been available for use in an emergency situation.
- During the inspection the trust provided CQC with information that stated, following the inspection in July 2014 when non-compliance with resuscitaire checking had been identified, environmental audits were carried out by external auditors and included resuscitation checks. Matrons were reported to have found 100% compliance when checking the monthly audit tools however, when spot checks were carried out, this was not the case. The information stated the system was then changed to department managers checking the resuscitaires and they had given verbal assurance to the matrons of compliance. Spot checks carried out by the matrons showed compliance was not 100%. We spoke with the Head of Midwifery and band 7 delivery suite co-ordinator. They confirmed two weeks prior to our inspection, steps to address the situation had been taken to try to ensure the daily checks take place. We also saw a copy of the 'Ward Managers (acute inpatients) Weekly Standard of Care Assurance Framework' dated 15 June 2015, which identified the action to be taken following the non- compliance. This included the recording of the named midwife responsible for checking the equipment each day. Although steps had been taken to try to address this prior to our inspection, it was too early to show changes in the daily recording had taken place.

Medicines:

- At our inspection in July 2014 we found the refrigerator temperature located in the antenatal clinic, (where the whooping cough vaccine was stored,) had not been recorded daily as per medicines guidance. At this inspection we found the drug refrigerator temperatures had been checked daily on the birthing unit and in the antenatal clinic; both were within the normal range of between 2 to 8 degrees C.

Midwifery staffing

- We found across the trust, the birth to midwife ratio had increased from 1:33 to 1:31 since our inspection in July 2014. National guidance for the birth to midwife ratio was 1:28. However, the King's Fund report ("Staffing in Maternity Units -Getting the right people in the right place at the right time" 2011) suggested, that whilst staffing levels were important, employing more staff may not necessarily improve safety and maternity services had found it unrealistic to increase staff numbers to meet this ratio.
- Specialist midwife roles for example the Bereavement, Teenage pregnancy, Antenatal screening, Substance misuse, and infant feeding midwives were not included in the 1:31 birth to midwife ratio.
- All women in established labour were reported to receive 1:1 care, and the midwives in the community reported their caseloads to be 1: 117, the national guidance being 1:100. Staff told us the staffing levels at the unit had improved since our last inspection and there were procedures in place to try to make sure when staff were on call they do not work the following day.
- We saw the trust had a 'Maternity and Neonatal Services Escalation and closure Policy' Staff in each area we inspected, were aware of the staffing escalation protocol should staffing levels per shift fall below the agreed levels. They reported cross department/ site team working when needed to address shortfalls and the use of bank, and agency staff.
- The Head of Midwifery (HOM) informed us of an extra layer of management which had been introduced. In the antenatal clinic we met one of these staff and although this person worked across the site in their new role staff reported how the posts had made an improvement to the management support and staffing in these areas. The HOM also acknowledged the band seven (manager) staff grade was currently reduced due to the impact of

sickness and absence and an acting interim post had been created. With the reconfiguration of services the establishment was said to allow for two band sevens; this would provide extra time for these staff to keep their skills up to date.

- Senior staff told us core midwifery staff worked in each area, whilst other staff rotated between departments and this included the community midwives.
- We saw the HOM had commenced a newsletter which she emailed out monthly to staff. The copy, dated 30 April 2014, referred to the rolling out of the rotation programme following a questionnaire asking where staff would prefer to work. This meant staff would have the knowledge and skills to be able to work in different areas and flexibly to meet the needs of patients on the maternity unit.
- We saw the 'Private meeting of the trust board executive summary,' dated March 2015. The information referred to an overall assurance that "Midwifery services are safe and have good operational plans to maintain the commissioned ratio of midwife to birth." And "When shortfalls occur – staffing numbers across in-patient areas are appropriately reported and risk assessed. These processes occur three times daily and are documented." The report also stated although the staffing position required monitoring, it was improving following successful recruitment.

Are maternity and gynaecology services well-led?

Good

We found the service was good for well-led. The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. A reconfiguration of women's and children's services was due for completion in 2016, when Dewsbury would become a midwife led unit like Pontefract and Pinderfields would become a consultant led/midwife led unit. Staff told us they were kept up to date with information about what was happening within the trust. They said the culture was open, transparent and felt their concerns would be dealt with appropriately; this included whistleblowing.

Vision and strategy for this service

- The women's service had a strategy and vision for the future of service provision in Wakefield, Dewsbury and Pontefract. Although the strategy did not include changes to the Pontefract midwife led unit, the reconfiguration of the services aimed to provide a midwife led unit at Dewsbury and a consultant/midwife led unit at Pinderfields. The changes should be completed by 2016. The reconfiguration was in progress following previous consultation with commissioners and other interested parties, such as families and members of staff.

Leadership of service

- There was a clear leadership structure within the service from chief executive to ward level. The leadership team had clear ambitions for the success of the reconfiguration of the women's services.
- There were a number of senior clinical and managerial staff roles which had become permanent since the last inspection and the consultant presence had become more cohesive and proactive in decision making.

Culture within the service

- In March 2014 women's services were placed into one directorate. At the previous inspection we could not fully establish how open the culture was within the leadership team, as we had mixed messages of their openness from staff. At this inspection staff reported a culture which was open and transparent.
- Staff told us they could raise concerns and they felt their concerns would be dealt with appropriately, and this included whistleblowing.
- Staff told us they felt supported. Staff worked well together and there were positive working relationships between the multi-disciplinary teams and other agencies involved in the delivery of service.
- Staff told us the chief executive had updates and blogs to keep staff informed; one staff member told us they had emailed the chief executive and had a reply.
- Staff told us the HOM was very supportive and accessible; we saw a monthly newsletter 'Current News' which was sent to staff, keeping them up to date with what was happening in the trust. For example, the first addition dated 30 April 2015 acknowledged and praised staff on how they were coping through difficult times. It congratulated staff on new appointments and informed them on how the rolling recruitment programme was maintaining the staffing ratio of 1:31. It acknowledged

staff having completed training, and how a survey would be completed to ensure they had the opportunity to use their additional skills and interests. It also informed staff about the rotation programme, and how following a questionnaire asking staff where they would prefer to work, everyone would have the opportunity to work in different areas and remain upskilled. The newsletter referred to the HOMs accessibility, stated they accessed their emails daily, and were happy to discuss any suggestions anyone had about improving the service.

Outpatients and diagnostic imaging

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provided a wide range of outpatient clinics at Pinderfields, Dewsbury District and Pontefract Hospitals. Across the trust between July 2013 and June 2014 there were a total of 344,706 outpatient appointments at Pinderfields Hospital, at Dewsbury District Hospital there was 178,830 attendances and 157,072 attendances at Pontefract Hospital.

Approximately 60% of outpatient core activity and management is under the responsibility of the Division of Access, Booking and Choice. The remaining 40% of outpatient activity is managed by other clinical services, such as diabetic medicine, ophthalmology and dermatology.

The outpatients departments ran a wide range of clinics, led by different professionals, including nurses, allied health professionals and medical doctors, across a large number of specialties.

Radiology provided a trust-wide diagnostic imaging service. The service offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and an ultrasound service. The trust was performing better than the England average for the percentage of diagnostic waiting times over six weeks.

During the inspection at Mid Yorkshire Hospitals NHS trust we spoke with patients and relatives, nursing staff, health care assistants, allied health professionals and medical staff. We observed the diagnostic imaging and outpatient environments, checked equipment and looked at patient information.

Summary of findings

Overall we rated safety as good. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented. The level of care and treatment delivered by the outpatient and diagnostic imaging services was good. We found there were sufficient numbers of staff to make sure that care was delivered to meet patient needs and sickness rates were below the trust target of 4%. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed. New equipment had now been purchased for pathology and would be in the trust from July 2015. There were planned dates for going implementation on 5 November 2015 for biochemistry and January 2016 for haematology.

Overall we rated the service as good for being effective. The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site. We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. Data showed that 64%-100% of staff in outpatients had completed training specific for their role appraisal rates ranged from 41% for nursing staff to 100% for estates

and ancillary staff. Within radiology services we were shown on the computer system that appraisal rates across the 340 staff was 88%. We found staff understood about consent and data showed that 64%-100% of staff had completed training specific for their role which included mental capacity training levels two and three.

Overall we rated the service as requiring improvement for being responsive. There continued to be capacity issues within some specialities particularly ophthalmology and cardiology. Some patients expressed concerned regarding cancellation of appointments. Analysis of data showed that since August 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for admitted and non-admitted pathways. The trust had implemented an action plan and completed the first two phases; the next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. The trust provided information on the outpatient backlog we saw in June 2015 this number was down to three patients from 9,501 when we inspected in July 2014.

Overall we rated the service as being good for well-led. Management teams had a vision for the future of the departments and were aware of the risks and challenges they faced. There were monthly governance meetings where trends from incidents and risks within the division were discussed. Staff reported they now had a secure management structure and staff were positive about the changes the management team had brought to the service. Staff throughout the service told us they felt the culture within the organisation had changed.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall we rated safety as good. There were systems in place to report incidents and staff told us they knew how to report incidents and received feedback from these. Staff were able to give examples on how they had learnt from incidents and how improvements were implemented.

The level of care and treatment delivered by the outpatient and diagnostic imaging services was good. We found there were sufficient numbers of staff to make sure that care was delivered to meet patient needs and sickness rates were below the trust target of 4%. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed.

New equipment had now been purchased for pathology and would be in the trust from July 2015. There were planned dates for going implementation on 5 November 2015 for biochemistry and January 2016 for haematology.

Incidents

- Staff we spoke with was aware of how to follow the trust's policies and procedures for reporting incidents on the trust's datix system.
- We reviewed information for incidents within outpatients for June 2015 and found there had been 22 incidents reported. On review of this information we noted that three incidents related to delays in follow-up appointments.
- The management team for outpatients told us staff reported issues raised by patients for example missed appointments and disputes about the access policy. The service was aware of the main themes and these were in relation to the waiting list and cancellation of clinics (on the day).
- We saw within outpatients there had been one serious incident reported in March 2015. This related to a patient who had had surgery in May 2014 and was due a follow-up appointment in three months. This had been

cancelled by the hospital and another appointment had not been given. This had been identified when the patient was reviewed in clinic in March and their condition had deteriorated.

- Within radiology senior managers told us they reviewed all incidents to identify themes and trends. The main theme from incidents had been near misses from their point pause process where they had identified either it was an incorrect referral or the wrong patient, these had all been investigated and letters had been sent to the referrers. The other main theme from incidents was related to aggression towards staff from patients and relatives.
- Within the ultrasound department staff told us of one incident where a patient had attended for a scan and thought they had come for a different procedure. When the service reviewed the referral card they found a lot of information had been crammed into a small space. As a result the electronic form had been expanded to information was clearly visible. This was an example of how the service learnt from incidents.
- The main function of the radiation protection safety committee was to ensure that clinical radiation procedures and supporting activities in the trust were undertaken in compliance with ionising and non-ionising radiation legislation. The committee met quarterly each year and received reports from the appointed radiation protection advisers, ensuring all recommendations were achieved. The meetings have representation from the senior management team (Associate Medical Director) who chaired the meeting.
- Following incidents in 2013 the trust had developed a six point checklist named PAUSE for clinicians to use before they exposed patients to radiation this also complied with IR(ME)R regulations. The trust had also shared this with other organisations to share learning.
- When we spoke with staff in medical physics they told us that all IR(ME)R incidents were seen and closed by the Chief Executive

Environment and equipment

- At our inspection in July 2014 we found there had been a long standing issue over the age and effective use of equipment used in the pathology services. Problems that had been experienced were frequent breakdowns and quality failures leading to potential risks to the accuracy of results.
- During this inspection we met with managers within the trust who told us new equipment had now been purchased for pathology (biochemistry and haematology) and would be in the trust from July 2015. There were planned dates for going implementation on 5 November 2015 for biochemistry and January 2016 for haematology.
- In radiology services the computer system (Q-Pulse) had an asset model and this listed all equipment into the appropriate rooms and stored calibration and maintenance records within the room.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- Daily equipment checks were carried out and records were seen and up to date. The department had introduced a traffic light system for the quality checks on the equipment which was immediately visible to the radiographers. For example green meant equipment was safe to use, amber meant use with care (reasons were provided) red meant the equipment was out of use.
- We saw daily checks also included record of any documented fault on equipment
- We found lead aprons were visually checked annually and any aprons which caused concern were scanned in CT. The department had invested in replacing lead aprons to the light weight lead – free aprons. The new light weight aprons reduce risk of musculo-skeletal problems to staff.
- We saw the checks had been performed by the medical physics department and all of the audits were documents. The next annual inspection of aprons was due in September 2015
- We found daily quality control tests were carried out on all of the equipment we saw evidence of these in all rooms inspected including CT.
- Within the outpatients department we saw the area was clean and tidy. A recent environment audit had identified that some of the chairs needed destroying this had been done and new ones had been ordered.
- Within the outpatient department at Pontefract Hospital all the areas we visited were clean and tidy. We found the resuscitation trolley was clean and had been checked appropriately.

Outpatients and diagnostic imaging

Medicine management.

- Within radiology we saw there were drug cupboards in each of the interventional rooms and a central store cupboard in the clean utility room. We found the room and cupboard was appropriately locked and secure.
- We saw the department undertook monthly audits to check stock against the records with pharmacy undertaking quarterly audits.
- We found there were no controlled drugs in the cabinet in the clean utility room, controlled drugs were stored in the interventional rooms and these were appropriately checked.
- Within the outpatients department at Pontefract we found the medications were stored securely in a locked cupboard and were all in date. The department did not have a supply of controlled drugs (CD's).
- We also found prescriptions were stored securely with the outpatient department.

Mandatory training

- Mandatory training data for outpatients across all three hospital sites showed that between 82 % and 95% of staff had completed their relevant mandatory training.
- Staff within radiology and diagnostics told us new members of staff had a large volume of mandatory training/ reading to do when they started in their role.
- Senior staff told us following feedback they had spread this out and had given additional support in the induction period.

Assessing and responding to patient risk

- We found the radiology service used an adapted version of the WHO surgical safety checklist for all radiological interventional procedures. We reviewed five patient checklists and found these had been completed appropriately.
- We saw all imaging requests included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation. The local policy was for all females aged 12-55 to complete a questionnaire there were two styles of questionnaire, one specifically designed for 12-15 age group.
- These were signed by the patients and the forms were scanned onto the Radiology Information System (RIS). If there was any discrepancy then the 28 day rule was applied which meant either the patient was rebooked to fit within next cycle or the patient may agree to a pregnancy test this was dependent on the clinical circumstances.
- We reviewed four records on females who had x-ray of either their pelvis or abdomen and found pregnancy questionnaires had been completed , signed and scanned onto the RIS system

Staffing

- Within nurse staffing for outpatient's there was one wte vacancy which had been filled but the person had not started yet, there were no reported vacancies within administration staff.
- Within the call centre a new recruitment process had been introduced which involved work simulation, group exercises and an interview.
- We found sickness within the call centre was 3% which was lower than the trust target of 4%.

Diagnostic staffing

- Within the department there currently were 24 wte radiologists and one radiologist vacancy. To manage this, senior managers told us they were currently "outsourcing" to another provider some of the reporting to compensate for the vacancy.
- The clinical lead for radiology told us the trust had a good rapport with the university for trainees and the trust had a good reputation for training and this had benefits when recruiting staff.
- Through discussions with staff no staffing issues were raised. Staff reported they had recently gone through a working practices change process. Since 1 June 2015 night hours were now part of staff core hours. This has been a long detailed process over three years with full staff involvement.
- Staff reported they had been given the opportunity to design the rotas. The next stage was for weekends to also be part of core hours. This was planned for 1 November 2015.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The trust monitored and identified whether they followed appropriate NICE guidance relevant to the services they provided. We found that policies based on NICE and Royal College guidelines were available to staff and accessible on the trust intranet site.

We reviewed information that showed that the service participated in national audits, which monitored patient outcomes and monitored service performance. There were formal processes in place to ensure that staff had received training, supervision and an annual appraisal. Data showed that 64%-100% of staff in outpatients had completed training specific for their role appraisal rates ranged from 41% for nursing staff to 100% for estates and ancillary staff. Within radiology services we were shown on the computer system that appraisal rates across the 340 staff was 88%.

We found staff understood about consent and data showed that 64%-100% of staff had completed training specific for their role which included mental capacity training levels two and three.

Evidence-based care and treatment

- We saw the radiology department had audited their compliance against NICE guidelines (CG176) for head injuries. The department found in the majority of cases the imaging part of the guidelines was met with the patient having the scan within one hour of request and the image reported on within one hour. The exceptions showed in the majority of cases these were out of hours when only one radiographer was available
- Across all three sites we found the lung cancer clinics followed NICE guidelines (CG121) on the diagnosis and treatment of lung cancer.
- Radiation Exposure was audited every 3 years the last audits were carried out in May and September 2014 in the rooms we inspected.
- We found the department had a detailed and comprehensive examination protocols and we saw these in x-ray rooms and in the CT department.
- Within radiology band 6 radiographers in CT could act a practitioner as determined by IR(ME)R . This meant they were allowed to justify requests for CT scans. We reviewed samples of referrals that had been justified with any comments made on the system. All of these were appropriately justified and documented.
- Clinical audits were undertaken and a list of recent audits was produced. These include audits as required by IR(ME)R.
- An audit was carried out on the completion of the radiology WHO checklist list. The outcome was 40% compliance for major interventional procedures and 25% for all procedures. The poor outcomes were due to the fact there was only one checklist and because some staff felt it was not specific to the needs of the different types of procedures, they didn't always complete them. As a result there were now three styles of WHO checklist and the band 7 radiographer responsible for the audit was confident that there has been an improvement. They had recently met with a research lead member of staff who was designing an audit template for radiology which will be performed monthly and results fed back to the Directorate Clinical Governance
- The reporting radiographers (advanced practitioners) produced reject analysis reports for all three sites. They looked for trends which may highlight a problem in image quality or radiographer technique. Recently staff reviewed lateral knees x-rays as the standard was noted not to be adequate. As a result additional training and personal mentoring was given and standards had improved
- We found the department policy was to always use left and right metal markers at the time of the x-ray and not to electronically add left or right on the image post processing. We reviewed a number of images were seen and all had markers on the image at the time of the x-ray
- Within the department different mentoring groups completed audits. There was currently two audits being carried out one was to check the last menstrual period (LMP) policy compliance and the other was check the correct use of markers on x-rays .

Patient outcomes

- Within the diagnostics and radiology service there was a designated radiologist for research. We found they produced an annual report on audit and research activities within the department.
- We found the department had an annual audit plan with estimated start and end dates. For example we saw

there was an audit planned to start in September 2015 of Magnetic resonance imaging (MRI) scans in Transient ischaemic attacks (TIA's) and was due to end in March 2016. This was to audit against NICE guidance.

- Within outpatients local audits had been undertaken one audit looked at the timeliness of the clinicians arriving for clinic and the impact of this. Results showed generally clinicians arrived on time however it did identify that some clinicians consistently arrived late and these were escalated to the relevant management team.

Competent staff

- Data showed that 64%-100% of staff in outpatients had completed training specific for their role, for example this included conflict resolution and consent training.
- Appraisal rates within outpatients ranged from 41% for nursing staff to 100% for estates and ancillary staff.
- Within radiology services we were shown on the computer system that appraisal rates across the 340 staff was 88%.
- Three staff we spoke in radiology with confirmed the date of their last appraisal which was up to date. One member of staff in the interventional department told us their last appraisal was May 2014 and the reason for the delay for annual appraisal was due the absence of a manager in the department.
- All of the staff we spoke to were up to date with their on line mandatory training. The only gap was for face to face moving and manual handling for which there was a planned date of 14 July 2015 for staff who need their update training
- The department had a small training budget, therefore external training had to be justified by the radiology manager. Staff were encouraged to attend any free training days.
- The department have introduced monthly evening CPD training sessions. Staff who attend were given the time back
- Staff across all sites reported they had received role specific training in caring for patients with dementia.

Seven-day services

- Within outpatients staff told us there were evening and clinics on Saturdays and Sundays for patients to access. The Trust has confirmed that this is for some specialties to provide additional capacity. For example the colorectal service was running outpatient clinics on a Saturday and Sunday.
- The lung cancer clinic was a Monday- Friday 9am-5pm service but staff told us all patients were advised on how to get support out of hours.
- The radiology service provided a range of services, some covering 24 hours, seven days a week, and some within normal and or extended working hours Monday to Friday. For example
  - GP Walk in chest x-ray service was open Monday-Friday 08.30 - 20.00 hrs.
  - All other GP plain film x-rays were booked appointments on Monday – Friday 08.30 - 20.00 hrs.
  - Outpatient plain x-ray service was run in conjunction with the outpatient clinics. The department was notified of any additional evening or weekend clinics so that additional staffing could be planned and organised.
  - At Pontefract the CT and MRI scanning department was open 9-5.
  - Ultrasound scanner was open 08.00-18.00hrs Monday to Friday and 09.00- 17.00 on Saturday and Sundays.
  - Ward plain x-ray 24/7 7 days a week (during the night patients sleep is not disturbed if possible. Mainly urgent requested carried out overnight).
- The outcomes of the working practices change review which as due to be completed on 1 November 2015 meant that all hours 24/7 will be part of staff contracted core hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff within outpatient's and diagnostics departments reported they had received training on mental capacity. Data showed that 64%-100% of staff had completed training specific for their role which included mental capacity training levels two and three.
- We saw within radiology services an information bulletin was sent to all staff with an update on "mental capacity at a glance." Managers told us staff had to acknowledge they had read the information.
- We found the majority of general x-ray procedures were carried out using implied consent from the patient

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Overall we rated the service as requiring improvement for being responsive. There continued to be capacity issues within some specialities particularly ophthalmology and cardiology. Some patients expressed concerned regarding cancellation of appointments. Analysis of data showed that since August 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for admitted and non-admitted pathways.

The trust had implemented an action plan and completed the first two phases; the next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. The trust provided information on the outpatient backlog we saw in June 2015 this number was down to three patients from 9,501 when we inspected in July 2014.

There were mechanisms to ensure that services were able to meet the individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Service planning and delivery to meet the needs of local people

- Managers in the call centre told us the centre was responsible for outpatient bookings for medicine and surgery, answering calls from patients, partial booking and follow-up appointments for patients who had been on a ward in the hospitals.
- We found the trust had a policy for the management of the follow up waiting list (January 2015) the purpose of this policy was to minimise the clinical risk to patients who were waiting for a follow up appointment. The policy also outlined the process staff should follow to manage patients within the backlog of appointments.
- The next phase of the overall outpatient improvement plan was to look at services who managed their outpatient bookings outside of the call centre. Each service was to be reviewed separately so that decisions about outpatient bookings would be based specifically around the needs of that speciality.
- Staff told us within the outpatient departments processes had been standardised so that this was the same at each hospital site this also made it easier and safer for staff when they rotated between sites.
- Within the outpatient call centre managers and staff told us that since the last inspection in July 2014 staff worked more flexibly to cover peaks in activity
- Staff within outpatients told us the process they had used to address the backlog of outpatient appointments identified at the inspection in July 2014. The process had been split into two parts a clerical validation and a clinical validation which looked at managing risks to patients.
- Staff within the call centre told us the most challenging areas for appointments was Neurology due to having several specialities within this and Ophthalmology where there were capacity issues.
- As part of the inspection one person contacted CQC directly and told us they had difficulties accessing their eye appointment they were supposed to have appointments monthly but had been told by the trust it could be 12 weeks before they would have an appointment. They reported they were worried in case their condition worsened.
- Prior to this inspection Healthwatch and patients raised some concerns about the Cardiology clinic and delays in receiving a follow-up appointment. Staff we spoke to at the inspection told us there were still issues with capacity within cardiology.

Access and flow

- At our inspection in July 2014 we found there was a backlog in overdue outpatient appointments of 9,501. At this inspection the trust provided information on the outpatient backlog we saw in April 2015 the number was 3,716 in June 2015 this number was down to three patients.
- Managers confirmed this and told us that as of 24 June 2015 there were 3 patients in the backlog who were waiting for an appointment.
- Admitted pathways are those that end in an admission to hospital (either inpatient or day case) Between

August 2014 and June 2015 for completed admitted pathways analysis of data showed the trust was performing between 76.4%-91.4% against a target of 90%.

- Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required. For completed non-admitted patients the performance in the same time period was between 85.9%-94.3% against a target of 95% for referral to treatment times (RTT) within 18 weeks.
- Incomplete pathways are patients whose RTT clock is still running at the end of the month. For incomplete pathways between August 2014 and June 2015 the trust performance was 90.4%-93% against a target of 92%. From September 2014 the performance has been above the 92% target.
- We reviewed information on the trust's performance for cancer waiting times. We found from October 2014 the trust performance for two week wait from urgent referral was between 97%-99% against a target of 93%.
- We found between November 2014 and June 2015 the trust was generally meeting the 85% performance target for all cancers for the 62 days wait for first treatment from an urgent GP referral with the exception of February 2015 when it was 78.8%.
- A mandatory process had been introduced to support staff to cancel or rearrange clinics where six weeks' notice had not been given. Staff within the call centre told us the clinician had to complete a form to state why the clinic needed to be cancelled. The patient list was then made available to the clinician so they could review and manage the patients care and make alternative arrangements where needed.
- Senior staff within outpatients told us the did not attend (DNA) rate had reduced within the department. The reasons for this had been the service had re-introduced a text and remind service and letters from the call-centre had improved the letters and tried to see patients at hospitals closest to where they lived. The DNA rate was now 9%.
- For June 2015 the call centre was consistently achieving 95% of all calls answered within the three-minute response time.
- If a patient who had been referred by their GP for an x-ray had a suspected fracture on their x-ray, staff took them to A&E where they would be seen immediately. Similarly, if significant pathology was seen on a chest x-ray, the radiographer would show the x-ray to a radiologist. The GP would be telephoned and the patient asked to go to their GP the next day for the results.
- Within the outpatient department at Pontefract Hospital we saw waiting times were clearly displayed and the service expected that patients should not wait longer than 20-30 minutes for their appointment. We saw waiting times were clearly displayed on a board in the department and staff also kept patients informed.

Meeting people's individual needs

- Staff told us within outpatients vulnerable inpatient cards (VIP) were used. The VIP card holds information about patients, which helps staff when patients seek medical help. The VIP card could be used in Dewsbury and District, Pinderfields and Pontefract Hospitals by anyone with a learning disability.
- Within the service the "forget me not" system was used to support patients living with dementia.
- Across all three sites there were specific clinics for patients with lung cancer. Nurses within the clinic told us the purpose of the clinics had changed to get to know patients prior to a diagnosis to improve the patient pathway.
- Translation telephone services were available across sites and an additional service had been introduced to support patients who were deaf.
- Within the sleep apnoea clinic at Pontefract Hospital staff told us in the previous week they had supported one patient with Down's syndrome and another patient with dementia to use an oxygen mask with training tailored to their needs.

Learning from complaints and concerns

- Staff were able to describe the clear processes they followed for complaints and the timescales to respond to any complaints they received.
- The trust provided information which showed between February to June 2015 outpatient services have received 220 complaints. The themes from these were 43% related to clinical treatment, 27% related to date for appointment/ attendance, 13% related to communication and 7% related to staff attitude.
- Staff within outpatient services told us the number of complaints about outpatient appointments had reduced since the inspection in July 2014 and the backlog of appointments had cleared.

Outpatients and diagnostic imaging

- In diagnostics and radiology managers told us complaints about the service tended to be a small part in a larger complaint regarding the patients care whilst receiving care at the hospital. Senior managers gave an example where a patient had been informed they had a fracture when they didn't.
- Staff within outpatient clinics told us they had not received any complaints in the last 12 months but had received compliments from patients and relatives.

Are outpatient and diagnostic imaging services well-led?

Good

Overall we rated the service as being good for well-led. Management teams had a vision for the future of the departments and were aware of the risks and challenges they faced. There were monthly governance meetings where trends from incidents and risks within the division were discussed.

Staff reported they now had a secure management structure and staff were positive about the changes the management team had brought to the service. Staff throughout the service told us they felt the culture within the organisation had changed.

Vision of the service.

- We met with the senior management team who told us they had completed the first two phases of the action plan and were in the last phase which was an improvement plan to embed processes into practice. The next phase also included further centralisation of appointments and follow-ups with stronger links to the identified needs of specialities.
- We saw within outpatient's service there was a draft two year operating plan to 2016/7 which identified divisional/directorate objectives and how these were to be delivered through clearly identified initiatives and the improvements expected in performance against key performance indicators.
- Further work was to be undertaken to look at more innovative ways to undertake outpatient services for example using "virtual clinics", telephone clinics, and use of telemedicine.
- Managers raised that one of the challenges for the service was to look at how they accommodated patient choice for where they attended their outpatient appointment. For example 20,000 appointments needed to be transferred to Dewsbury from the other two sites to accommodate patient choice. The service was working through this at the time of our inspection.
- Within radiology the department was planning to enrol for Imaging Services Accreditation System (ISAS) in the next few months. This schemes aim was to help diagnostic imaging services ensure their patients consistently receive high quality services delivered by competent staff working in safe environments.

Governance, risk management and quality measurement

- The management team told us there had been a complete turnaround of the service which had included the standardisation of processes, following up of the backlog of outpatients, compliance with performance targets which included RTT and a restructuring across the other services.
- The senior management team reported the improvements had removed the backlog of appointments, improved communication with staff and rewarded staff for their hard-work in making the improvements.
- Staff told us there was an action plan for the improvements needed within outpatients and there had been a positive turnaround. Staff told us the action plan identified what was needed to be done on a daily basis and staff was accountable to make sure these were completed. One member of staff told us the action plan had focussed staff on what needed to be done and "it was excellent".
- The outpatient management teams were working closely with Heads of Clinical services to ensure they had the responsibility for outpatient's clinics within their directorate.
- We reviewed the action plan and saw that key actions were identified that would address the areas for improvement and that progress was monitored against targets.
- We found within both outpatients and diagnostics and radiology there were monthly governance meetings where trends from incidents and risks within the division were discussed. For example senior managers told us they had discussed at one of these meetings there had

been a slight increase in radiation risks one month no reason for this had been identified and the following month this had decreased. Managers told us this was quite unique and the department were hoping to present about this at UK Radiological Conference next year.

- The diagnostics and radiology department use the Q-Pulse document management system. All governance documents were filed on Q-pulse, including mandatory training, all polices and incidents. The system sends alerts via email either to individuals or across departments when updates were required. For example individual updates for mandatory training.
- Within Q-Pulse under the list of policies and protocols local Rules were available. Staff showed us how they were alerted and how they acknowledged them electronically.
- We saw samples of risk assessments for the x-ray rooms were seen and we found they were comprehensive and completed to a high standard.
- The reporting radiographers (Advanced practitioners) met monthly to discuss discrepancies and any interesting cases. There was a proforma for staff to complete at the time of reporting which was then added to the list for discussion.
- Staff told us the department had raised an issue regarding the effect on the department on windy days. The main corridor becomes like a 'wind tunnel' and impacted on patients who may be waiting in the corridors including unwell ward patients. This has been raised through the risk register and risk assessment. Staff had put forward a solution is to have the doors open and close on a timer mechanism which would give sufficient time for the porters to pass through. Staff raised concern of the length of time it was taking to resolve the issue

Leadership of service

- Staff within outpatients told us that since the last inspection in July 2014 they now had a secure management structure and staff were very positive about the changes the management team had brought to the service.
- One member of staff told us "(the manager's name) is the best manager I have ever had and I've worked in the NHS for 20 years."
- Staff told us following the concerns within outpatients which started in the "winter of 2013" the Chief Executive of the trust had got involved with the work to improve the service and this had changed the focus. The Chief Executive chaired a fortnightly meeting about the service which monitored the outpatient improvement plan.
- Staff reported they had felt valued by their managers and executives in the trust as they had received recognition and congratulations for the turnaround they had achieved.
- Staff also reported they were proud of the outpatient service as they had all worked together as a team to secure improvements.
- Across the outpatient service listening into action (LIA) events had been held these were called the "big conversation". LIA is a programme which supports staff to transform their services by removing barriers that get in the way of providing the best care to patients and their families.
- To support the development of the outpatient service staff across sites told us they had been involved with the improvements, they had had the opportunity to make suggestions and additional permanent staff had been recruited to support the work that needed to be done.
- Some staff told us they had used the "ask Chief Executive blog" where questions could be asked of the chief Executive. One person told us they were surprised but welcomed that the Chief Executive answered the questions himself.
- Staff told us a new Matron had been appointed but had not started yet to cover the outpatient department and they had not had a matron for a number of years. One member of staff told us "they felt reassured they would have a matron who would act as an advocate for nurses with senior management."
- Within radiology staff spoke positively of the management. One member of staff said 'it's a very supportive team. We found team leaders worked well across all three sites.

Culture of the service.

- Staff throughout the service told us they felt the culture within the organisation had changed and one person told us "it is now completely different."
- Staff reported that there was now more open doors, they were made to feel they could ask questions, there were no "stupid" questions and managers always had time for the staff.

Outpatients and diagnostic imaging

Public Engagement

- We saw displayed information for May 2015 on the friends and family test. This showed 97.6% of respondents were "likely or extremely likely" to recommend the service to a friend or a member of their family.
- Within radiology services a voluntary survey had been carried out by the Picker Institute in November/ December 2014 across all three hospital sites. Results showed that 93% of respondents rated their care as excellent or very good. Areas for improvement were also identified for example one area was that only 60% of respondents had stated that all staff treating and examining them had introduced themselves.
- From October – December 2014, both local Healthwatch's carried out a piece of work looking at outpatient appointments across the Trust and completed 749 surveys with patients. Generally patients reported that they were happy with the service they received from the outpatient clinics at the hospitals they visited. They found that a majority of patients were happy with the time, date and location of the appointment they had been given. 99% of patients said the reception staff were friendly and welcoming and 86% of patients were satisfied with the length of time it had taken to get an appointment.

Outstanding practice and areas for improvement

Outstanding practice

- There had been a turnaround of the outpatient service which had included the standardisation of processes, following up of the backlog of outpatients, compliance with performance targets and a restructuring across the other services. As a result the 9,501 backlog of overdue outpatient appointments we found at our inspection in July 2014 had reduced to three patients in June 2015.
- Across services in the trust listening into action events had been held to support staff to transform their services by removing barriers that get in the way of providing the best care to patients and their families. Overall in the NHS staff survey 2014 the trust had improved scores on 59 questions compared to the results in the 2013 survey.
- Most of the staff we spoke with told us they felt the culture within the organisation had changed and that there was a desire to improve from the senior management team, management was better, communication had improved and there was more clinical engagement.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board.
- The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed.
- The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- The trust must ensure where actions are implemented to reduce risks these are monitored and sustained.
- The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented.
- The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are adequately met.
- The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must continue to strengthen staff knowledge and training in relation to the mental capacity act and deprivation of liberty safeguards.
- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines, and that oxygen is prescribed in line with national guidance.
- The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment.
- The trust must ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.

Outstanding practice and areas for improvement

- The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users.
- The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.

Action the hospital SHOULD take to improve

- The trust should continue to review the prevalence of pressure ulcers and ensure appropriate actions are implemented to address the issue.
- The trust should continue to improve interdepartmental learning and strengthen governance arrangements within the accident and emergency departments.
- The trust should review the use of emergency theatres and improve the processes to prioritise patients in need of emergency surgery.
- The trust should take action to reduce the number of last minute planned operations cancelled for non-clinical reasons.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1), (2 a, b, d, e, f, g, h) Safe care and treatment The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines and that oxygen is prescribed in line with national guidance. The trust must ensure that infection control procedures are followed in relation to hand hygiene, the use of personal protective equipment and cleaning of equipment. The trust must ensure all patients identified at risk of falls have appropriate assessment of their needs and appropriate levels of care are implemented and documented. The trust must ensure there are improvements in referral to treatment times and accident and emergency performance indicators to meet national standards to protect patients from the risks of delayed treatment and care. The trust must also ensure ambulance handover target times are achieved to lessen the detrimental impact on patients.

This section is primarily information for the provider

Requirement notices

The trust must ensure there are improvements in the number of Fractured Neck of Femur patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours.

The trust must improve the discharge process for patients who may be entering a terminal phase of illness with only a short prognosis.

The trust must ensure in all services resuscitation and emergency equipment is checked on a daily basis in order to ensure the safety of service users and to meet their needs.

The trust must ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14 Meeting nutritional and hydration needs (2 a) (4 a, b, c, d). The trust must ensure there are improvements in the monitoring and assessment of patient's nutrition and hydration needs to ensure patients' needs are met.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance (2 a, b, f) (3 b) The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients. The trust must ensure where actions are implemented to reduce risks these are monitored and sustained. The trust must be able to demonstrate they follow and adhere to the ten expectations from the national quality board. The trust must ensure policies and procedures to monitor safe staffing levels are understood and followed. The trust must ensure robust major incident and business continuity plans are in place and understood by staff. This must include fire safety at QEH.
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing (1) (2 a) Ensure at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.

This section is primarily information for the provider

Requirement notices

The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.

The trust must continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.