

The Mid Yorkshire Hospitals NHS Trust

Quality Report

Trust Headquarters
Pinderfields Hospital
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2017
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow-up inspection from 16 to 19 May 2017 to confirm whether The Mid Yorkshire Hospitals NHS Trust had made improvements to its services since our last inspection in June 2015. We also undertook a unannounced inspections on 11 and 22 May and 5 June 2017.

To get to the heart of patients' experiences of care and treatment we always ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

The inspection took place as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust and to follow up on progress from our previous comprehensive inspection in July 2014, a focused inspection in June 2015, and unannounced focused inspections in August and September 2015. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection.

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

When we last inspected this trust in June 2015, we rated services as 'requires improvement'. We rated safe as inadequate, effective, responsive, and well-led as requires improvement. We rated caring as good.

There were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to staffing, safe care and treatment, good governance, and meeting nutritional and hydration needs.

The trust sent us an action plan telling us how it would ensure that it had made improvements required in relation to these breaches of regulation. At this inspection we checked whether these actions had been completed.

We found that the trust had improved in some areas, particularly within community services. However, it remains rated as 'requires improvement' overall, with safe, effective, responsive, and well-led rated as 'requires improvement', and caring rated as 'good'.

Our key findings were as follows:

- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts across the trust remained unfilled despite these escalation processes. This was a significant concern within medical care wards where actual nurse staffing figures were significantly below establishment planned numbers evidence by poor fill rates. Some staffing escalation procedures within this division added little to the staffing situation.
- Within the medical care division across the trust, staff shortages impacted on the ability of ward staff to provide the level of care they would like to. As a result of working under such pressure and time constraints we did observe some care which was not of an acceptable standard. Some patients also reported this was affecting the length of time it took for call bells to be answered.
- At Pinderfields Hospital privacy and dignity of patients being cared for in extra capacity beds was compromised. Divisional leaders recognised this impacted on the quality of the patient experience.
- At Dewsbury Hospital we were very concerned that patients were not having observations monitored or had appropriate escalation when there was elevated NEWS scores.
- Staff across most specialties were not meeting the trust's mandatory training targets.
- Patient outcomes from national audit data were variable. Overall, heart failure, myocardial infarction

Summary of findings

and diabetes outcomes were worse than national average. The trust was an outlier in a number of mortality alerts across divisional services. The trust has six active mortality outlier alerts as at 3 April 2017.

- Within medical care services, the meal time initiative to support patient nutrition and hydration was not robust. Nursing documentation to support nutrition and hydration was poor.
- Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable across some services within the trust.
- Access and flow, across the emergency department, medical care and surgical services, and outpatients remained a significant challenge.
- The emergency department was failing to meet the majority of national standards relating to Accident and Emergency performance. However, recent information showed that this was improving.
- The use of extra-capacity beds in existing bays within medical care wards, particularly in Pinderfields Hospital was impacting negatively on patient experience and at times compromising privacy and dignity.
- Medical boarders were impacting in most clinical areas within the trust.
- There were a considerable number of patient moves after 10pm causing distress, inconvenience and confusion to many patients. Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- There were issues regarding referral to treatment indicators and waiting lists for appointments. The backlog of patients waiting for first and follow up appointments across the trust outpatient departments had deteriorated since the last inspection.
- The senior team was aware of the challenges and issues within the organisation and had developed strategies and tightened governance processes to meet these challenges. However, these needed embedding the pace of this improvement needed to increase.
- There was some improvement in strengthening of governance processes across the trust. However,

within some services, particularly medical care and critical care, there were gaps in effective capturing of risk issues and in how the services monitored quality and performance.

- Governance and assurance processes within the medical care division, for the care and management of patients, did not support the provision of safe care, quality outcomes and positive patient experience on these wards.

However:

- Overall, the culture within the trust had improved since the last inspection and there were indications of a positive cultural shift.
- There was effective multi-disciplinary (MDT) working to secure good outcomes and seamless care for patients across the trust.
- Community services within the trust had improved since our last inspection.

We saw several areas of outstanding practice including:

- The emergency departments had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The facilities at Pinderfields Hospital on the spinal unit for rehabilitation and therapies were modern, current and progressive.
- The cardiology e-consultation service at Pinderfields Hospital which provided a prompt and efficient source of contact for primary care referrers who sought guidance on care, treatment and management of patients with cardiology conditions.
- The proactive engagement initiatives used by the dementia team involving the wider community to raise awareness of the needs of people living with dementia. The use of technology to support therapeutic engagement and interaction with patients, stimulating activity and reducing environmental conflict.
- The Plastic Surgery Assessment Unit was developed November 2016 at Pinderfields Hospital. This was designed to improve the patient experience and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department. Faster pre-theatre assessment was provided which helped ensure

Summary of findings

treatment was delivered quicker. The surgical division had reduced pressures on Surgical Assessment Unit (SAU) by taking the bulk of ambulatory plastics patients out of SAU.

- The burns unit play specialist ran a burns club, which provided psychological support to children and their families. This included an annual camp and two family therapy weekends a year.
- The maternity service at Pinderfields Hospital had implemented the role of 'Flow Midwife', a senior member of staff who had oversight of the service during the day. The aim of this role was to ensure a smooth flow of patients throughout the unit; this included the risk of transfers from the stand-alone birth centres and concerns with the discharging of patients from the postnatal ward and labour suite.
- There was direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The trust had a new electronic process with remote monitoring to alert staff to fridge temperatures being below recommended levels to store drugs.
- At Dewsbury Hospital panic buttons had been installed for staff to use in the emergency department if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department.

- We saw evidence of the risk assessment in patients' notes and falls bands were visible on patients. This enabled all staff in the hospital to identify patients at risk of fall no matter where they were in the hospital.

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

Importantly, the trust must:

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

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to The Mid Yorkshire Hospitals NHS Trust

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, as well as having some community services. In total, the trust had approximately 961 general and acute beds, 66 beds in Maternity and 25 critical care beds. The trust also employed 6,796 staff, which included 790 medical staff, 3248 nursing staff and 3903 from other staff groups.

We carried out a comprehensive inspection of the trust between 16-19 May 2017. This included an unannounced visit to the trust on 11 and 22 May, and 5 June 2017. We inspected the three main hospital sites as well as community services included community adult, inpatient and dental services. The inspection took place as part of our comprehensive inspection programme of The Mid Yorkshire Hospitals NHS Trust and to follow up on progress from our previous comprehensive inspection in

July 2014, a focused inspection in June 2015, and unannounced focused inspection in August and September 2015. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection.

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

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

Our inspection team

Our inspection team was led by:

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

Inspection Manager: Sandra Sutton, Care Quality Commission

The team included CQC inspectors a pharmacist inspector, and a variety of specialists including: a

consultant surgeon, medical consultant, nurse specialists, executive directors, midwives, senior nurses including a children's nurse. We were also supported by an expert by experience that had personal experience of using or caring for someone who used the type of services we were inspecting.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Summary of findings

The inspection team inspected the following eight core acute services and three community services at The Mid Yorkshire Hospitals NHS Trust:

Accident and emergency;

Medical care (including older people's care);

Surgery;

Critical care;

Maternity and gynaecology;

Services for children and young people;

End of life care;

Outpatients;

Community Adults;

Community inpatient services;

Community Dental.

Prior to the announced inspection we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These organisations included Clinical Commissioning Groups (CCG), NHS Improvement, NHS England, and the local Healthwatch organisations.

We interviewed members of staff and talked with patients and staff from all the ward area, outpatient and community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We used all of this information to help us decide which aspects of care and treatment to look at as part of the inspection.

We would like to thank all staff, patients, carers, and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at The Mid Yorkshire Hospitals NHS Trust.

What people who use the trust's services say

- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all of the questions.
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between March 2016 and February 2017. In latest period, February 2017 trust performance was 97% compared to an England average of 96%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for 11 questions.
- The trust performed similar to the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Cleanliness, Food and Facilities. For Privacy/dignity/wellbeing the trust performed worse than the England average.

Facts and data about this trust


In total, the trust had approximately 961 general and acute beds, 66 beds in Maternity and 25 critical care beds. The trust also employed 6,796 staff, which included 790 medical staff, 3248 nursing staff and 3903 from other staff groups.

During 2016/2017 the trust had 245,330 emergency department attendances, 141,103 inpatient admissions, and 722,632 outpatient appointments. Across the trust, there were 54,683 surgical admissions between December 2015 and November 2016.

Across the trust, there were 54,683 surgical admissions between December 2015 and November 2016. Emergency admissions accounted for 18,777 (34.3% %), 30,317 (55.4% %) were day admissions, and the remaining 5,589 (10.2% %) were elective across the surgical division of The Mid Yorkshire Hospitals NHS Trust.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as requires improvement because:</p> <ul style="list-style-type: none">• The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts across the trust remained unfilled despite these escalation processes. This was a significant concern within medical care wards where actual nurse staffing figures were significantly below establishment planned numbers evidenced by poor fill rates. Staffing escalation procedures within this division added little to the staffing situation. Nurse staffing shortfalls were a continued concern identified from previous inspections.• At medical services at Dewsbury Hospital we were very concerned that patients were not having observations monitored or had appropriate escalation when there was elevated NEWS scores.• The medical care division there was a serious backlog of incident investigations, reported to be in the region of 250 outstanding at the time of our inspection. Divisional leaders acknowledged and recognised this by including the same on the divisional risk register.• Learning opportunities from incidents was variable and not embedded across some services within the trust.• Staff across most specialties were not meeting the trust's mandatory training targets.• Clinical validation within some waiting lists, in particular ophthalmology, was a concern. <p>However:</p> <ul style="list-style-type: none">• The trust had effective and comprehensive safeguarding strategies, policies and procedures.• The trust had an effective medicines governance and incident reporting structure. <p>Incidents</p> <ul style="list-style-type: none">• Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have	<p>Requires improvement </p>

Summary of findings

happened for an incident to be a never event. Between March 2016 and February 2017, the trust reported three incidents which were classified as never events. Two of the never events were surgical/invasive procedure and one medication incident.

- In accordance with the Serious Incident Framework 2015, the trust reported 94 serious incidents (SIs) which met the reporting criteria set by NHS England between March 2016 and February 2017. Of these, the two most common type of incident reported were pressure ulcers and slips trips and falls.
- There were 16,210 incidents reported to NRLS between February 2016 and January 2017. During this period NRLS incidents were reported at a rate of 9.9 per 100 admissions, higher than the England average of 8.9 per 100 admissions.
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents.
- Learning from incidents was shared through ward and department meetings, safety huddles, weekly safety briefs and handovers.
- Matrons had an overview of every incident, complaint and concern and operated a system of response and feedback to patients and staff. Evidence of this was documented in minutes of clinical governance meetings.
- Within the medical care division there was a serious backlog of incident investigations, reported to be in the region of 250 outstanding at the time of our inspection. Divisional leaders acknowledged and recognised this by including the same on the divisional risk register.
- Learning opportunities from incidents was variable and not embedded across some services across the trust.
- The trust held regular mortality and morbidity (M&M) meetings which for most services was cross site, and staff frequently attended and discussed relevant cases. However, within critical care, the service did not hold specific morbidity and mortality meetings.

Cleanliness, infection control and hygiene

- There was one case of Methicillin Resistant Staphylococcus Aureus (MRSA) reported between March 2016 and February 2017. Trusts have a target of preventing all MRSA infections, so the trust failed to meet this target within this period. Additionally, the trust reported 28 MSSA infections and 42 C.Difficile infections over the same period.
- The trust had infection prevention and control (IPC) policies, which were accessible, understood and used by staff.

Summary of findings

- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus, and MRSA. These were available as paper copies and on the trust intranet.
- Across the trust patients received care in a clean, hygienic and suitably maintained environment.
- The trust healthcare associated infection (HCAI) prevention and control improvement strategy was underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety. This was outlined in the IPC Annual Report 2016.
- Infection control audits were completed each month and monitored compliance with key trust policies such as hand hygiene, 'bare below the elbow', catheter and cannula insertion and on-going care. Compliance was high in most areas.
- We observed staff washing their hands and all patients we spoke with told us that this was done. Hand gel was available throughout the hospital and at the point of care.
- There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection.
- Within community dental services, the service operated systems and procedures across all clinics visited to promote cleanliness, reduce the scope for infections and maintain hygiene to comply with guidelines for decontamination and infection control in primary dental care: Health Technical Memorandum (HTM) 01-05.

Medicines

- The trust had an effective medicines governance and incident reporting structure.
- On admission to the trust, figures for medicines reconciliation (57%) were in the Interquartile Range but below the England Average (72%) for non-specialist trusts (NHS England Medicines Optimisation Dashboard April 2016 to March 2017). Medicines reconciliation supports the safe use of medicines by ensuring that prescribers have a complete record of the medicines a patient is taking when admitted to hospital. The trust was working to improve this figure for example, through the introduction of a ward based clinical pharmacy service over the weekend from April 2017. There were also plans to increase the hours of pharmacist technician support to the wards.
- In response to the Carter Report, the Director of Pharmacy had reviewed the trusts Medicines Optimisation Strategy and submitted the trusts Hospital Pharmacy Transformation Plan (HPTP) to NHS Improvement. The HPTP measures the trusts

Summary of findings

current performance against the Carter recommendations and identifies where improvements could be made. Key themes to support the implementation of these improvements included increasing the ward based clinical pharmacy service, increasing the number of non-medical prescribers; and electronic medicines ordering. The trust had not yet secured funding for the implementation of ePMA (electronic prescribing and medicines administration) but was refreshing the ePMA business case as part of the trusts IM&T Strategy and Capital priorities.

- The Director of Pharmacy was engaged in work streams assessing pharmacy services within the Yorkshire and Humber collaborative, working to assess how joint working could reduce duplication, waste and unnecessary cost to support delivery of the key priorities within the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).
- Medicines incident reporting levels had increased in the trust from 2015/16. However, the trust was in the lower quartile (below the England Average) for the number of medication incidents reported to NRLS but broadly in line with the England Average for the percentage of medicines incidents resulting in harm (NHS England Medicines Optimisation Dashboard April 2016 to September 2016). Work to improve medicines incident reporting was highlighted in the medicines safety group annual report 2016/17 with plans to develop and launch an app to facilitate incident reporting. The Trust had reported a 'Never Event' (Never Events are serious incidents that are wholly preventable, NHS England) involving administration of medication by the wrong route. The Trust's investigation was completed and action had been taken to alert staff to the incident, highlighting key issues and directing staff to current medicines policy.
- The trust had a programme of medication related audit. Medicines errors were trended by type and by directorate to identify areas for improvement. There was pharmacist attendance at all the divisional governance groups to support discussion of medicines safety incidents and of new guidance and updates relating to medicines. Learning was also shared via the trusts medicines optimisation group newsletter. Recent topics included oxygen prescribing, insulin and paracetamol prescribing. Regular audits of medicines storage and security were completed and action plans were monitored regarding areas for improvement. Electronic refrigerator temperature monitoring was being implemented to ensure medicines requiring refrigeration were kept at the correct temperature.

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- The trust pharmacy team provided regular medication education sessions to junior doctors and medical students. Training focussed on both national guidance and alerts for example; medicines reconciliation and the Carter Review, and on learning from trust incidents and audits for example, oxygen prescribing and antimicrobials. Compliance with the trusts bi-annual medicines training is just below the trust standard of 85% (80% average previous 12M).
- Department of Microbiology Antimicrobial Stewardship Management Group Meetings in November 2016 and in January and March 2017 were not quorate. Additionally, antimicrobial ward rounds were not happening due to a shortage of consultant microbiologists. Public Health England Guidance, Start Smart - Then Focus 2015 recommends that trusts have a ward-focused antimicrobial team to review prescriptions at ward level as part of multi-disciplinary antimicrobial stewardship ward rounds. A consultant antimicrobial pharmacist had been appointed but the trusts Antimicrobial Resistance CQUIN action plan (May 2017) reported that microbiology resources remained a concern and that a business case for a speciality doctor had been submitted and rejected. The trust was meeting the CQUIN [commissioning for quality and innovation] target for 72h review of antibiotic prescribing but was not meeting the target for reduction in Piperacillin, Tazobactam and Carbapenem usage.

Mandatory training

- The trust set a target of 95% for completion of mandatory training, which included diversity awareness, infection control, manual handling, mental capacity, fire safety, health and safety, information governance, safeguarding adults and safeguarding children. Role specific training had a target completion rate of 85%. A breakdown of compliance for mandatory training courses between April 2016 and March 2017 for medical and dental staffing group in the trust showed that the target was not met for each of the mandatory training modules. For example 76% of medical and dental staff had completed infection control training, 65% fire safety training, and 66% health and safety training.
- For the nursing and midwifery staffing group in the trust the target was not met for all mandatory training modules. These included information governance (71%) and fire safety (72%).
- This group of staff did meet the trust target within diversity awareness (95%) and Health and safety (99%).

Assessing and responding to patient risk

Summary of findings

- The national early warning score system (NEWS) was used in each ward area as a tool for identifying deteriorating patients. The trust had also introduced the a software system to help monitor the condition of hospital patients. Nurses recorded patient observations and entered them onto an electronic device that automatically calculated the NEWS score and when observations needed to be rechecked. There was a clear escalation policy in place for when patients had an elevated NEWS score.
- A trust wide re-audit in to NEWS scores and the escalation of deteriorating patients was undertaken during September 2016 and December 2016 with the report published in February 2017. The results were compared with previous data before the introduction of the software system.
- Results showed that only 49% of patients had observations recorded as indicated by the software system. Further data showed that 45 of the 89 patients did not have their observations recorded on time. This was worse than the previous audit data.
- The results also showed that 12.5% of the patients reviewed at Dewsbury Hospital did not have appropriate escalation.
- During our inspection, at Dewsbury, we were shown the software system and conducted case reviews of patients with an elevated NEWS score of four or above across four of the medical wards. Out of 15 patients only five had evidence of appropriate escalation.
- The trust's public board papers for March 2017 reported 24 incidents on the medical wards at Dewsbury hospital where NEWS scores had not been recorded. We were very concerned that patients were not having observations monitored and escalated as per trust guidance
- A trust audit (November 2016) showed 97% compliance with the 'Five Steps to Safer Surgery' for the team brief before surgery. The audit also showed 91% 'time out' opportunities taken by all members of the theatre team to stop and listen to patient safety information. Debrief was recorded at 98% attendance rate.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.
- The trust did not use the maternity specific WHO checklist but had developed their own version of the checklist.
- The trust used a paediatric advanced warning score (PAWS), to help with the detection and response to any deterioration in a child's condition.

Summary of findings

- A PAWS audit carried out in March 2017 showed a need for improved documentation and recommended the development of guidelines for prescribing the frequency of observations, and the escalation of PAWS scores and how these should be documented. Staff training was ongoing.
- We reviewed 10 nursing records and saw appropriately completed PAWS charts.
- The medical care division highlighted patient safety as a key concern within the trust and had increased resource to address particular areas of priority such as falls and pressure ulcer reduction. A falls lead had been appointed and was leading on falls reduction across the trust and the TVN team were strengthening education across the division with link nurse champions. All wards had purchased new equipment and there was greater engagement with the wider MDT, patient and carers to reduce risk associated potential patient harms. This had been very successful with the number of falls resulting in severe harm or death reducing by 72%.
- The Mid Yorkshire Hospitals NHS Trust has been flagged as a mortality outlier for rates of septicaemia. The aim is that 90% of patients in the Trust's emergency departments and 98% of inpatients would be screened for Sepsis. Sepsis has been included in induction, mandatory training and continuous development for doctors and nurses and is promoted through handover communications. An extensive trust wide awareness promotion campaign was launched to advertise use of the new sepsis screening documentation (December 2015).
- There were backlogs in ophthalmology outpatients for first and follow up appointments. Managers told us that Glaucoma patients had an administrative validation to check they were on the correct waiting list followed by a consultant validation. The Glaucoma service had two forms, one was the partial booking referral form, which went to reception staff and the booking centre to book an appointment and there was another referral form, which was used for appointments which had to be booked in the following 12 weeks. The 12 week form for appointments was used to ensure the appointment was booked within the required timeframe. There was no clinical validation in other ophthalmology appointment backlogs.
- Managers told us there were no issues with first appointments for the macular unit and for the first 12 months of treatment, however after 12 months there was a six week additional wait for follow up appointments.
- Within out patients, some waiting lists had been clinically validated, however not all had been. There were patients waiting for appointments in the allocated slot issue list where

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they were waiting for an appointment to become available and these had not been clinically validated. The planned care improvement programme plan had clinical validation and review of follow ups as part of the plan and stated that review and validation of follow up patients was in progress as at February 2017.

- The adult community services completed risk assessments for patients as part of a core assessment on the electronic record. Risk assessments were carried out to identify patients at risk of pressures ulcers and malnutrition. Staff were aware of what action to take to protect patients from these risks. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage these risks.
- At Pontefract Hospital there was an escalation process in the event of a patient deteriorating and requiring transfer to Pinderfields.

Nurse Staffing

- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels. The trust also monitored acuity and staffing levels using the safe care system on a twice daily basis, as well as care hours per patient days (CHPPD), red flags and professional judgment in order to respond to fluctuations in patient need and changes to anticipated staffing levels. All wards run on a ratio of 1:8 unless agreed by the Director of Nursing.
- As of February 2017, the trust reported a vacancy rate of 10%. Outpatients is the core service with the largest vacancy rate at 15%.
- As at March 2016 and February 2017, the trust reported a turnover rate of 12%. A&E has the largest turnover rate at 19%.
- As at March 2016 and February 2017, the trust reported a sickness rate of 7%. Community has the largest rate of sickness out of all the core services at 10%.
- As at March 2016 and February 2017, the trust reported a bank and agency usage rate of 18%.
- Medical care wards were consistently understaffed. The medical care division failed to meet safe registered nurse staffing ratios and actual nurse staffing figures were significantly below establishment planned numbers evidence by poor fill rates.
- Within medical care wards, there was a reported and identified correlation between deficient nurse staffing and patients

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suffering harm. The ripple effect of the current nurse-staffing situation affected all clinical areas. This was compounded by current demand and extra capacity being staffed from within the existing nurse compliment.

- Within medical care wards, some staffing escalation procedures added little to the staffing situation. The divisional 'bleep holder' initiative was criticised and staff were cynical about the 'badge system' as a means to identify staff suitable to support outside their ward expertise. Senior clinicians considered highly skilled and specialist nurses were being misused as part of the escalation process.
- The qualified nursing staff levels required across all surgical wards at Pinderfields General Hospital was 335.9 whole time equivalent (WTE) for March 2017. The number of qualified staff in post were 309.87 WTE. The areas with the largest staffing vacancies were in theatres (16.2 WTE), the plastics and burns surgical services (6.23 WTE) and gate 33 (4.17 WTE).
- Within critical care services the establishment for registered nurses was three whole time equivalent (WTE) band seven, 10.4 WTE band six, and 54 WTE band five. The service had 15 WTE vacancies cross site. Between March 2016 and February 2017 the unit reported a sickness rate of 7.9%. Information provided by the trust showed the agency usage for registered nurses from December 2016 to March 2017 was between 0.7 and 16.4%. This was in line with GPICS standards.
- The trust did not meet the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:32 across both community and hospital staff against the recommended 1:28. The service did not include maternity support workers within the establishment.
- The service used Birthrate Plus® to enable a comprehensive review of midwifery staffing numbers based on the different models of care. The review identified a shortfall of 18.42 whole time equivalent midwifery staff. The service had plans in place to recruit to these posts between 2017 and 2020.
- Children and young people services were not always meeting the 2013 RCN guidance on staffing. The shift supervisor was not supernumerary and there was not always the required nurse to patient ratio for the age of the child. The RCN recommend a ratio of one nurse to three patients for under twos and one nurse to four patients for over twos. Service leads told us they did not work to this guidance but looked at patient dependency to determine staffing numbers.

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- Specialist palliative care nurse staffing met the national guidance with 10.8 whole time equivalent (WTE) Macmillan specialist palliative care nurses. Staffing included one WTE end of life care facilitator / team leader, five WTE Macmillan Nurse band 7 and 4.8 WTE Macmillan Nurse band 6. Of these, three WTE specialist palliative care nurses were hospital-based to manage end of life patients while inpatients at the trust. This also met national guidance.
- Sickness levels with the adult community nursing teams had been high above the trust target of 4% for the majority of months. Most adult community nursing teams also had vacancies for a period of time. This had impacted on the amount of staff and the caseload available to provide patient care. We identified that improvements had been made but these had not been fully implemented at the time of inspection.

Medical Staffing

- As of March 2017, the trust reported a vacancy rate of 11%; A&E has the largest vacancy rate at 15%.
- As at March 2016 and February 2017, the trust reported a turnover rate of 9%. A&E has the largest turnover rate of 20%. Sickness rates during the same period were 1%.
- Between 1 December 2016 and 31 December 2016, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England average.
- Medical staffing across the medical care division had improved since the inspection in 2015 with all specialist heads being substantive appointees. At our meeting with the divisional leadership team, they reported 21 consultant vacancies across the division. All posts were filled by locum staff with the majority on long term contracts. There were identified 'hot-spots' in acute medicine and gastroenterology. All clinical heads were substantive consultant appointments. Divisional leaders also highlighted challenges in covering middle grades positions which was also supported by locum staff.
- To support recruitment matters, the medical care division had appointed a recruitment lead.
- As at 28 February 2017, the trust reported a vacancy rate of 8% in surgical care. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing. Over the same period, the trust reported a turnover rate of 6% and a sickness rate of 1% at Pinderfields.

Summary of findings

- Locum usage in theatres between January 2017 and March 2017 was highest in anaesthetics with 981 shifts filled by locums across the trust. A further 921 shifts were covered by locum staff across the trust for all other specialities in the same period.
- Staff we spoke with told us the unit had a high usage of locum medical staff within critical care. The service used regular locum doctors and they would work a day shift on the unit before working out of hours. Information the trust provided showed locum medical staff usage in anaesthetics, not critical care as a speciality; however, over 300 shifts a month in anaesthetics were filled by locums for the 12 months prior to the inspection.
- The delivery suite had consultant cover 98 hours per week. This was based on an onsite consultant presence for 14 hours a day seven days a week. This was in line with recommendations in Safer Childbirth (2007)
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours' work when they were on call. There was a separate consultant-on-call rota for gynaecology; this meant there was a second consultant on site in emergencies if needed.
- Every child admitted with an acute medical problem was seen by a paediatric consultant within 14 hours of admission as recommended in the Royal College of Paediatrics and Child Health (RCPCH) guidance Facing the Future: Standards for acute general paediatric services (2015).
- There was a national shortage of radiologists. However, this trust experienced no difficulties in recruitment to consultant or specialty training grade posts. There were 28 WTE consultant posts and 27 of these were filled.
- In community inpatients, a consultant or a registrar visited the unit daily Monday to Friday to provide medical cover. They could be contacted between the hours of 8am to 5pm on weekdays. At weekends and outside of these hours, staff contacted the out of hours GP service if a patient became unwell and needed a medical review. In an emergency, staff would call 999 and the patient would be transferred to the emergency department.

Safeguarding

- The trust had a clear safeguarding strategy and safeguarding board meetings. Minutes and action plans were clear and these meetings were well attended by senior staff from across the trust. Learning from serious case reviews was monitored and there was good attendance and compliance of staff at safeguarding training.

Summary of findings

- The trust had an integrated safeguarding team in place. The team held skills and experience in the application of the Mental Capacity Act, Deprivation of Liberty Safeguards, Children and Adult Safeguarding, and Learning Disability. The safeguarding lead was a qualified Mental Health Nurse.
- We found that the trust safeguarding group met every eight weeks. All representatives from the trust and the Clinical Commissioning Group (CCG) attended. Information from the safeguarding group was fed into the quality committee and board. An annual report was submitted as well as a summary report to the quality committee. In addition to this, the reportable incident log fed into monthly board meetings.
- Safeguarding information was shared with the patient safety panel on a fortnightly basis with regular feedback received and disseminated to all teams trust wide. Safeguarding updates were discussed at ward rounds and safety huddles.
- The trust had an executive and non-executive lead and designated team for safeguarding across the organisation. The team were fronted by a Head of Safeguarding and a Named Professional Safeguarding Adults.
- Senior divisional staff were involved in safeguarding board meetings and in the development of the trust wide strategy.
- Staff were aware of safeguarding policy and accessed safeguarding information such as the strategy, reporting systems, key contacts, training information, signposting guidance and policies and procedures on the intranet.
- The trust set a mandatory target of 95% for completion of mandatory safeguarding training level one and 85% for level two and level three training. For the entire medical and dental staffing group in the trust the target was not met for each of the safeguarding modules. These modules were safeguarding adults level one and two. For the entire nursing and midwifery staffing group in the trust the target was not met for three out of the four training safeguarding modules. The only module met was safeguarding adults level 2.

Duty of Candour

- Most staff knew of the Duty of Candour (DoC) requirements and of the trust policy. Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.

Are services at this trust effective?

We rated effective as requires improvement because:

Requires improvement



Summary of findings

- Patient outcomes from national audit data were variable. Overall, heart failure, myocardial infarction and diabetes outcomes were worse than national average. The trust was an outlier in a number of mortality alerts across divisional services. The trust had six active mortality outlier alerts as at 3 April 2017.
- Staff knowledge and understanding of deprivation of liberty safeguards and the Mental Capacity Act principles was variable across some services within the trust. There was confusion around the internal processes and in the completion of the associated documentation. We found the completion of this element of the care documentation to be variable specifically within the medical care division
- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed.
- Within medical care services, the meal time initiative to support patient nutrition and hydration was not robust. Patients did not always have ease of access to drinks and the use of the 'red jug, red tray' was inconsistent. Nursing documentation to support nutrition and hydration was poor.
- Within maternity services there was a lack audit over and above the national requirements, to support continuous improvement. There was not a regular programme of skills and drills in all areas of the obstetric department.
- The caesarean section rate was better than the trust target, additionally the rates of elective caesarean sections were better than the England average. The induction rate was worse than the England average.
- The numbers of mothers experiencing post-partum haemorrhage was worse than the trust targets.

However:

- There was effective multi-disciplinary (MDT) working to secure good outcomes and seamless care for patients across the trust.

Evidence based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons. The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.

Summary of findings

- The medical care division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. Staff fed these into the respective business units and incorporated into local quality improvement projects.
- The medical care division had developed guidance for the management of sepsis (March 2017) in line with NICE recommendations (Sepsis: recognition, diagnosis and early management, NG51) updated in July 2016. This included treatment pathways, management plans and risk stratification tools. The division met 118 of the 119 recommendations for sepsis management. The division were involved in the development of the trust sepsis action plan to meet the sepsis CQUIN targets.
- The endoscopy service had JAG accreditation status changed to 'assessed: improvements required' in 2015 (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards). The trust has not since gained accreditation.
- During 2015/16, the surgical division prioritised 33 level one clinical audits covering a range of specialties. Outcomes from each audit were reported to the trust's quality panels and directorate operational team meetings.
- We found the care of women using the services were in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- Following the amalgamation of services on the Pinderfields site we found a lack of additional audit activity. For example, there were no pain audits, and no audit of the number of women reviewed in 30 minutes of arrival to the unit and time to consultant review.
- The UNICEF Baby Friendly Initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK. Although the maternity services had been awarded UNICEF Baby Friendly accreditation, the neonatal unit had not.
- The neonatal unit took part in the BLISS family-friendly accreditation scheme and information about the 'Mid-Yorkshire neonatal family-centred care group' was displayed on the ward.
- End of life care needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures

Summary of findings

were based on guidance produced by the National Institute for Health and Clinical Excellence (NICE) or other nationally or internationally recognised guidelines including Actions for the End of Life 2014/2016 (NHS England).

- The trust was planning to introduce the Gold Standard Framework to hospital staff on eleven wards in 2017. The Gold Standard Framework is a provider of quality improvement, accredited, evidenced based end of life care training for health and social care staff.
- The trust provided care which followed approved national guidance such as: NICE; the British Society for Disability and Oral Health (BSDH); the Faculty of General Dental Practice; the Royal College of Surgeons and the Royal College of Anaesthetists Standards for Conscious Sedation in the Provision of Dental Care 2015; and the Delivering Better Oral Health Toolkit 2014.
- There was a programme of clinical audit projects for community inpatient services. These included documentation, pressure ulcer and falls audits.

Nutrition and hydration

- The trust recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care.
- We saw a range of food choice, meals and snacks.
- Overall, patients commented favourably on food quality, choice and portion sizes. This was mirrored in the PLACE assessments (2016) which reported a food score of 89.1% (better than national average of 88.2%).
- Across the trust, staff identified patients at risk of malnutrition by working with patients and their families to complete a Malnutrition Universal Screening Tool MUST score. We found the completion of the Malnutrition Universal Screening Tool (MUST) variable within medical care.
- Food provision trust-wide was monitored against external standards namely the Nutrition Alliance, The British Diabetic Association, Malnutrition Universal Screening Tool (validated by British Association of Parenteral and Enteral Nutrition), Public Health England and Department of Environment, Food and Rural Affairs. Compliance against these standards was self-assessed and RAG (red/amber/green) rated according to compliance. Compliance was variable, within the medical care division, there was only one of the five standards deemed to meet the required standards.
- Within the medical care division, meal time initiatives to support patient nutrition and hydration was not robust. Staff

Summary of findings

were distracted whilst supporting patients with eating and drinking. Due to patient demand, some meals were allowed to go cold and were wasted. Patients did not always have ease of access to drinks and the use of the 'red jug, red tray' was inconsistent. Nursing documentation to support nutrition and hydration was poor. Fluid charts, food diaries and intentional rounding documentation was absent, incomplete or partially completed.

Patient outcomes

- Pinderfields General Hospital takes part in the quarterly Sentinel Stroke National Audit (SSNAP) programme. On a scale of A-E, where A is best, the trust achieved grade C in the latest audit, December 2016 to March 2017. Compared to the previous quarter, there had been noted improvements in three domains relating to occupational therapy, speech and language therapy and the patient centred key indicator. The thrombolysis domain score had reduced from a B to a C. Three domains were A graded; these related to occupational therapy and discharge processes. The multi-disciplinary team working domain rated the lowest with grade E.
- Pinderfields results in the 2015 Heart Failure Audit were worse than the England and Wales average for three of the four of the standards relating to in-hospital care and worse in four of the seven standards relating to discharge.
- Pinderfields took part in the Myocardial Ischaemia National Audit Project (MINAP). Between April 2014 and March 2015, 29.8% of nSTEMI patients were admitted to a cardiac unit or ward at Pinderfields and 90.2% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1%. The proportion of nSTEMI patients who were referred for or had angiography at Pinderfields was 66.7% compared to an England average of 79%.
- The 2015/16 MINAP report, published in June 2017, showed an improvement in outcomes at Pinderfields. The trust HSMR (Hospital Standardised Mortality Ratio) data from June 2014 to May 2017 for 'acute myocardial infarction' was reported as 58.9 (better than the national average).
- In the National Diabetes Inpatient Audit (NaDIA) 2016, the division at Pinderfields reported variable findings and some improvements against 2015 outcomes. Patients receiving renal replacement therapy was reported at 1.5% (compared to 3.5% nationally). Foot risk assessment within 24 hours increased from 9.4% to 10.4% however remained worse than national average of 30.1%. There had been a reduction in insulin pump usage down from 11.7% to 10% (national average at 8.2%)

Summary of findings

however 7.7% of the infusions were deemed not appropriate (compared to 7.4% nationally). The audit reported 37.5% of patients received a multidisciplinary foot team assessment within 24 hours (compared to 56% nationally). Medication errors were higher than national average 39.1% to 37.8% nationally however had improved from 2015. Prescription errors were also higher than national average, 28.3% compared to 21.1% respectively; this was similar to insulin errors which was also higher than national average. The division also reported higher mode3rate and sever hypoglycaemic episodes compared to national average. 60% of patients reported meal times to be suitable and 55.9% reported choice to be suitable. 50.5% of patients reported they could take control of their diabetes care (compared to 60% nationally). Patients also commented on staff knowledge of diabetes and these findings were below national average. Overall, 67.6% of patients were satisfied with their care at Pinderfields which was lower than the national average of 83.7%.

- In the 2015 heart failure audit, Dewsbury and District hospital performed worse than the England and Wales average for all four of the standards relating to in-hospital care. They were also worse than the England and Wales average for five of the seven standards relating to discharge.
- In the NaDIA Audit for 2016, Dewsbury and District Hospital scored better than the England average in ten metrics and worse in seven. The indicator relating to 'patients with active foot disease seen by the multidisciplinary foot team in 24 hours had the largest difference against the England average at 0% compared to an England average of 56.1%.
- The division took part in the National Diabetic Foot Audit (NDFA) compiled between July 2014 and April 2016. The headlines reported 44.7% of patients in the audit had a SINBAD (assessment tool covering the variables of site, ischemia, neuropathy, bacterial infection, and depth to predict ulcer outcome) score of 3 or above (compared to 45.6 nationally). 34% of patients self-presented to the service (compared to 29.9% nationally) and 14.9% were seen within two days of initial presentation compared to 13.4% nationally. 6.4% of the ulcer episodes were not seen for two months or more, compared to 8.6% nationally. The division reported 12 week outcomes under and these three variables (outcome recorded, alive and ulcer free and persistent ulceration) were better than national average figures. The division also reported 24 week outcomes with two of the three variables better than national average.

Summary of findings

- In the British Thoracic Society (BTS) Community Acquired Pneumonia (CAP) Audit 2015, the division reported variable outcomes. Only 39% of patients had a senior review within 12 hours (compared to 70% nationally). The service had better length of stay, better in-patient mortality, better time to chest x-ray and antibiotic administration compared to national average figures. The division also reported findings above national average figures confirming diagnosis of CAP within four hours (88% compared to 77%) and x-ray review before antibiotics (78% compared to 61%). There was poor compliance against urinary pneumococcal antigen testing (5% against 60% benchmark).
- Between November 2015 and October 2016, patients at the trust had a lower than expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions when compared to the England average. Of the top three specialties with the highest activity, General Surgery and Plastic Surgery both have relative risk of readmission higher than the England average for elective admissions. On a site level, Pinderfields General Hospital has a higher risk of readmission for elective admissions and a lower risk of readmission for non-elective admissions.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.9%, which falls within the expected range. The 2015 figure was 5.5%. The proportion of patients having surgery on the day of or day after admission was 38.8%, which does not meet the national standard of 85%. The 2015 figure was 61.2%. The perioperative surgical assessment rate was 93.7%, which does not meet the national standard of 100%. The 2015 figure was 92.5%. The proportion of patients not developing pressure ulcers was 95.7%, which falls in the middle 50% of trusts. The 2015 figure was 90.4%. The length of stay was 20.9 days, which falls in the middle 50% of trusts. The 2015 figure was 21.6 days. The hospital met best practice criteria 38.2% of the time.
- In the 2016 Bowel Cancer Audit, 81% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 80%. The risk-adjusted 90-day post-operative mortality rate was 5.4%, which was within the expected range. The 2015 figure was 2%. The risk-adjusted 2-year post-operative mortality rate was 18.9%, which falls within the expected range. The 2015 figure was 24.6%. The risk-adjusted 30-day unplanned readmission rate was 6.5%, which falls within the expected

Summary of findings

range. The 2015 figure was not recorded. The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54%, which falls within the expected range. The 2015 figure was 58.2%.

- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 10.5%. This placed the trust within the middle 50% of all trusts for this measure. The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.3%, significantly lower than the national aggregate. This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level with better co-operation between hospitals within a network would be expected to produce better results.
- In the 2016 National Emergency Laparotomy Audit (NELA), Pinderfields General Hospital achieved an amber (50-79%) rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 119 cases. The Pinderfields hospital achieved an amber (50-79%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 86 cases. The Pinderfields hospital achieved an amber (50-79%) rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 65 cases.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2016 to March 2017, three indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Four indicators showed fewer patients' health improving and more patients' health worsening than the England averages, and four were in line with the England averages.
- Within critical care at PGH, the Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 31 December 2016 showed risk adjusted hospital mortality was 1.13. This was within the expected range. This data also showed that the unit had a 0.5% unplanned readmission in 48 hours rate. This was better than similar units' rate of 1.2%.
- Within critical care at DDH, the Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 31 December 2016 showed that the risk adjusted hospital mortality was 1.23. This was within the expected range. This data also showed that the unit had a 1.6% unplanned readmission in 48 hours rate. This was in line with similar units. Between April 2016 and

Summary of findings

March 2017, the service reported a trust wide caesarean section rate of 25.4%, which was better than the 26.2% target set by the service. Emergency caesarean section rates were 15.5%, which was in line than with trust target of 15.2%. For elective caesarean sections, the service achieved 9.9%, which was better than the England average of 11%. The instrumental vaginal delivery rate was equal to the England average at 13%.

- Between April 2016 and March 2017, the trust wide induction of labour rate was 32.5% this was worse than the England average of 24%.
- Trust data showed the antepartum stillbirth rate over 24 weeks between April 2016 and March 2017 as 24. This is equal to the number in the previous financial year. The service dashboard showed that there were nine stillbirths at term. This was worse than other comparable trusts. Data for April 2016 to March 2017 showed there were four neonatal deaths. The service was identified by MBRRACE-UK (2017) as having a stabilised and extended perinatal mortality rate, which showed the perinatal mortality rate was 10% higher than the average for trusts of the same size and demographic.
- Between April 2016 and March 2017, 10% of mothers birthed had a blood loss measured at greater than 1000mls this was worse than the trust target of 7.7%. Of the women birthed during this time 0.6% of women experienced, a life threatening blood loss of 2500mls or more.
- The service achieved a trust wide normal vaginal delivery rate of 63%, which was better than the national average of 60%.
- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed better than the England average for three of the five clinical indicators. The trust scored particularly well for KPI3 'is there any documented evidence that the patient was given an opportunity to have concerns listened to', scoring 98% compared to a national result of 84%. Scores for the remaining two indicators were slightly worse than the England average score. These related to documented evidence that the needs of the person important to the patient were asked about, and that a holistic assessment of needs and individualised plan was completed in the last 24 hours of life.
- The trust has six active mortality outlier alerts as at 3rd April 2017. This total included five open alerts currently being considered for follow up by CQC's expert panel and one alert already approved for follow up. Alerts were for the following indicators: Acute cerebrovascular disease; Septicaemia (except in labour) – x2; Acute and unspecified renal failure; Coronary atherosclerosis and other heart disease; and Fluid and electrolyte disorders.

Summary of findings

Multidisciplinary working

- There were many examples of multi-disciplinary (MDT) working to secure good outcomes and seamless care for patients across the trust.
- The Emergency Department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite.
- There was good access to psychiatry clinicians within the department with 24 hour access to psychiatric liaison staff. The mental health liaison team were very responsive and aimed to attend the department within one hour of being called. Delays for mental health patients were a result of waiting to see the crisis team who supported mental health patients who had further support needs.
- There was a substance and alcohol misuse liaison team available to support patients and staff treating them with advice. This service was available to patients of any age.
- The trust had an admission avoidance team who worked to support staff and patients to access alternative services in the community and avoid hospital admission. Any patients who required admission were transferred to a ward as soon as a bed was available.
- Twice daily handovers were carried out on surgical wards with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed. Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- Staff advised that there were good working relationships between wards and pharmacy staff, that the pharmacy department was easily accessible and additional support available as required. There was pharmacy input on the wards during weekdays and with pharmacy access 7 days per week.
- Staff explained to us that the wards worked with local authority services as part of discharge planning. We saw that discharge planning commenced at pre-assessment. We observed staff, including those in different teams and services, become involved in assessing, planning and delivering people's care and treatment.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.

Summary of findings

- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks. Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.
- Staff worked closely with the Child and Adolescent Mental Health Services (CAMHS), they gave us an example of working on a joint care plan for a patient who had been admitted whilst waiting for a CAMHS bed.
- The burns unit had multi-disciplinary ward rounds twice a week, which included psychologists and dieticians. The play specialist from the burns unit worked closely with schools, devising care plans for when the child returned to school.
- The Specialist Palliative Care Team (SPCT) attended weekly meetings with two local hospices to discuss referrals, inpatients, and deaths. The palliative care consultants attended other specialty multidisciplinary (MDT) meetings for haematology, lung cancer, cancer of unknown primary and the hospice MDTs. A member of the SPCT nursing team attended the lung cancer, heart failure, and upper gastroenterology MDT meetings.
- The SPCT worked with the ward staff, specialist nurses (such as oncology, respiratory and cardiac specialists), physiotherapy, occupational therapy, the chronic pain team and discharge liaison coordinators to arrange for safe discharge home.
- The oral health promotion team worked closely with health visitors and school teachers as part of a multi-disciplinary team to promote good oral healthcare. For instance, the team ran the 'Brushing for Smiles' initiative which involved training health visitors to run the child health assessment for children at eight to 12 weeks after birth. The 'Just brush' programme involved training teachers at selected schools to help children develop a life skill. In addition, the team managed a 'school resource loan service'. This involved the team putting together a box of resources that school teachers could use following initial training from the team.
- A multi-disciplinary meeting was held on Mondays and Thursdays every week for community inpatients. This included therapy, nursing staff, administration staff and a social care coordinator.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Records showed patients had consented to surgery in line with Department of Health guidelines. This included the risks, benefits and alternative options for treatment.

Summary of findings

- The trust had a consent to examination and treatment policy and included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.
- We found the completion of this element of the care documentation to be variable specifically within the medical care division. In 28 patient records reviewed within this division, there were five (18%) where the capacity assessment documentation was incomplete.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- Staff we spoke with had varying degrees of understanding around safeguarding policies and procedures and MCA principles. Staff were aware however this was underpinned by legislature and the significance of failing to consider such issues where patients may lack capacity and be unable to consent to treatment.
- Within the medical care division, we found assessment of capacity completion of MCA/DoLS documentation to be inconsistent and a 'Care Plan for a Vulnerable Patient who required help with Decision Making' to be completed incorrectly.
- We reviewed 21 DNACPR forms in patient records across the hospital. These were all placed at the front of the patient record. Ten patients were recorded as not involved in the decision-making and of these; two DNACPR forms referred to lack of capacity but associated medical notes were unclear as to whether mental capacity was assessed and two forms provided no evidence as to why the patient was not involved in discussions. All forms were authorised by a doctor of appropriate seniority.
- The resuscitation team carried out an annual audit of 120 DNACPR forms trust-wide in September 2016. Documentation to evidence the reasons why the patient was not involved in decision-making had improved from the previous year's audit from 57% to 78%. Evidence of documentation of a capacity assessment where required, had improved from 50% to 67%. An action plan was in place and included disseminating the results to the consultant body and to improve education of patients and relatives to increase understanding of DNACPR orders and to promote active and early engagement in the decision making process.

Summary of findings

Are services at this trust caring?

We rated caring as good because:

- In most areas throughout the trust we observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- In most areas throughout the trust each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- There were positive results in most areas across the trust in the NHS Friends and Family Test and good recommendation rates for the service.
- There was evidence of patients and their relatives being involved in the development of their care plans throughout all services within the trust.
- Staff considered physical, emotional and social elements of wellbeing equally. Patients and family members were included when discussing care decisions and treatment plans.

However:

- Within the medical care division across the trust staff shortages impacted on the ability of ward staff to provide the level of care they would like to. As a result of working under such pressure and time constraints we did observe some care which was not of an acceptable standard. Some patients also reported this was affecting the length of time it took for call bells to be answered.
- At Pinderfields Hospital privacy and dignity of patients being cared for in extra capacity beds was compromised. Staff commented, and we observed, how utilisation of extra capacity beds on wards restricted space to deliver care, impinged on neighbouring patients bed areas and were hazardous due to a lack of nurse call bells and inadequate screening. Divisional leaders recognised this impacted on the quality of the patient experience.

Compassionate care

- Staff across the trust considered the patients to be central to everything they did and there was a determination to ensure care delivered was of a high standard.
- In most areas across the trust there were many examples of compassionate and dignified care being delivered. This included end of life care where a patient who was bed-bound and asked to go outside for fresh air during the last hours of life.

Good



Summary of findings

Staff arranged for the patient to be taken outside on the bed to fulfil this final wish. We were informed of an emergency wedding that had been conducted in the hospital for an end of life patient. The trust chaplaincy team facilitated this.

- However, within the medical care division we found that staff shortages and where patients were being cared for in extra capacity beds, there were examples of privacy and dignity being compromised.
- Patients did not always have access to a nurse call bell to summon assistance when required. One patient stated she relied on other patients in the bay to use their call bell on her behalf.
- We found the use and availability of screens to ensure patient privacy and dignity was variable; in some areas the screens were unavailable and in others the screens were not of a suitable size to allow care to be delivered in a private manner. One neighbouring patient informed us he had vacated his bed overnight to allow staff to use the fitted curtains while delivering care.
- There was insufficient space in between the extra capacity beds and existing beds in the bay. This restricted personal space, compromised the area for neighbouring patients, reduced the extent to which care could be delivered and disallowed personal furnishings in the area (such as bedside lockers, designated patient tables and patient/visitor seating).
- Staff from all disciplines commented about the frustrations they had in dealing with patients in extra capacity beds. Consultants found the screens (when available) did not provide the privacy required when holding ward rounds. Nursing staff commented how delivering care in the restricted space was difficult and therapists echoed these concerns.
- Patients and family members had raised concerns about extra capacity beds to ward managers and matrons. Divisional leaders acknowledged the additional beds open across the division and the current staffing shortage affected the patient experience.
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England average between March 2016 and February 2017. In latest period, February 2017 trust performance was 97% compared to an England average of 96%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 20 questions and in the bottom 20% for 11 questions.

Summary of findings

The questions in the top 20% were: Patient definitely involved in decisions about care and treatment; Staff definitely did everything to control side effects of chemotherapy; and Hospital staff told patient they could get free prescriptions.

- The trust performed worse than the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to privacy, dignity and wellbeing.
- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all of the questions.

Understanding and involvement of patients and those close to them

- Staff recognised the importance of engaging patients, and those close to them, in care decisions, treatment options and care recommendations.
- Staff informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks and the likely time to be spent in hospital.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.
- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out, and did their best to keep patients reassured. We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to take relatives or friends to the consultation should they prefer to.
- Women were involved in their care throughout the antenatal, birth, and postnatal periods. We observed staff involving women in the planning of their care, and the women we spoke with said they felt involved in their care and understood choices available to them.
- Parents told us that staff listened to children's and parent requests and would work with them to provide the best care for that child. They were encouraged to ask questions.

Summary of findings

- Parents in the neonatal unit told us that the medical and nursing staff explained the plans for care and prepared the parents for what may happen. Staff arranged care around the parents, so that they could feed and bath their baby when they were on the unit.
- One patient and their guardian we spoke with described how staff understood their family needs and made sure appointments were arranged in such a way that the maximum number of children could be seen at once. The child patient we spoke with explained how staff were friendly and took care when removing their teeth. It was clear that staff had taken time to understand the needs of this family.
- One relative told us that they had met a palliative care doctor on the ward who explained the treatment plan and discussed with the family aspects of quality of life and the patient's wishes. The relative told us they felt that the doctor "listened to her and the family and took their views on board".

Emotional support

- The chaplaincy team provided a range of spiritual and holistic support, including regular visits to wards to meet with patients and appoint of contact with the appropriate faith community, Christian and Muslim worship and prayers in the hospital chapels and prayer rooms, Holy Communion at the bedside by request and 24-hour on-call service including out-of-hours cover for emergencies via hospital switchboards.
- Clinical nurse specialists in areas such as pain management, colorectal, stoma and breast care were available to give support to patients.
- Staff invited relatives and family to a bereavement group they held twice a year. Staff read poems, lit candles and invited relatives to write in the bereavement book and share memories. Staff gave relatives a book containing the readings and details for counselling and bereavement support groups.
- The critical care outreach team provided emotional support for patients on the ward following discharge from critical care.
- A consultant obstetrician specialised in providing holistic care for women who had previously suffered pregnancy loss. Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death.
- Children and young people on the burns unit had the support of a psychologist. The play specialist on the burns unit ran a burns club, which provided psychological support to children, young people and their families.

Summary of findings

- Play specialists were able to provide support to children and young people to alleviate their anxieties.
- Patients with life-limiting illnesses could access the Rosewood Centre based at Dewsbury Hospital, which is a palliative day support and therapy unit. It aimed to enhance the quality of life of those struggling with the physical and mental impact of their illness. Services included a palliative pulmonary rehabilitation programme to help patients with progressive lung disease and primary or secondary lung cancer, manage chronic breathlessness.
- End of life patients and their carers could also access a drop-in service at the local hospice for supportive services including music therapy, benefits advice and complementary therapies.

Are services at this trust responsive?

We rated responsive as requires improvement because:

- The use of extra-capacity beds in existing bays within medical care wards, particularly in Pinderfields Hospital was impacting negatively on patient experience and at times compromising privacy and dignity.
- Medical boarders were impacting in most clinical areas within the trust.
- There were a considerable number of patient moves after 10pm causing distress, inconvenience and confusion to many patients. Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- Referral to treatment time (RTT) data varied across specialities, particularly in outpatient services.
- The backlog of patients waiting for first and follow up appointments across the trust outpatient departments had deteriorated since the last inspection.
- Within the medical care division there were significant numbers of patients medically fit for discharge where care could not progress outside the hospital setting due to multi-factorial variables. These included delays in social care assessments, a lack of community placement facilities, issues around securing funding approval for specialist equipment and slow engagement with patients and family members in the discharge process.

However:

- The trust worked closely with its commissioners and external stakeholders on service redesign and the local health economy strategy.

Requires improvement



Summary of findings

- The trust had an escalation policy and procedure to deal with busy times, and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Services met the needs of people, particularly those patients with multiple and complex needs.
- Systems were in place for the management of complaints, and there was evidence of improvements following complaints.

Service planning and delivery to meet the needs of local people

- Divisional management staff across the trust attended meetings with local CCG representatives in order to feed into the local health network and identify service improvements to meet the needs of local people.
- At the time of the inspection, as part of the reconfiguration programme, Pinderfields accepted a wide range of patients including those suffering stroke, trauma, cardiac arrest, surgical emergencies and obstetrics and gynaecology emergencies. There were some patients such as those having a heart attack, or victims of major burns or major trauma who were taken to their nearest major trauma centre.
- The trust separated emergency and high risk surgery from routine surgery in September 2016 and all emergency (unplanned) surgery moved to Pinderfields General Hospital. This was undertaken to meet national guidance of separating planned and urgent care to improve clinical outcomes, access to urgent surgery, improve local treatment for non-complex planned surgery, reduce cancellations, improve surgical cover and to reduce infection risk.
- Critical care service was actively involved in the acute hospital reconfiguration plans. This involved the relocation of critical care services from Dewsbury and District Hospital to Pinderfields Hospital. At the time of the inspection staff were planning for the move to take place in September 2017.
- Community-based maternity services were provided from a number of locations within the area; these were predominantly GPs' surgeries, children's centres, and women's own homes.
- The gynaecology service provided an outpatients clinic and both planned and emergency gynaecological surgery and procedures. There were a number of nurse-led and consultant-led clinics.
- Diabetes outpatients had re-designed clinics and introduced practice nurses. The service held a walk in service to help prevent admission at each site. The trust had a separate paediatric diabetes team. There was a clinical nurse lead for diabetes at each of the three sites services was provided.

Summary of findings

- Dermatology outpatients held a nurse led “suspected skin cancer clinic” held every Thursday afternoon and Friday morning. This had been a trial from November 2015 and became permanent from September 2016. This was currently held mainly at Dewsbury Hospital and Pinderfields Hospital on a Thursday and Friday.
- The specialist palliative care (SPCT) team and local hospices participated in the local multiagency strategic project board working on the end of life care strategic outline case. This was sponsored by the local clinical commissioning group (CCG) to support the development of an integrated and comprehensive end of life care service for local communities including those in care homes and prisons.
- There were clinical networks in place linking the hospices, hospital and community services to ensure effective communication as the patient moved between services. Weekly meetings were held at the local hospices to discuss referrals, inpatients and deaths. The palliative care consultants worked across the two trust sites and provided clinical care to the local hospices as well community services
- The access, booking and choice directorate included a booking and call centre which was based at Pinderfields Hospital. This service carried out partial bookings for the trust and took calls from patients regarding appointments. The service had performance indicators and these were indicated on the call centre electronic boards which highlighted whether they were achieving their performance indicators and the number of calls waiting to be answered.
- We found that community inpatient services were planned to meet the needs of the local population and they were able to provide appropriate support to the patients in their care. The service had worked closely with commissioners to redesign community inpatient services with a focus on rehabilitation and timely discharge. As part of this redesign, clear admission criteria to the unit had been developed and introduced. The service redesign had involved staff at the unit, colleagues in the acute hospitals and social care workers.

Meeting people's individual needs

- Staff could access interpreters if required, either face to face or by telephone. The Mid Yorkshire Hospitals trust had recently updated its translation and interpreting policy and have

Summary of findings

interpreting and translations services available to patients whose first language is not English. Patients were encouraged to ask a member of staff to help organise this for themselves and their families.

- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- The South Kirkby community dental clinic had a bariatric surgery and bariatric chairs in the waiting area so that it could provide services to that group of people making sure they had equal access to the service. We saw that all community dental clinics had hoists to help make the service equal for people with mobility issues. All clinics had their own foldable wheelchairs so patients who were transported to the clinic (but left without a wheelchair) could be seen.
- All wards followed the Vulnerable Inpatient Scheme (VIP). The VIP symbol was used on the VIP hospital passport. The passport helped the hospital staff to understand the patient's additional needs and was accessible in the patient's notes and a VIP sticker was placed above the patient's bed.
- There was a weekly, specialist, antenatal clinic for women with diabetes. A midwife and specialist diabetic nurse ran this jointly to ensure continuity of care at clinic appointments.
- The service was in negotiation with local CCGs to improve services for pregnant women with Body Mass Indices (BMIs) of over 35. Additionally, midwife sonographers were undertaking training to perform foetal growth scans for these women, and the service was considering the development of a specialist clinic alongside scanning to offer specialist support and coordinate interventions.
- Staff felt confident to care for patients with a learning disability. They encouraged relatives and carers to stay with the patient to assist with care and communication. Staff would seek support from the nurse in charge on the unit or the learning disability nurse in the trust if they needed it.
- The burns unit at Pinderfields Hospital had a calm room and the children's centre had a Snoezelen room, which were multi-sensory environments that could help reduce agitation and anxiety. The burns unit had a motorised car, which patients could drive down to theatre in. This helped alleviate some of their anxieties.
- End of life care support was offered to local prisons and mental health units by the team. Nursing staff at these units had access

Summary of findings

to the end of life care training given to all trust nurses and were invited to the end of life care link nurse meetings to provide support and multi-agency working. The SPCT also worked with people with learning disabilities.

- The nurse who led on special needs had undertaken a course in special care dentistry. The lead nurse for special needs dentistry described to us how they regularly liaised with the trust's acute liaison nurse for learning disability, the anaesthetist, and nurses as part of the special needs general anaesthetic pathway.

Dementia

- The trust had a dementia strategy.
- During the course of our inspection, we observed various dementia initiatives in place to improve the care for this cohort of patients.
- Psychiatric liaison and dementia support workers were employed by the trust and supported patients as necessary. The trust aimed to screen all patients admitted acutely over age 75 years for potential and actual dementia and delirium.
- All wards had access to link nurses specialising in dementia, learning disability and safeguarding.
- The trust offered a 'forget me not' passport of care for patients with dementia or learning disability. This was completed by families and carers, telling the staff how to care for the person in their unique way, offering individual detail to give that personalised approach.
- The trust operated a befriending service across all wards. The befrienders provided social and emotional support, helped with drinks and nutrition, were able to refer to community services and assisted patients with information relating to their discharge home.
- The trust had access to the psychiatric liaison team by telephone. Staff told us that this team was very quick to respond. However when patients were referred on to the CRISIS team for further mental health support, long delays occurred meaning patients had to wait in the department. Staff we spoke with thought this was not an ideal situation for the patient since an ED is not the most suitable place for a person with mental health problems.
- One member of staff on the community inpatients unit was a dementia champion. Reminiscence boxes were available for patients with dementia and there was a reminiscence pod in

Summary of findings

one of the lounge areas. We saw dementia friendly signage was in place and dementia clocks were installed in the lounge areas so patients could easily see the time, day and date. Staff had attended dementia training.

Access and flow

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust consistently breached the standard between February 2016 and January 2017. Performance was also consistently worse than the overall England performance over this period. In January 2017 the trust's performance was 77.1%. Performance then improved in February and March 2017, with only a slight deterioration in April. In both March and April 2017 the trust's performance was better than the England average. In March the trust's performance was 92.6% and in April 91.4%. However the 95% standard was not met in any of the 12 months to April 2017.
- Between February 2016 and January 2017, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was consistently worse than the England average, with periods of large variance between the England Average and trust performance. The trust's trends followed the England average, an improvement in April 2016 was followed by a trend of decline until January 2017. In April 2016 performance was 24.9%; in January 2017 it was 50.0%.
- Performance then improved over the following three months. In February 31.6%, in March 9.3% and in April 8.4% of patients waited between four and 12 hours from the decision to admit until being admitted. In both March and April the trust's performance was better than the England average.
- At the time of our inspection we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using GPs to see some patients, managing ambulance arrival patients better and the introduction of 'streaming' to make sure patients went to the correct part of the department, e.g. majors, minors or to see the GP or ANP. Staff reported that this had a positive impact on waiting times and were hopeful that the number of patients waiting more than four hours would be significantly reduced by the time the new monitoring data was published.
- The medical care division had 72,684 medical admissions between December 2015 and November 2016 of which 41,848 (58%) were at Pinderfields. These were broadly categorised as

Summary of findings

emergency admissions accounting for 24,988 (60%), 16,017 (38%) were day case, and the remaining 843 (2%) were elective. The top three admitting medical specialties were General Medicine, Clinical Haematology and Gastroenterology.

- Within the medical care division there were significant numbers of patients medically fit for discharge where care could not progress outside the hospital setting due to multi-factorial variables. These included delays in social care assessments, a lack of community placement facilities, issues around securing funding approval for specialist equipment and slow engagement with patients and family members in the discharge process.
- The use of extra-capacity beds in existing bays within medical care wards, particularly in Pinderfields Hospital, was impacting negatively on patient experience and at times compromising privacy and dignity.
- Medical boarders were impacting in most clinical areas within the trust.
- There were a considerable number of patient moves after 10pm causing distress, inconvenience and confusion to many patients. There was no upper time limit cut-off and patient moves during the night had become a normal feature in divisional flow within medicine.
- There were high numbers of 'on the day' cancellations across endoscopy services causing inconvenience to patients and delay in patients receiving necessary investigations.
- Between February 2016 and January 2017, the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently similar to the England average. In January 2017, this showed 93% of this group of patients were treated within 18 weeks versus the England average of 89%. Thoracic medicine, gastroenterology, neurology and cardiology all performed better than England average (for admitted RTT pathways). Geriatric medicine, general medicine, rheumatology and dermatology were below England average reporting.
- Between November 2015 and October 2016, medical patients at Pinderfields had a higher than expected risk of readmission for elective admissions and a lower than expected risk for non-elective admissions when compared to the England average. Elective Medical oncology had the highest risk of readmission from the top three specialties based on count of activity.
- Between December 2015 and November 2016, the average length of stay for medical elective patients at Pinderfields was

Summary of findings

6.2 days, which was higher than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 5.9 days, which was lower than the England average of 6.7 days.

- Between December 2015 and November 2016 the average length of stay for Surgical elective patients at trust level, as well as at Pinderfields, was lower than the England average at 3.1 days and 2.6 days respectively, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was lower than the England average at all sites, and trust level. At trust level, it was 3.1 days, at Pinderfields it was 2.9 days compared to 5.1 for the England average.
- Between February 2016 and January 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been worse than the England overall performance.
- The latest figures for January 2017, showed 44% of this group of patients were treated within 18 weeks versus the England average of 71%. Over the last 12 months there has been a gradual decline in performance.
- There were no surgical specialties above the England average for admitted RTT (percentage within 18 weeks). Seven surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- RTTs were not met within trauma and orthopaedics (43%, England average 65%), general surgery (61%, England average 75%), urology (74%, England average 79%), ENT (40%, England average 68%), ophthalmology (38%, England average 77%), plastic surgery (66%, England average 82%) and oral surgery (41%, England average 69%).
- The trust created a joint Planned Care Group with the Clinical Commissioning group (CCG), with work streams addressing RTT issues in relation to follow-up appointments, operative efficiency, consultation and GP referral.
- For the period Q4 2014/15 to Q3 2016/17, the trust cancelled 726 surgeries. Of the 726 cancellations, 1% were not treated within 28 days. The trust's performance has been consistently better than the England average for the period.
- Cancelled operations as a percentage of elective admissions include only short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q4 2014/15 to Q2 2016/17 at the trust were lower than the England average.
- The Intensive Care National Audit and Research Centre (ICNARC) data from 1 April to 31 December 2016 showed the unit had transferred 0.6% of patients due to non-clinical reasons. This was in line with similar units' rate of 0.4%. The ICNARC data from the same period showed the bed days of

Summary of findings

care post eight hour delay rate was 2.3%. This was better than similar units' rate of 6.9%. Data also showed the bed days of care post 24 hour delay rate was 1.1%. This was better than similar units' rate of 4.5%. The ICNARC data from 1 April to 31 December 2016 showed the out of hours discharge to the ward rate was 3.1%. This was worse than similar units' rate of 2.2%.

- Waiting times for paediatric outpatients varied between specialities, but the average of total weeks waiting for all specialities, between April 2016 and March 2017, did not exceed 11 weeks.
- Children's therapy services had average waiting times, between April 2016 and March 2017, of seven weeks for occupational therapy, six weeks for speech and language and three weeks for physiotherapy. Some waiting times were seen to exceed 18 weeks, however these were patients waiting for specific groups to be run or through parental choice for a specific therapist or location.
- Between October 2016 and March 2017 there were 1353 elective operations carried out on patients aged 0-16 years. There were 63 cancelled operations, of these 29 were because surgery was not required, 15 were due to staffing problems, 10 were due to no beds being available, seven were due to running out of theatre time and two were because the surgeon was unavailable.
- The children's assessment unit accepted referrals from GP's, accident and emergency and direct from families. Paediatric consultants took phone calls from GP's to determine whether the child needed to be seen. A child could be on the assessment unit for 24 hours; this meant that not every child needed to be admitted as an inpatient.
- A new referral process for community paediatrics had led to a reduction in waiting times. For example, attention deficit hyperactivity disorder ADHD clinics had reduced from a 16 week waiting time in May 2016 to an eight week waiting time in April 2017. Bowel management clinics had reduced from a 17 week waiting time in May 2016 to seven weeks in April 2017 because of the introduction of nurse led clinics. Enuresis clinics had seen an increased waiting time due to an increase in referrals and additional clinics had been arranged.
- The end of life care service reported that in February 2017, 73% of new referrals were seen within 24 hours of being referred to the team. Staff told us that the electronic patient administration system was checked several times a day for new alerts or referrals and urgent referrals were seen the same day. If this could not be achieved, the team called the ward to check on the patient and saw them within 24 hours.

Summary of findings

- The key performance indicator for urgent referrals was for all to be seen within 24 hours during the working week. The service met this 100% target for February to April 2017.
- From the minimum data set submitted by the trust for April 2016 to March 2017, the total number of patients seen by the end of life service was 1714. Of these 822 (48%) were new referrals, 32 were the existing caseload and 860 (50%) were re-referred during the year. There were 359 deaths and 1225 discharges from the service.
- Between April 2015 and March 2016, the hospital reported that 1,209 trust-wide referrals were made to the SPCT. Of these referrals, 905 (75%) were cancer related and 304 (25%) were non-cancer related. The service submitted annual data to the National Council for Palliative Care national minimum data set project on specialist palliative care hospital support.
- The service did not report or monitor the number of patients referred to the end of life services who achieved their preferred place of death.
- The backlog of patients waiting for first and follow up appointments across the trust outpatient departments had deteriorated since the last inspection and information provided by the trust showed at the end of March 2017 there was a backlog of 19,647 patients who had waited over three months for a follow up appointment.
- There were patients overdue their appointment by three months in different specialities across outpatients. Ophthalmology had the largest backlog of patients overdue their appointment by three months with 6942 patients waiting; this was followed by trauma and orthopaedics with 2512 patients and gastroenterology with 1382 patients overdue for their appointment.
- Ophthalmology outpatient managers told us they had a backlog of patients waiting to be seen in outpatients. Managers told us there were no current issues with the macular clinic and first appointments followed by the first 12 months treatment; however after the first 12 months there was a delay in follow up appointments of around 6 weeks. Ophthalmology was at 68.1% for non-admitted RTT (percentage within 18 weeks) against an England average of 92.1%. Ophthalmology was at 79.6% for incomplete pathways RTT (percentage within 18 weeks) against an England average of 92.3%.
- Managers told us there were particular challenges around first appointments, follow up appointments and appointments in the surgery directorate. Managers told us that a number of specialities had long waits for appointments. Each speciality had an action plan to address waiting lists and referral to

Summary of findings

treatment indicators. Managers told us demand was high and there had been consultant vacancies across different specialities. The services were trying to address this by working with other qualified providers, putting extra clinics on and job planning. Managers also told us of their aim to make the services sustainable.

- For community dental waiting lists, in period 1 April 2016 to December 2016 there were 448 new patients on the waiting list. The clinical lead explained that once the new dental officer started with the service then the waiting list should become shorter. In the interim, minutes of team briefs showed discussion and review of waiting lists took place.
- Within the community dental service the referral to treatment target only applied to the general anaesthetic lists. In quarter one (April to June 2016) (for the 18 week pathway for general anaesthetic) there were no referral to treatment breaches, whereas in quarter two (July to September 2016) there were four, rising to 11 in quarter three (October to December 2016). We saw no data for quarter four but we were told that the service was on track to meet the target for quarter one (April to June 2017).
- For the period March 2016 to February 2017, the average length of stay at the Wakefield Intermediate Care Unit (WICU) was 20 days per month. This was significantly better than the standard set by the commissioners of 28 days. The length of stay had gradually decreased from 34 days in March 2016 to 16 days in May 2016. From May 2016 onwards, it had stayed between 16 and 18 days. This reflected the work staff and managers had undertaken to improve the responsiveness of the unit.
- From March 2016 to February 2017, occupancy rates at WICU averaged 84% per month. This was slightly less than the standard set by commissioners of 85%. During March 2016 and April 2016 occupancy rates were higher than average with rates of 97% and 95% respectively. During January and February 2017 occupancy rates were once again higher than average at 91% and 94% respectively.

Learning from complaints and concerns

- A comprehensive and current complaints policy covered the complaints management process for the trust.
- Between March 2016 and February 2017 there were 1,632 complaints about the trust. The trust did not give us the

Summary of findings

complaints data so that we can see the average of days to investigate and close complaints. 36 of the complaints were rated by the trust as high, 677 complaints were rated as medium and 919 complaints were rated as low.

- All substantive complaints are reviewed by the Chief Executive.
- Ward meetings discussed complaints received as a standing agenda item. A full report was provided to the Directorate Operational Team (DOT) meeting on a monthly basis.
- We saw evidence of audit activity and learning from complaints in some services.
- Contact details for the Patient Advice Liaison Service (PALS) and Complaints were clearly available. Wherever possible the PALS team would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS and the mechanisms for making a formal complaint.

Are services at this trust well-led?

We rated well-led as requires improvement because

- Governance and assurance processes within the medical care division, for the care and management of patients, did not support the provision of safe care, quality outcomes and positive patient experience on wards. This has been a continued concern since the last inspection.
- The senior team was aware of the challenges and issues within the organisation and had developed strategies and tightened governance processes to meet these challenges. However, these required embedding and the pace of improvement needed to increase.
- The governance and risk strategy framework had improved since our previous inspection. However, further improvements and embedding of processes were required.
- In the medical care and maternity divisions some of the inclusions in the risk register dated back to 2013 however remained current concerns. Within medical care, the top three rated risks according to the risk register did not mirror exactly the managers top three concerns
- There was limited evidence to show how the critical care service monitored quality and performance.

However

Requires improvement



Summary of findings

- Overall, the culture within the trust had improved since the last inspection and there were indications of a positive cultural shift.
- The trust had introduced a number of new initiatives to enable them to manage demand and work towards achieving the government set indicators.

Leadership of the trust

- There had been changes in the senior executive team since our previous inspection, with the appointment of a new chief executive.
- The senior team was aware of the challenges and issues within the organisation and had developed strategies and tightened governance processes to meet these challenges. However, these needed to be embedded and the pace of this improvement needed to increase.
- The chief executive had recognised the need to strengthen and develop clinical leadership within the organisation.
- Although the executive team members were relatively new they appeared to be credible, and there were positive comments overall from staff regarding their visibility.
- The triumvirate management arrangement within divisions had also been changed and was continuing to be embedded at the time of the inspection.
- Senior staff were motivated and enthusiastic about their roles and had clear direction, with plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, skills, and experience.
- Staff said service leads and managers were available, visible across the trust, and approachable. Staff we spoke with told us that leadership of the service was better but required further improvement. Clinical management meetings were held and involved service leads and speciality managers.
- We found that leadership teams were aware of the challenges for their service and, in nearly all cases; these were reflected in risk registers.

Vision and strategy

- The Trust was part of the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP). STPs are place-based, multi-year plans built around the needs of local populations, which aims to drive a sustainable transformation in health and care between 2016 and 2021.

Summary of findings

- Working with local and regional commissioners to shape plans for new models of care, the trust are part of West Yorkshire Association of Acute Trusts (WYAAT) which brings together NHS acute hospital trusts from West Yorkshire and Harrogate to drive forward the best possible care for patients.
- At the time of our inspection the trust was implementing its acute hospital reconfiguration (AHR) programme. This was impacting upon some areas and needed to embed within the appropriate divisions.
- Divisions across the trust had strategies in place which underpinned the trusts vision and strategy. The medical care divisional strategy reiterated the organisational mission ‘to provide high quality healthcare services and to improve the quality of people’s lives’ to achieve ‘excellent patient experience every time’.
- Medical care divisional managers had progressed the strategy into a ‘12-point plan’ which formed the basis of the divisional objectives. This broadly mirrored the trust core values addressing issues such as performance and standards, staff engagement, reducing patient harms and improving services.
- The trust is in a first wave implementation for the four priority ‘Keogh’ seven day standards of time to consultant review; access to diagnostics; access to consultant directed interventions; and ongoing review.
- At the time of inspection, the community dental service was going through a re-commissioning process with a new contract due to commence on 1 September 2017 and so the vision and strategy was in development. The service was clearly focussed on putting the patient first and we saw at each clinic the nine principles of the General Dental Council were displayed which put patient safety and care at its core.
- Community inpatients had its own ethos which was; ‘A multidisciplinary team; working as one to provide holistic care, underpinned by patient-centred principles and best practice. The trust values and behaviours are embedded in everything we aspire to; enabling patients to heal, improve and grow in confidence; to leave the unit to their preferred place of discharge in a timely way.’
- The trust had a draft end of life care strategy 2017-2019, which was for review in April 2019. The document referred to key priorities including “each person is seen as an individual”, “each person gets fair access to care” and “care is coordinated”.

Governance, risk management and quality measurement

Summary of findings

- The governance and risk strategy framework had improved since our previous inspection. However, the trust acknowledged that further improvements and embedding of processes were required.
- The framework had received both external and internal reviews by a governance consultancy service and internal audit. These acknowledged that progress was being made but further work was required in some areas.
- The Board Assurance Framework (BAF) was aligned to strategic objectives and we saw evidence that it was linked appropriately to divisional risk registers, which were regularly reviewed.
- The quality committee, a sub-committee of the trust board, received monthly reports from the clinical divisions regarding their quality and safety dashboards.
- Each division had clinical governance meetings which reviewed complaints, incidents, and risk. These were cross site.
- Divisions held local risk registers and there was a clear process for escalation of risk.
- In the medical care and maternity, some of the inclusions in the risk register dated back to 2013 however remained current concerns for the division. The top three rated risks according to the risk register did not mirror exactly the managers top three concerns (stated to be endoscopy and the JAG accreditation status, patient harms and nurse staffing) however there was some correlation to those rated as 'major'.
- Governance and assurance processes within the medical care division, for the care and management of patients, did not support the provision of safe care, quality outcomes and positive patient experience on divisional wards.
- Within critical care services, we did not see evidence that the areas of non-compliance with GPICS was recognised as a risk or recorded on the risk register. We reviewed the critical care risk register and found some of the risks were overdue for review.
- The critical care service did not have a forum where all the senior clinical staff met to discuss operational and quality issues. Medical staff we spoke with told us that they met informally at handover or at other times to share information about the service.
- The critical care service did not have an audit lead or audit strategy.
- There was limited evidence to show how the critical care service monitored quality and performance, for example, the critical care outreach team did not report formally report their

Summary of findings

activity or performance outcomes to the senior management team and data from the Intensive Care National Audit and Research Centre was not discussed with senior managers or the clinical teams.

- The service had not benchmarked the critical care rehabilitation service with other units or against National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness.
- We reviewed the West Yorkshire Critical Care Operational Delivery Network peer review report dated January 2017. At the time of the inspection senior staff had not identified an action plan based on the recommendations from the report.
- We reviewed root cause analysis reports from serious incident investigations. The reports included contributory factors and root cause analyses. Action plans were in place. Duty of candour was addressed, with specific details of when the patient and/or family were communicated with and given an apology.

Culture within the trust

- Overall, the culture within the trust had improved since the last inspection and there were indications of a positive cultural shift.
- Divisional leaders reported a positive cultural shift in the past 12 months with more focus on recognition, reward and improvement.
- Staff at all levels spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made over the last 18 months.
- Staff described how the organisational and divisional culture was evolving and becoming more open, honest and transparent.
- Staff also reported a shift away from a culture, of what they considered historically, to be blaming. Staff added how there was more focus on understanding why things may have gone wrong or on how things could be bettered in the future.
- Within the emergency departments, in particular at the Dewsbury and Pontefract sites, medical and critical care divisions, staff morale was variable and the amount of goodwill shown by staff was wavering. This was due to capacity and staffing concerns.
- Staff recognised the issues impacting on performance and morale but also considered there no quick fix for many challenges faced by the organisation.

Summary of findings

- The trust's sickness levels between December 2015 and October 2016 were higher than the England average. The trust followed a similar trend to the England average however the trusts rate is consistently higher than the England average.
- Most staff described good teamwork within the trust and we saw staff worked well together. We saw examples of good team working on the wards between staff of different disciplines.

Equalities and Diversity – including Workforce Race Equality Standard

- We found that the trust had a positive and inclusive approach to equality and diversity. We found that staff were committed and proactive in relation to providing an inclusive workplace.
- Governance arrangements were in place to ensure that the trust board received regular assurance that the trust was meeting its Public Sector Equality Duty.
- The Workforce Race Equality Standard (WRES) has nine specific indicators by which organisations are expected to publish and report, as well as put action plans into place to improve the experiences of their black and minority ethnic (BME) staff. As part of this inspection we looked into what the trust was doing to embed the WRES and race equality into the organisation, as well as its work to include other staff and patient groups with protected characteristics.
- The 2015/16 WRES data indicated that there had been increases in BME staff reporting experiencing harassment, bullying, or abuse from staff in last 12 months, and personally experiencing discrimination at work from their managers/team leaders or other colleagues.
- To address these issues the trust has an equality, diversity and inclusion (EDI) action plan in place which is incorporated into EDI annual report 2015/16.
- Progress against the EDI action plan is monitored through the workforce and quality committees.

Fit and Proper Persons

- The trust met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We looked at employment files of all of the executive team members and non- executive directors. These had all been completed in line with the FPPR regulations.

Public engagement

Summary of findings

- Staff and senior managers within the trust actively engaged with patients, family members, and the local population to canvas their opinions and obtain feedback on current services and future proposals.
- The trust had a Patient, Family and Carer Experience Strategy. The strategy included programme plans for various services.
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and Patient Advice Liaison Service (PALS). ‘Tell us what you think?’ questionnaires were available on all ward areas.
- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- The Friends and Family Test (FFT) survey (February 2017) was used to elicit patient feedback on how likely patients are likely to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Test performance (percentage response rate) was 97.5%. The response rate was 33.1%.
- A ‘you said, we did’ board was on display in the waiting areas. These included examples of changes practice following comments from patients and the public
- Staff in the critical care outreach team shared feedback from patients and relatives who attended the follow up clinic with staff on the unit to help improve the service.
- The maternity service actively sought the views of women and their families. There were two maternity services liaison committees (MLSC) one for each Kirklees and Wakefield. These were functional groups, which met bi-monthly and quarterly respectively.
- The members of the MSLC we consulted in respect of the reconfiguration of services, including the provision of services, transfer arrangements and decoration of the units.

Staff engagement

- In the NHS Staff Survey 2016, the trust performed better than other trusts in two questions, about the same as other trusts in 16 questions and worse than other trusts in 16 questions.
- The questions for which the trust performed better than other trusts were: Recognition and value of staff by managers and the organization (3.31 compared to the England average of 3.45); and Percentage of staff working extra hours (66% compared to the England average of 71%).
- Examples of the questions for which the trust performed worse than other trusts were: Effective use of patient / service user

Summary of findings

feedback (3.57 compared to the England average of 3.7); Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse (35% compared to the England average of 45%); Staff confidence and security in reporting unsafe clinical practice (3.54 compared to the England average of 3.66); Percentage of staff reporting good communication between senior management and staff (28% compared to the England average of 33%); Staff motivation at work (3.80 compared to the England average of 3.93).

- The trust had an action plan in place to respond to areas in the 2016 staff survey where staff engagement needed to improve. This included establishing a range of activities and events to show staff how the trust recognised and appreciated them such as celebrating International Nurses' Day, long service awards, team of the week and MY star of the month awards. The action plan also addressed the workforce strategy, health, and well-being of staff.
- Staff friends and family survey results published Q2 2016/17 showed 61% of staff would recommend the Mid Yorkshire Hospitals NHS Trust as a place to receive care and treatment. Figures showed 18% would not recommend the trust as a place to receive care and treatment; this had improved from 24%. The response rate was 22%.
- The staff friends and family survey results published Q2 2016/17 showed 44% of staff would recommend the trust as a place to work, with 32% not recommending the trust as a place to work. The response rate was 22%.
- The trust chief executive had completed a series of "big conversation" events and sent out a monthly team brief to update staff on the latest news about the organisation and at a local level, the SPCT received updates at the joint operational monthly meeting and during daily handover.
- We were told that management engaged with the staff more now than in recent years. We saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held staff meetings eight weekly, which discussed key issues for continuous service development.
- Staff reported that most difficulties on the wards areas were related to staff shortages, which compromised their ability to provide more care and time for patients.

Innovation, improvement and sustainability

- The trust had introduced a number of new initiatives to enable them to manage demand and work towards achieving the government set indicators.

Summary of findings

- The department ran hot clinics such as an emergency surgery clinic, gynaecology assessment clinic and plastics assessment clinic. These enabled patients with these conditions to access treatment quickly with an appropriate member of staff.
- The use of an IT system 'ICE' enabled some emergency ambulatory care patients to leave the ED department overnight and return in the morning.
- The trust had a fractured neck of femur improvement project to improve outcomes and patient experience.
- The dementia team within the trust secured funding for 'MY Life' computers and 'REMPODS' to promote engagement and stimulation for vulnerable patients living with dementia.
- Emergency Surgical Clinics were established in January 2017, which provided an opportunity for admission avoidance for the less acute patient that requires a surgical review. These patients were previously admitted and waited as an inpatient for this service. The service also provided fast track access to diagnostics for the patient e.g. ultra sound and CT scans as well as providing access to theatre lists, which provides 20 hours of expedited operating capacity.
- The Plastic Surgery Assessment Unit was developed November 2016. This was designed to improve the patient experience and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department. Faster pre-theatre assessment was provided which helped ensure treatment was delivered quicker. The surgical division had reduced pressures on Surgical Assessment Unit (SAU) by taking the bulk of ambulatory plastics patients out of SAU.
- The trust had centralised acute surgery. All acute surgery has been provided at Pinderfields General Hospital since September 2016.
- Staff on the critical care unit had been nominated for, and won some trust awards; for example, the support staff gave to newly qualified nurses, the excellent front of house the ward clerk team provided and for the compassionate care staff provided to an extremely unwell patient.
- There was a flow midwife to ensure the flow of women across the service was seamless.
- There was a break midwife to relieve staff on the labour suite for breaks; this helped to support one-to-one care in labour.
- The play specialist on the children's burns unit had been awarded a British Empire Medal in the New Year's Honours List 2017 for services to children with severe burns.

Summary of findings

- The access, booking and choice division had an improvement action plan. This had 14 actions included, six of these were complete, and eight of these were not complete at the time of the inspection. One action had not been completed in the target date; all other actions were within the target date.
- A programme of improvement to the environment had been carried out at the community inpatient unit, which was evident at our visit. The improvements had been made in two phases and were still ongoing. Further improvements were planned for the year ahead, which included a vintage tearoom and developing the garden to make it more accessible for patients and included the installation of a permanent gazebo in the grounds. Other local quality improvement projects were underway which included improving outcome for falls, increasing compliance with the Therapy Outcome Measures (TOMS) standardised assessment, maintaining positive feedback with the friends and family test, and increasing learning from patient feedback.
- A red bag initiative was launched in May 2017 to improve and speed up transfers between hospitals, ambulance and care home settings. Each care home has received a red bag to keep important information about a patients care, including transfer documents, medication, and consent information. The bag had room for personal belongings which remained with the patient whilst they were in hospital until they returned home.

Overview of ratings

Our ratings for Pinderfields Hospital

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

Overview of ratings

Our ratings for Dewsbury and District Hospital

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

Our ratings for Pontefract Hospital

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

Overview of ratings

Our ratings for The Mid Yorkshire Hospitals NHS Trust

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

Our ratings for Community Services

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

Outstanding practice and areas for improvement

Outstanding practice

- The emergency departments had introduced an ambulance handover nurse. This had led to a significant reduction in ambulance handover times.
- The facilities at Pinderfields Hospital on the spinal unit for rehabilitation and therapies were modern, current and progressive.
- The cardiology e-consultation service at Pinderfields Hospital which provided a prompt and efficient source of contact for primary care referrers who sought guidance on care, treatment and management of patients with cardiology conditions.
- The proactive engagement initiatives used by the dementia team involving the wider community to raise awareness of the needs of people living with dementia. The use of technology to support therapeutic engagement and interaction with patients, stimulating activity and reducing environmental conflict.
- The Plastic Surgery Assessment Unit was developed November 2016 at Pinderfields Hospital. This was designed to improve the patient experience and ensure capacity was maintained for the assessment of ambulatory patients that required a plastic surgery assessment by assessing patients direct from the emergency department. Faster pre-theatre assessment was provided which helped ensure treatment was delivered quicker. The surgical division had reduced pressures on Surgical Assessment Unit (SAU) by taking the bulk of ambulatory plastics patients out of SAU.
- The burns unit play specialist ran a burns club, which provided psychological support to children and their families. This included an annual camp and two family therapy weekends a year.
- The maternity service at Pinderfields Hospital had implemented the role of 'Flow Midwife', a senior member of staff who had oversight of the service during the day. The aim of this role was to ensure a smooth flow of patients throughout the unit; this included the risk of transfers from the stand-alone birth centres and concerns with the discharging of patients from the postnatal ward and labour suite.
- There was direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The trust had a new electronic process with remote monitoring to alert staff to fridge temperatures being below recommended levels to store drugs.
- At Dewsbury Hospital panic buttons had been installed for staff to use in the emergency department if they felt in any danger from patients, visitors or anyone walking into the department. The panic buttons had been installed in direct response to and following a review of a serious incident which occurred in the department.
- We saw evidence of the risk assessment in patients' notes and falls bands were visible on patients. This enabled all staff in the hospital to identify patients at risk of fall no matter where they were in the hospital.

Areas for improvement

Action the trust MUST take to improve

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

Outstanding practice and areas for improvement

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12(1)(c)</p> <p>Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include—</p> <p>(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.</p> <ul style="list-style-type: none">• Staff continued to fail to meet the trust mandatory training standard of 95%.• Staff attendance at other statutory training such as life support skills were not always meeting the trust standard.• Lack of training across the departments in triage/IAT. This means that potentially less experienced staff were triaging/IAT patients. This occurred in both adults and children.
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part</p> <p>(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)</p> <ul style="list-style-type: none">• Local audit activity was not always embedded.• National guidance was not always adhered to.

This section is primarily information for the provider

Requirement notices

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

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>10(1) Service users must be treated with dignity and respect.</p> <p>Why there is a need for significant improvements:</p> <ul style="list-style-type: none">• Transfers after 10pm occurred frequently medical wards.• During care observations, we found the privacy and dignity of patients being cared for in wards where extra capacity beds were situated was compromised. There were 53 additional beds at Pinderfields.• It was difficult for staff to deploy the correct and appropriate use of curtains to ensure privacy and dignity when delivering care, and there were insufficient nurse call bells for all patients.
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>11(1) Care and treatment of service users must only be provided with the consent of the relevant person.</p> <p>Why there is a need for significant improvements:</p> <ul style="list-style-type: none">• We identified a number of records across the Trust where capacity assessment documentation was incomplete.• We reviewed 28 patients' records across medical wards at Pinderfields and found five of the 28 patient records (18%) where the capacity assessment documentation was incomplete.• We also reviewed a 'Care Plan for a Vulnerable Patient who requires help with Decision Making and found this to be completed incorrectly.

This section is primarily information for the provider

Enforcement actions

- We identified two patients where deprivation and/or restriction of liberty practices were in force without the necessary documentation being completed
- It was acknowledged by the Safeguarding leads that there was a gap in the knowledge and understanding of some staff regarding the legislative process, documentation and trust procedures in relation to Mental Capacity Act and Deprivation of Liberty Safeguards.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(1) Care and treatment must be provided in a safe way for service users. The things which a registered person must do to comply with that paragraph include—

2(a) assessing the risks to the health and safety of service users of receiving the care or treatment

2 (b) doing all that is reasonably practicable to mitigate any such risks

Why there is a need for significant improvements:

- We reviewed care plan documentation and risk assessments of 28 patients throughout medicine wards at Pinderfields. In seven sets of the 28 records (25%), we found the falls risk assessment and/or care bundle documentation to be incomplete, inaccurate or absent.
- Twenty two falls with harm had been reported as serious incidents since April 2016. Of these, two resulted in patient deaths.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

14(1) The nutritional and hydration needs of service users must be met.

Why there is a need for significant improvements:

This section is primarily information for the provider

Enforcement actions

- We reviewed care plan documentation and risk assessments of 28 patients throughout medicine wards at Pinderfields. We found 12 out of the 28 records (43%) where fluid, food and/or intentional rounding charts were absent, incomplete or partially completed.
- We observed that staff could not focus on feeding due to work pressures; some food and drinks were left out of the reach of patients who required assistance.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Why there is a need for significant improvements:

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