Mid Yorkshire Teaching NHS Trust

Pinderfields Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Pinderfields Hospital

Requires Improvement 

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

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

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

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

We carried out an unnanounced focussed inspection of medicine (including older peoples services) and urgent and emeregency care at Pinderfields Hospital and Dewsbury and District Hospital. Our inspection was a follow up on concerns about the quality and safety of urgent and emergency care and medical services raised during the last inspection in April 2022. At this inspection we found the core service overall ratings of emergency care and medicine remained the same, requires improvement. However, at Pinderfields Hospital the domains of effective and well led in urgent and emergency care had improved to good. The domain of responsive had improved in medical services to good. At Dewsbury and District Hospital the rating of the well led domain for urgent and emergency care improved to good. We also saw other improvements since our last inspection althrough the overall and domain rating did not change.

The team that carried out the inspection of urgent and emergency care services comprised of an inspector, assistant inspector and 2 specialist advisors with expert clinincal knowledge in the areas inspected.

The team that carried out the inspection of the medicine service comprised of 2 inspectors and 2 specialist advisors plus an inspector who carried out a short observational framework on one of the medical wards.

An inspection manager oversaw the inspection of both services.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Requires Improvement ➔➔

Our rating of this location stayed the same. We rated it as requires improvement because:

- Staff were not always compliant with the trust mandatory training compliance target.
- Mandatory training compliance figures did not include information governance training.
- The service did not always have suitable numbers of staff to keep patients safe.
- Staff did not always respond quickly to patients at risk of deterioration.
- The service did not always control infection risk well.
- The environment did not always meet the needs of patients.
- Staff did not always have easy access to patient records.
- Staff did not always keep good records or store these securely.
- Staff did not always manage medicines well.
- The service did not always ensure that patients made decisions based on all the information available.
- The service did not always deliver improvement actions in a timely way.
- Leaders did not always manage risk well.

However:

- Staff understood how to protect patients from abuse. Staff assessed risks to patients. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Medical care (including older people's care)

- Leaders used reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services.

Is the service safe?

Requires Improvement 

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

Mandatory Training

The service did not always provide mandatory training in key skills to all staff and make sure staff completed it.

Staff compliance with mandatory training had significantly improved since the CQC inspection in 2022. Staff were 93.8% compliant with core mandatory training which met the trust target of 90%, but only 82.5% compliant with role specific mandatory training which did not meet the trust target of 85%.

The mandatory training did not always meet the needs of patients and staff. Mandatory topics included fire safety, health and safety, equality and diversity, infection control, moving and handling and safeguarding. Initial compliance figures provided did not show a mandatory training module for information governance, following the inspection the trust provided details of how information governance training could be arranged. There was a module in resuscitation, but staff were only 70.2% compliant with this which did not meet the trust target.

Leaders continued to view mandatory training as a priority and were aware that this was still an improving picture. Mandatory training was a standard agenda item of several senior leadership governance meetings and we saw compliance rates had improved since the last inspection.

Managers monitored compliance rates at service and individual level. Since the last inspection, the trust had implemented the electronic staff record (ESR) which automatically notified staff and managers when an individual was required to undertake training. We saw examples of how managers on individual wards monitored mandatory training.

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

Safeguarding

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

Core safeguarding training showed an overall compliance rate of 97% for safeguarding adults' level 1, 87% for safeguarding adults' level 2 and 93% for safeguarding adults' level 3 against the trust target of 90%.

Medical care (including older people's care)

The trust provided training in mental health awareness and dementia awareness within the safeguarding training package and complex needs which included mental health, learning disabilities, and autism as part of the safeguarding level 3 (adults and children) training. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw examples in patient records where safeguarding concerns had been escalated in line with local procedures.

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

The trust had safeguarding policies in place which had been regularly reviewed. There was a female genital mutilation (FGM) policy and the service monitored FGM cases reported and mapped this against locations and their populations.

The complex needs team provided support at ward level for safeguarding concerns including support to review the needs for enhanced care, risk assessment processes and facilitate escalation if required, staff spoke positively about the support offered by the team.

The trust had an enhanced care observation policy for those requiring close supervision. Patients level of observations were categorised into green, amber and red dependant on the level of enhanced care they required, where staffing figures did not allow for one-to-one observation, the trust had sourced an external company to provide 'bed guardians' to deliver this. We observed healthcare assistants observing bed bays (bay tagging) for group of individuals at higher risk of incidents such as falls.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures in a way to protect patients, themselves and others from infection.

They kept equipment and the premises visibly clean.

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

Staff followed infection control principles, ward areas having ample supplies of PPE and hand washing facilities.

The trust had oversight of infection rates, with processes in place to investigate any confirmed infections. Patients identified as having a current infection were isolated in side rooms where possible or cohorted in a bay, and appropriate signage was used to indicate the potential for infection in order to protect staff and patients.

Staff were not compliant with aseptic non-touch technique (ANTT), a practice of avoiding contamination by not touching key equipment and surfaces and is required whenever carrying out a procedure that involves contact. There were 11 out of 16 gates that did not meet the 90% compliance target for ANTT training, with gate 42 being only 32% compliant and gate 39 being only 39% compliant We saw no actions taken from this audit to achieve the training target compliance.

Medical care (including older people's care)

The service generally performed well for cleanliness. In audits provided for the month prior to inspection, gates scored 100% compliance for bare below elbows, and between 95% and100% for compliance with hand hygiene practices.

Cleaning records were up-to-date and demonstrated that areas were cleaned regularly, we observed regular cleaning throughout the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Ward areas had secure entry systems to gain access and enough equipment for staff to carry out their role. Storage space on wards was limited and there were trolleys, linen towers, equipment and drink and food trolleys in some corridors and bathrooms.

Utility rooms and linen cupboards were left open, some of these had lock pads and were fire doors that needed to be kept shut, however we found no hazardous substances or sharps inside.

Resuscitation trolleys on all wards we visited were not sealed with a tamper proof seal system. However, the drug boxes/ containers stored on the trolleys all had tamper evident seals. This was compliant with current Resuscitation Council (UK) guidance. We reviewed checks of resuscitation trolleys and found these were not always completed in full. We also found 2 trolleys were overstocked, although this did not pose an immediate patient safety risk, checks had been completed to confirm the amounts of product in the trolleys despite these being inaccurate.

The trust continued to care for patients in unplanned locations across the trust. For example, on Gate 45 and 45b there continued to be patients nursed in unplanned bed spaces, this meant they did not have piped oxygen or suction in their bed space, privacy screen were portable and they did not have access to a call bell.

The trust had created a standard operating procedure for staff to care for patients in unplanned locations and included suitability criteria for extra capacity beds. Staff completed risk assessments and there was a handbook in place to assist ward managers with decision making. Patients that were placed in unplanned bed spaces were given an apology letter.

Gate 12, the acute assessment unit, had completed the renovation of ‘my safe space.’ The space was in a designated side room where all furniture and potential risks to people vulnerable to self-harm had been removed. Utilities were operated by sensors; the ceiling was not suspended, and doors were two-way opening.

Patients with therapeutic needs, such as stroke rehabilitation, had access to fully functional therapy rooms and equipment.

Sharps bins were not always correctly and fully assembled, signed or dated.

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients’ families.

Staff disposed of clinical waste safely.

Medical care (including older people's care)

The service had recommenced Patient-Led Assessments of the Care Environment (PLACE) audits but had conducted a PLACE-lite audit which reviewed fewer areas over longer periods of time but only one audit was provided for March 2023. The audit identified some areas of improvement including that not all patients had access to a television, an inconsistent use of 'I am clean' stickers that continued to be seen during the inspection. However, the audit identified storage issues and inconsistent signage across wards which had been improved by the time of inspection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2) and escalated them appropriately. However, there were two occasions during the inspection where high scoring NEWS2 scores were not escalated to the outreach team in line with trust policy. Staff could describe actions taken in response to elevated scores and we saw these were appropriate and had positive outcomes for patients. Staff training compliance with NEWS2 was only 67% against the trust target of 85%.

We reviewed the report from May 2023 NEWS2 audit data, 10 patients were reviewed from all inpatient areas trust wide. The audit for 56% of observations were recorded on time with 44% recorded as overdue. Recommendations and an action plan had been put in place in response to the audit.

The service had a deteriorating adult response team (DART), a 24/7 service with the purpose of being able to respond promptly to support staff teams to deliver care to acutely unwell and recognised as deteriorating patients.

Wards we visited had electronic whiteboards which provided a headline of key information for staff such as NEWS2 score, time since seen by a consultant and when observations where due.

The division of medicine had improved its monitoring of patients being reviewed by a consultant within 14 hours of admission. Consultants started ward rounds on elderly assessment units with newly admitted or unwell patients to support timely senior oversight and to ensure appropriate medical plans were in place. An audit sample of 20 patients was taken to review compliance to be seen by a consultant in under 14 hours, although the percentage of compliance had improved, we could not see how often audits were undertaken or how results had been used to decrease the timeliness of review. Gate 41 audit data from September showed an 82% compliance for patients to be seen within the timeframe, however May audit data showed only 65% of patients were seen within 14 hours meaning although timeliness of review was improving, the service continued not to be in line with NICE best practice guidance.

The trust had a sepsis policy in place, this was due for review, but the trust had extended the review date to ensure that the policy was in line with most recent NICE guidance. Staff were trained in sepsis awareness. Electronic sepsis screening was available via the Trust electronic patient record. When eObservations were taken and recorded, the NEWS score was automatically calculated and if screening was recommended, staff were prompted to consider sepsis and complete an additional screening tool.

Staff completed risk assessments for each patient on arrival, however these were not always reviewed regularly in line with policy. We looked at Venous thromboembolism (VTE) assessments, these were completed on admission and therefore patients had measures in place such as anticoagulant medications if at risk of blood clots, but they were not reviewed regularly which meant we could not identify if measures in place were remained appropriate.

Medical care (including older people's care)

Safety huddles took place each day on all the wards that we visited. They discussed things such as general risks, DNACPR, incidents and staffing. This information was then included in a handover which was available to all staff. Handover sheet we looked at accurately reflected patient information.

The service had 24-hour access to psychiatric liaison team, safeguarding team and complex needs team.

Audit data showed varied compliance with meeting trust target compliance of 85%. Regular audit of patient risk assessments was undertaken through the Ward Health check (WHC), this reviewed documentation such as pressure area, nutrition and falls assessments.

Recent audits showed that Purpose T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) had been completed in accordance with trust policy for 94% of patients. However, SSKIN (skin and wound management) plans were only in place on 77% of occasions. Wound charts were only in place on 33.3% of occasions where pressure ulcers were present on the body.

The service had introduced a 'Purpose T' clock which used patient pressure area risk assessment to identify the time they next required repositioning in an obvious and pictorial method to staff., SSKIN)

The nutrition screening tool had been calculated in line with trust policy for 83% of patients but only 78% of hydration assessments were completed. Where food and hydration charts were in place, 87% of these had been completed in full.

Falls risk assessments had been completed in 91% of patients records in line with trust policy.

Nurse staffing

The service did not always have enough nursing and support staff, however managers took appropriate action such as regularly reviewing and adjusting staffing levels and skill mix, to keep staffing levels safe and gave bank and agency staff a full induction. Staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not match the planned numbers on the wards we visited during the inspection.

The department had policies in place for addressing staffing issues and we saw senior and ward level leaders implementing these and adjusting staffing levels daily to mitigate risks of low staffing levels.

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

The trust used the safe care acuity tool to secure safe rosters and review skill mix.

Staff told us that escalation of under establishment was reported as red flag incidents and discussed with senior management.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites. They discussed expected admissions and discharges, wards with closed bays and other information that may have made it difficult to move or admit patients to wards.

Medical care (including older people's care)

Staff told us that staffing had improved.

The service had low vacancy rates.

The service had low turnover rates.

The service had low sickness rates.

The service had reducing rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

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

Medical staff told us there was not enough senior cover on consultant rotas and that there were often only 2 consultants when there should be 3 to see up to 48 patients and this had resulted in incidents where they were unable to see every patient.

The service had a good skill mix of medical staff on each shift.

The medical staff did not always match the planned number.

Medical staff continued to not be able to review all patients within 14 hours in line with best practice guidance.

The risk register highlighted that medical staffing to patient ratio particularly during out of hours periods were inadequate, this had been recently reviewed and continued to be a moderate risk in in May 2023. The risk register had ongoing actions in place to reduce the number of gaps in rotas and therefore risk.

Sickness rates for medical staff were low with the exception of stroke, dermatology and neurology which had increased long term sickness rates.

Managers could access locums when they needed additional medical staff. The service had stable rates of bank and locum staff, with 62% usage of agency in August 2022 compared to 60% in August 2023, and 38% bank usage in August 2022 compared to 40% in August 2023.

The service had reducing vacancy rates for medical staff.

The service had low turnover rates for medical staff.

Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment. Records were not always clear, up-to-date and stored securely.

Staff could access patients notes easily.

Patients' notes were not always comprehensive. We reviewed 7 patient records. Although we saw that all required risk assessments were completed on admission, these were not always regularly reviewed in line with policy.

There were also gaps in recording in patient's care records in paper based bedside notes, including skin and wound management and nutrition and hydration charts.

We reviewed 'do not attempt cardiopulmonary resuscitation' orders (DNACPR) on wards inspected. These were not always appropriately completed with examples that had insufficient information to detail why a DNACPR decision was made. Senior leaders told us there was heavy emphasis on the introduction of Recommended Summary Plans for Emergency Care and Treatment (ReSpect) forms which they believed would give better opportunities to document DNAR and advanced decision-making. There was however no immediate response taken to review existing DNACPR information. Staff conducted DNACPR audits, however these did not have a focus on the details of decisions made but the legitimacy of the documentation. However, these audits had not identified and therefore rectified when DNACPR's had not been countersigned.

Records were not stored securely on most of the wards we visited, trolleys were left unlocked, and we observed instances of staff leaving computer records open, however these were on ward areas with secure access.

Electronic whiteboards were used on all wards we visited, these recorded key information and ensured that staff had easy access to key information, such as reviews by other members of the multidisciplinary team and clinical observations.

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

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes to prescribe and administer medicines safely. We found that all prescription records examined had allergy status recorded.

Staff stored medications securely including controlled drugs and oxygen. Staff knew how to report any discrepancies with medications. However, we found emergency trolleys did not have tamper proof seals including on some emergency hypoglycaemic kits.

The pharmacy team were visible on the wards we visited and reviewed patients' medicines. However, staff we spoke to weren't aware of audits undertaken by the pharmacy team or the outcomes of these.

Staff checked patients had the correct medicines when they were admitted, or they moved between services.

Medical care (including older people's care)

The trust shared with us audit data for medicines reconciliation that were completed within 24 hours, this showed that the rates for completion had marginally improved since the last inspection and were now between 33% and 85%.

Staff completed medicines records accurately. The trust used an electronic system to prescribe and record the administration of the patients' medicines.

Staff now risk assessed patients that self-administered their medications, these were recorded on arrival to wards and stored appropriately. The self-administration policy had been reviewed and updated.

Body maps were in use for patients where medication patches would be indicated.

Staff did not always review each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients that were prescribed anticoagulant medications on admission did not have these reviewed throughout their inpatient journey.

Oxygen continued was not prescribed, however patients that required oxygen were receiving it. Oxygen is a medication and should be prescribed except for in emergency situations. The monthly oxygen prescribing audit showed that between July and September there had never been more than 51% of patient on oxygen that had had this appropriately prescribed with the 3 monthly total being only 47% of patients being prescribed oxygen appropriately.

The trust shared with us audit data for. Medicines reconciliation audits only took place on the acute assessment unit (Gate 12) and found in September 2023 80% of medicines reconciliation were completed within 24 hours.

The health and safety team disseminated safety alerts and incidents to improve practice.

Incidents

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

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system.

Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

Incidents were monitored for timeliness against the 60-day deadline and discussed at patient safety and clinical effectiveness sub-committee.

A patient safety bulletin was cascaded amongst staff which detailed shared learning from recent incidents. Staff we spoke with confirmed they receive these along with emails and talks within daily team meetings for dissemination of immediate learning.

Staff received feedback from investigation of incidents and lessons were shared at team meetings. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Medical care (including older people's care)

Most staff we spoke to understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

The service had not had any never events on any of the medicine wards in the 12 months before inspection. A never event is a serious incident that is entirely preventable.

Is the service effective?

Requires Improvement ➔➔

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

Evidence-based care and treatment

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

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). Staff could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Leaders monitored staff use of policy and took action when staff did not adhere to policy such as developing human factors training.

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

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

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

The service had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition (MUST). The staff used a process of 'MUST Monday's' as a prompt to review patient MUST scores.

Catering staff were informed of any dietary requirements and/or allergies each morning.

Staff met the needs of patients through the dining experience. We observed lunch service on Gate 44 and found this to be a calm experience that met people's dietary needs. Patients were fed out of bed, sat up, where possible, portion sizes were discussed and personalised for the patient and religious and cultural dietary needs were catered for.

We observed additional comfort rounds taking place with options for biscuits, tea and coffee.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

We saw nutrition boards which listed patients requiring assistance with eating and drinking, those who were nil by mouth and patients who were diabetic requiring dietary support.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Staff did not always give pain relief in a timely way or record this accurately. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool.

Staff did not always give pain relief in line with individual needs and best practice. Pain management audits showed that 70% of patients in August, 100% in July and 75% of patients in June, had analgesia administered when they scored a pain score of 2+ in the last 24 hours.

Staff did not always record pain relief accurately. Pain management audits showed that 91% of patients in August, 67% in July and 80% of patients in June had the effectiveness of analgesia documented in nursing notes.

Staff prescribed and administered pain relief accurately. Patients record showed accurate prescribing of pain relief and as and when required medication was offered.

We observed that nurses administering controlled drug pain relief always had a second nurse with them to check the medicine in line with guidance.

Auditing of pain relief was part of the ward health check. The trust told us they were developing a specific pain improvement plan to improve the performance of effective pain assessment and management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Medical care (including older people's care)

The service participated in relevant national clinical audits such as the diabetes safety audit, national hip fracture database, national oesophageal gastric cancer audit, national lung cancer audit sentinel stroke national audit programme (SNNAP). The service had received an overall SNNAP audit compliance band of A (performing well) between January and March 2023.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

Managers told us they used information from audits to improve care and treatment. We saw a weekly schedule of audits used at ward level, this gave a specific day to prompt audits, such as 'MUST Monday's' and 'Purpose T Wednesday.' Staff we spoke to were aware when audits should be taken place in line with this schedule.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Mortality and morbidity reviews took place within a learning from deaths agenda item within specialist clinical governance meetings. These findings were then shared at the corporate learning from deaths meeting to share learning from deaths trust wide.

Competent staff

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

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Staff received an annual appraisal and specific competency training relevant their role.

Managers supported staff to develop through yearly appraisals of their work.

Managers gave all new staff a full induction tailored to their role before they started work. New staff received a supernumerary and preceptorship period.

Managers had regular team meetings with staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward managers ensured that staff remained compliant with specialist competencies required to work in their area, such as naso-gastric feeding.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff were given protected time to complete training. Heads of service discussed the top 3 required training areas needed to increase training compliance and cascaded these through matron and ward level meetings.

Medical care (including older people's care)

The clinical educators supported the learning and development needs of staff. All staff that we spoke with spoke highly of the clinical educators and the additional learning that they supported them to undertake. Study days were held for additional training and staff were also able to complete their mandatory training in this time.

Managers identified poor staff performance and supported staff to improve.

The service recruited international nurses and gateway medical staff, medical staff recruited internationally and working towards UK registration. Staff described being inducted into departments, education opportunities, time working supernumerary, and being supported by senior staff members.

The service were trialling training and development roles to upskill staff and support qualified positions. There were roles such as healthcare assistant apprentice, where staff worked within the hospital 4 days a week supporting nursing staff and attended college 1 day, and doctors assistants who worked alongside doctors to complete tasks such as medical plans and discharge letters.

Multidisciplinary working

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

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

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

Most wards had consultant led daily ward rounds on acute wards, including weekends.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Therapy services offered a 7-day service.

Discharges were planned so they could still take place on a weekend to maintain flow out of the hospital.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on gates.

Medical care (including older people's care)

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff did not always gain fully informed consent from patients. We saw in records that consent had been discussed and documentation completed with patients however the documentation had not been reviewed to ensure this highlighted all risks associated with their care and treatment. We followed up on a patient death where the coroner findings had highlighted that consent documentation did not sufficiently detail risk information to patients. We found that the same consent documentation, a version from 2017, continued to be used throughout the trust.

Staff did not always record consent in the patients' records. Although we saw evidence of consent in some records and observed staff gaining consent from patients, staff were only 71% compliant with consent training against the trust target of 85%.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Nursing staff received and kept up to date with training in the Mental Capacity Act (MCA). Audits showed 95% of nursing staff and 92% of clinical staff were compliant with MCA training.

Medical staff received and kept up to date with training in the Mental Capacity Act. Audits showed 93% of medical staff were compliant with MCA training.

Deprivation of Liberty Safeguards (DoLs) training was covered within Safeguarding adults and children training.

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. The clinical teams received daily information patient with a DoLs in place via the daily bed report, to enable them to meet needs and manage daily risks.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. In the ward health check audit, the medical division scored 100% in the most recent audit for evidence that capacity to consent to daily nursing tasks had been considered and documented in patient records.

Do Not attempt cardiopulmonary resuscitation (DNACPR) documentation showed that decisions were made with people and their loved ones or in the best interests of the patient, however these did not always give a clear description of the medical conditions that prompted the consideration of a DNACPR.

Medical care (including older people's care)

Is the service caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for or talking about patient needs.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgemental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patient records encompassed a holistic picture of patients care needs.

Many patients we observed continued to be nursed in bed. We observed that there were some patients up and mobilising around the wards and patients were raised from their beds to chairs to eat meals where possible.

Several beds did not have call bells as they had been out into bays meant for less bed space. We did not observe and alternative means of these people accessing assistance from staff.

Some of the wards had access to a shared television, but staff were aware of the need for increased activities. Staff were aware that patients had lengthy stays with minimal activities and brought in books and puzzles to share and complete with patients.

The trust committed to the 'End PJ Paralysis' campaign in 2017, acknowledging the risks associated with reduced mobility in hospital settings; and staff we spoke to were knowledgeable about this.

Family and friends could visit patients on the ward and are free to bring additional items in for the patients.

The service used the gold standard framework for providing end of life care.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Medical care (including older people's care)

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

Staff did not complete training on breaking bad news as part of the core or role specific training. The trust supported staff to access bereavement training from an external provider.

We observed kind interactions between patients and staff and there were instances of patients being comforted by staff members.

We observed staff safely supporting patients with dementia whose comfort was to walk around the ward with patience.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. There were daily MDT meeting where input and preferences of the person and their families were included. We observed multiple occasions during the inspection where staff members were discussing a patient's condition with their loved one over the phone.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this, we saw feedback posters and boxes on the wards we visited which requested feedback in a variety of languages.

The service was introducing ReSpect forms and had a training programme planned to help staff better support patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients we spoke with gave positive feedback about the care from staff members.

In a recent staff survey only 51% of staff said that they would be happy with the standard of care provided by the organisation if a friend or relative required treatment.

Is the service responsive?

Good  

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

Service planning and delivery to meet the needs of the local people

Medical care (including older people's care)

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service was an active member of the West Yorkshire Health and Care Partnership and worked with them to reduce health inequalities.

Facilities and premises were appropriate for the services being delivered however, they were short of bed space within wards and people were placed in bed bays that did not have all equipment appropriate for any acute need or deterioration.

Staff knew about and understood the standards for mixed sex accommodation. There were no mixed sex breaches on any of the wards we visited.

Facilities and premises were appropriate for the services being delivered and the endoscopy service was JAG accredited.

Staff could access psychiatric liaison team for patients with mental health problems, learning disabilities and dementia. There was access to a clinical psychologist on site.

The service had the complex needs team that provided support to staff for patients in need of additional support or specialist intervention.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff knew to refer to the complex needs team for patient with enhanced care needs to be assessed and to request additional support and guidance.

Wards were adapted to meet the needs of patients living with dementia such as having pictorial signage on doors and coloured handrails and toilet seats. There were activity boxes for people living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There were dementia friendly clocks on all wards, however we saw these were not always in date which could lead to confusion.

Staff used symbols above people's beds to identify specific needs such as the mayflower for dementia, sunflower for mental health, green wrist bands for falls, clocks with times of repositioning, cutlery for requires assistance feeding.

We saw most patients had access to their call bells and we did not observe call bells sounding for extended periods of time.

The service had information leaflets available in languages spoken by the patients and local community. Feedback information in patient facing areas was in a variety of languages.

The service made improvement based on patient information, for example they had reduced wipeable charts to record patient possessions to reduce lost property after receiving feedback this was an issue.

Patients told us they were given a choice of food and drink to meet their cultural and religious preferences if requested.

The trust had a multi faith chaplaincy which offered a range of spiritual and holistic care; however, we did not see a non-denominational space. Prayer rooms and chapels were available, and chaplains could visit individuals by arrangement.

Staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Staff did not always use communication aids to support patients communicating their wishes. Patients and relatives told us that communication aids were not always used.

The hospital had a complex needs team that staff could contact for support with patients who had complex or challenging needs and staff told us how they accessed the team for support with patients with enhanced needs such as learning disabilities or potentially requiring DoLs.

Staff restricted visiting for patients on gates positive for COVID-19 but had exceptions in place for those with a learning disability, autism or dementia.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

The service had introduced coordinator roles, an appointed clinical person to support the needs of the gate by managing the flow of patients through the department and ensuring appropriate referrals and pathways were followed in admitting patients. Staff told us this role was invaluable in the running of their services and funding for the role had been extended.

On Gate 12, we observed patients waiting to be admitted onto wards. Patients waited in observable areas and a ward coordinator was aware of their arrival and working to find capacity within the hospital. A healthcare assistant was allocated and observed attending to patients waiting for bed space. There was a bed coordinator in place for oversight of flow within the hospital and responsible for finding bed space.

Patients continued to be cared for in extra capacity bed spaces, the trust informed provided the standard operating procedure and risk assessment for the extra capacity plan. Staff comments around extra bed spaces had improved.

Staff moved patients between wards at night. Staff told us it was common practice to move patients whenever a bed and transfer was available, if this was within the night, patients would be transferred at this time. We saw in 2 patient's record they were transferred between trust sites (Dewsbury and Pinderfields) after 11:00pm at night. One of these patients had been transferred between the sites 5 times with several of these transfers occurring at night.

Medical care (including older people's care)

Managers monitored patient transfers. Clinical governance meeting minutes we reviewed noted that the average stay for people transferred from Pinderfields to Dewsbury was significant and could take over 30 days. It had been identified that patients were spending too long in the emergency department and becoming deconditioned, this meant they were unable to be seen by consultants until the afternoon ward round which resulted in delays in transferring people.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Patients that were residing on other wards due to bedspace were overseen by the consultant with the speciality for their acute need.

Step down wards continued to be used for patients who were medically optimised for discharge but may still need extra support arrangements for going home and oversight from clinicians in the meantime. These wards were supported by discharge coordinators to facilitate discharge to all areas for ongoing care.

Managers and staff started planning each patient's discharge as early as possible and there was a dedicated discharge team to support with complex discharges. Managers and staff worked hard to make sure patients did not stay in hospital longer than they needed too. There was a discharge lounge where people awaiting discharge from the hospital were overseen by nursing staff which allowed bed space to become available in a timelier way.

The trust had oversight of patients within the hospital with no reason to reside. Discharge co-ordinators within the integrated transfer of care hub, worked with wider system partners to review and triage these patients to make timely and appropriate referrals.

The trust did not always manage to meet referral to treatment (RTT) times. For 2 week wait times for patients with suspected cancer, in August 2023 the trust only managed to see 73% of these patients within this time frame.

The trust performed well for ensuring that patients received diagnostic testing within 6 weeks. In August 2023, 99% of patients received diagnostic testing within this timeframe.

Learning from complaints and concerns

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

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

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

Staff understood the policy on complaints and knew how to handle them. Staff were knowledgeable about complaints their service had received and the outcome of these. They responded sensitively and apologetically to complaints.

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

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

Medical care (including older people's care)

Managers investigated complaints and identified themes. A six-monthly review of complaint information was undertaken to identify themes and trends and improvements made to the service.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service, but they did not always understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The division of medicine was led by a director of operations (DOP), clinical director and two assistant directors of nursing (ADoN).

Leaders were visible at location level; staff spoke positively about ward managers and matrons and told us they felt supported. Managers demonstrated how they supported staff clinically. Most staff told us they felt the senior leadership team were visible.

Senior leaders were visible within the service and had created listening events with staff and introducing initiatives such as senior leadership tea rounds to support and listen to staff at ward level.

Leaders at ward level showed a good understanding of challenges faced within the division including risks and areas for improvement.

There were programmes and courses in place to develop Band 6 and 7 staff into leadership roles such as skills in practice and clinical leadership programmes.

Managers of speciality areas continued to ensure staff were competent in areas such as NIV and tracheostomy, this was ongoing with the clinical education team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The medicine division followed the trusts overall vision and strategy with a mission statement of “To provide high quality healthcare services at home, in the community and in our hospitals, to improve the quality of people’s lives.”

Medical care (including older people's care)

There was a current five-year strategy in place for 2023-2028 called Delivering MY Future which aimed to achieve excellent patient experience each and every time. The service aimed to achieve the vision through five strategic goals known as the Five 'P's: population, people, purpose, places and progress.

The trust had values to support their vision. These were caring, high standards, improving and respect. Staff that we spoke with knew what the values were, and we saw these displayed within the service.

Progress of the trusts vision and strategy was monitored through various governance meetings at operational level and progress against the five P's was reviewed at Board meetings.

Culture

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

There had been an 36% increase in complaints regarding staff attitude compared to the same period, 1 October 2022 to 31 March 2023, the year before. The Trust had implemented a number of initiatives and workshops to promote a positive culture across the organisations such as: MY values into action workshops, embedding Values and Behaviours and the staff mental health and wellbeing hub.

Staff told us that they were able to transfer to other clinical areas to support their career development as a vacancy arose if staff met the agreed essential criteria.

Staff we spoke with were mostly complimentary about the culture of their wards. Staff who had been internationally recruited said they felt very welcomed into their teams.

Staff created boards on wards to promote a positive culture and safety towards other marginalised communities such as LGBTQ+, we saw several boards promoting safe expression of sexuality.

Ward leaders spoke highly about their teams working on the wards. Staff said they felt that they were valued members of their teams and that all colleagues worked very well together to support each other.

The division newsletter included key updates and improvements to support staff morale, welcomed new staff and praised a team of them week.

The trust provided evidence to support work initiatives to support staff health and wellbeing. For example, the division of medicine do care and listening events. Wellbeing had become a standard agenda item at ward, matron and senior management meetings.

The division reviewed the most recent staff survey and identified the key areas surrounding, staff wellbeing and satisfaction in their work. Regular updates were given via newsletter during the development of action in response.

In response to the cost-of-living crisis the service were handing out fruit and vegetable boxes on a Wednesday to staff who may be struggling.

The trust had a designated freedom to speak up guardian and staff we spoke with knew how to contact them if needed.

Medical care (including older people's care)

The trust offered staff several mental and physical health support services, these included but were not limited to, an employee assistance provider, mental health first aid network, access to a clinical psychologist, occupational health, physiotherapy, and exercise classes.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical division had its own governance structure for the services it delivered, including but not limited to respiratory, gastroenterology, elderly care, acute medicine, and stroke.

Governance meetings were held to ensure information was escalated and cascaded to relevant staff as necessary for all wards. These included clinical, medical, governance, ward management and team meetings.

Reports for the division were discussed monthly and an action log created from this. They discussed priorities, progress made within the division, key challenges and support required from other to achieve aims. They also discussed performance in planned care against right to treatment wait times, cancer services, diagnostics.

Clinical governance meetings were well attended, items discussed included but were not limited to clinical quality, patient safety and experience, clinical incidents, complaints, risk and workforce. Meeting minutes evidenced positive escalation of risks in response to operational pressures due to ongoing Operational Pressures Escalation Levels (OPEL) 4 demand (OPEL level range from 1 to 4 with 4 being the highest level of operational pressures and response).

Managers met monthly for quality assurance meetings, information from these is then cascaded amongst their teams.

Ward information was collected through heatmaps, ward health checks of clinical indicators and ward accreditation reviews to identify how wards were performing. Audit results were released monthly on the Trust intranet and reported via the quality assurance group. Monthly themes for areas of non-compliance were shared for learning and monitored through local and divisional improvement plans. Improvement themes which may have impact trust wide were monitored in the patient safety improvement group.

Ward leaders told us they have a specific job description and were clear about the role they played in the governance of their area.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact however these were not always actioned in a timely manner. They had plans to cope with unexpected events.

The risk register had risks we identified throughout the inspection with actions taken to reduce or manage the risk and were regularly reviewed. Risks were dated, with specific staff allocated, with dates for review and with mitigation, where appropriate.

Medical care (including older people's care)

Infection prevention and control continued to be a moderate risk on the corporate risk register with infection rates only marginally reducing since 2021. Staff compliance with IPC measures was highlighted as a target focus with HR input to reduce infection rates, however we continued to see mixed IPC practices by staff throughout the trust and did not observe this being addressed by senior staff members.

Oxygen prescribing had reduced to a minor risk on the corporate risk register with a mitigating action of monthly audits used to ensure oxygen prescribing was taking place, however we continued to find that oxygen was not prescribed throughout the inspection despite this being an action at the last CQC inspection in April 2022.

Staff completed 'MY Quality' boards on the wards. This included information such as the wards top risks, ward health check score, key ward performance metrics and things to improve. Quality boards on wards demonstrated that staff were aware that oxygen prescribing continued to not take place and be a key risk.

Ward managers we spoke with told us of the individual ward risks. Ward level leaders had good oversight of their team's risks, issues and performance through ongoing ward level audits and improvement plans.

Divisional meeting minutes showed that the highest risk at across the division was staffing recruitment.

Risks were clearly described on the divisional risk register Senior leaders told us about the biggest risks for the division and these were reflected in the risk register. All the risks had action owners, updates on progress, mitigation, and review dates.

Leaders cascaded National Patient Safety Alert (NatPSA) information throughout the service and actions reviewed by the deputy chief medical officer.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required. However, information systems were not always integrated and secure.

Staff were not aware of their responsibilities in relation to data protection, within the mandatory training records provided, information governance and/or GDPR (general data protection regulation) were not included in training compliance figures provided.

Staff continued not to always keep patient information appropriately secured on the wards. For example, notes trolleys were left unlocked some wards visited and we saw multiple computers with personal information were left unlocked and accessible.

Senior medical staff told us that medical colleagues employed through the Gateway Access Programme were not given access to patient records which made the timeliness of supporting staff and reviewing patients slower. Following the inspection, the trust told us gateway trainees were given a full induction package and access to electronic systems.

The service used different IT systems on different departments, this meant messages weren't always communicated effectively. A patient from A&E asked for a relative not to be contacted and this was documented using 'symphony' system, however, the ward areas use PPM and therefore did not receive the information, the relative was contacted and this caused the patient distress.

The risk register identified that the use of 3 different IT systems by the administration team to receive referrals, add patients to waiting lists and book appointments could pose a risk to the patients as one of the functionalities could get missed. Measures were put in place to reduce the risk in August 2022, including a task and finish group, however the moderate risk rating remained when reviewed in September 2023.

Staff could access information technology (IT) systems to record and view information such as test results and patient records. Patient records were mostly electronic, and staff demonstrated the usability of information systems. They could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals. This information now included training compliance which automatically notified managers and staff when due.

The trust website contained detailed information about the wards, site maps, innovation and how to book an appointment to support patients when accessing the service.

Engagement

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

Wards had staff engagement boards that included general information about their ward's performance in various areas.

Family and friends test boxes and posters were displayed on each of the wards we visited, this gives patients and their families the chance give feedback about their care.

We requested patient survey feedback but did not receive any information collected by the trust. The trust had used results from the CQC inpatient survey 2022 to inform a trust wide patient, families and carers engagement and experience action plan.

The service had good links with the local integrated care board and wider system and we saw examples of how they had worked with the system to improve access to services and outcomes for patients.

Learning, continuous improvement and innovation

Leaders were not always committed to continually learning and improving services. They did have a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Medical care (including older people's care)

Ward leaders were continuing to learn and improve services; however, this was not always at pace. We followed up the regulatory breaches from the previous CQC inspection in March and April 2022, although we found improvement in practices, not enough improvement had been made to remove most breaches and not all action plans had been completed to time frames. The service was 7 months into a 12-month delivery plan at the time of the re-inspection, and therefore improvement actions were still in progress.

Leaders did not always take timely action to make immediate improvements to the concerns we identified on inspection. We escalated that DNACPR documentation was not always reflective of the reasons people were having the decision put in place, when we talked to the triumvirate about this, they were heavily dependent on ReSpect documentation coming into practice. We requested the package of learning for this but did not receive it but instead received anticipated compliance rates for the training.

The trust had a variety of progression opportunities for staff of all grades. There were learning opportunities such as the 'Mycareermyway' professional development education unit we to give nursing staff support and skills to advance in their career.

The trust had a designated research team and took part in various research studies. Updates of research studies were shared on wards relevant to their research area. There were information boards for patients should they wish to get involved in research projects.

Wards trialled and adopted positive initiatives to improve patient experience where possible such as 'Year of quality outcomes,' and, 'I CAN.' The Year of quality outcomes developed from improvement work on specific wards in 2022 and asking whether ward managers could give assurance of their confidence of care provided at the bedside. From this, an element of daily living would be addressed each month for 12 months such as looking at mobilisation in February, and communication in June. The I CAN initiative aimed to assess patient for personal care needs they were able to perform themselves, this would then be marked and displayed above their bed space to ensure that staff did not complete tasks that patients were able to complete themselves.

Areas for improvement

Pinderfields Hospital

Actions the trust MUST take to improve:

• The trust must ensure that care is carried out collaboratively with the relevant person, an assessment of the needs and preferences for the care and treatment of the service user. Regulation 9 (3) (a)

• The trust must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b)

• The trust must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. Regulation 12 (2) (b)

• The trust must implement an effective system to ensure all patients receive timely review by a consultant within 14 hours of admission to a medical ward. Regulation 12 (1) (a)

Medical care (including older people's care)

• The trust must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. Regulation 12 (2) (h)

• The trust must ensure that oxygen is prescribed as required by national guidelines and a record of its administration maintained. Regulation 12 (1) (g)

• The trust must ensure there are appropriate numbers suitably qualified, competent, and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1)

• The trust must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b)

• The trust must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, against plans and take appropriate action without delay where progress is not achieved as expected. Regulation 17 (2) (a)

• The trust must maintain securely an accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)

Pinderfields Hospital

Actions the trust SHOULD take to improve:

The trust should consider the time of day in which people using the service are transferred between sites to receive care and treatment and keep the number of transfers to a minimum.

Urgent and emergency services

Requires Improvement 

There was a co-located emergency department for paediatrics which was not included as part of this inspection.

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always assess risks to patients nor act upon them in a timely manner.
- Staff did not consistently apply the principles for infection prevention and control.
- Staff did not consistently record interactions in the patient care records.
- People could access the service but would have to wait for assessment and treatment.
- The service planned care to meet the needs of local people, but did not always make it easy for people who did not have English as a first language or with additional needs to give feedback.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires Improvement 

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

Urgent and emergency services

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Information provided following inspection showed that 97% of all nursing staff had completed their role specific training.

Medical staff received but did not always keep up-to-date with their mandatory training. Information provided following inspection showed that 82% had completed their role specific training against a trust target of 85%.

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

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. Information provided following inspection showed that the target compliance for training as stipulated by intercollegiate guidance was met and exceeded for all staff.

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

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

We saw that all safeguarding referrals received were reviewed and audited to highlight any themes or trends that would require further investigation and to drive learning.

Cleanliness, infection control and hygiene

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

Urgent and emergency services

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

At this inspection we observed some staff moving between isolated patients due to infectious illness not donning and doffing uniforms or changing their PPE. This meant there was potential for an increased infection risk to patients and staff.

Most staff did follow the principles of ICP and PPE, we noted handwashing when appropriate and the correct use of PPE.

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

We noted that audit results from the preceding months prior to inspection demonstrated an ongoing improvement.

At the last inspection we found not all sharps boxes were signed, or changed when full. At this inspection we found that all sharps boxes were managed in accordance with best practice.

Environment and equipment

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

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

The service generally performed well for cleanliness. Local audits provided following inspection showed an average of 95% over the three months prior to inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that staff routinely utilised 'I am clean' stickers which were dated to demonstrate when they had last been cleaned.

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

At the last inspection we found not all equipment that was required to be PAT tested (Portable Appliance Testing) had been completed. At this inspection we found PAT testing completed where appropriate.

At the last inspection we found not all airflow ports are covered as per national guidance, at this inspection we found all airflow ports covered.

During the last inspection we observed the streaming nurse was only able to speak with patients through the window at the front desk of the department. During this inspection we saw that staff had access to private rooms for assessment.

During the last inspection we observed all patient bays had access to call bells, however they were not always within reach. At this inspection we saw that all patients had a call bell within easy reach.

We noted that the mental health assessment room was compliant with national standards.

Urgent and emergency services

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration however the escalation of sepsis risk was not always consistent or timely.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We saw examples of risk assessments being completed on admission into the department such as falls risk assessments, however, information provided following inspection showed that between January 2023 to September 2023 only 71% had completed falls risk assessments. We did note that work had been undertaken prior to inspection to address this issue but it was not yet fully embedded.

Staff knew about and dealt with any specific risk issues, but we saw an inconsistent approach to the assessment and escalation of sepsis risk. Following our review of medical notes, we found that sepsis risk assessments were not always fully completed, and time critical medicine was either delayed in prescribing or in the administration. Information provided following inspection showed 33% of registered staff had yet to complete the sepsis training competencies and that between January 2023 and September 2023 only 73% of patients received time critical medicines within the timeframe stipulated. We did note that work had been undertaken prior to inspection to address this issue but it was not yet fully embedded. We did note that the pace of change was sufficient to provide assurance that there were improvements in care for patients.

We found that consultants and senior nurses oversaw streaming and triage utilising SOPs created since last inspection

At the last inspection we saw examples of lengthy waiting for triage and the lengthy time it took to see a doctor presented a risk to patients as staff did not know how unwell these patients were.

At this inspection we found that whilst there was greater oversight of patients who were waiting, the time to see a clinician following triage was up to 124 minutes.

At the last inspection we found the Trust had a process for staff to follow for patients who had chosen to leave the department prior to assessment by a clinician, or patients who have left after assessment by a clinician. During this inspection we were told that all patients who had left the department prior to being seen or completing treatment would be reviewed the following day and if deemed necessary, they would call and request the patient reattend the department. We did note that this process was not recorded as being completed and there was no guidance provided nor was there any oversight or audit of the decision making to ensure consistency and safety. Information provided following inspection demonstrated that in the 12 months preceding inspection, 8% of patients left the department prior to assessment or the completion of treatment.

At the last inspection we saw nine examples of patients in the department during the inspection who had not had their observations recorded in line with the local policy or national guidelines. Recording observations is important for clinical staff to monitor patients. In the examples we saw, two patients' records showed National Early Warning Score 2 (NEWS2) had been incorrectly calculated, and two patients' records showed some vital signs were not recorded. A trust audit showed that 15% of a sample had NEWS2 observations missing.

At this inspection we saw that observations were recorded in all patient records that we reviewed, and we found that audits completed prior to inspection demonstrated improvement with 100% compliance with NEWS observations and escalation.

Urgent and emergency services

At the last inspection we saw examples of patients with existing wounds where a full skin assessment had not taken place. Following this inspection, we saw that there was improvement in the completion of skin assessments with 85% of appropriate patients receiving assessment. We also noted that the pace of change for improvements was sufficient to provide assurances that care was improving.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. During inspection we saw that staffing had been affected due to short notice sickness absence but staffing levels were still safe. We noted that the department had policies in place for addressing staffing issues.

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

The department manager could adjust staffing levels daily according to the needs of patients. We were given examples of how the department flexed it's staffing model in response to patient acuity.

During inspection the number of nurses and healthcare assistants did not match the planned numbers but we saw how senior leaders addressed the issue to bring staffing to a safe level.

The service had low vacancy rates.

The service had low turnover rates.

The service had low sickness rates.

The service had reducing rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. We spoke with non permanent members of staff and all reported that they had received a full induction into the department.

Medical staffing

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

The service had enough medical staff to keep patients safe.

Urgent and emergency services

The medical staff matched the planned number. The service met national guidance on consultant cover within the department.

The service had low vacancy rates for medical staff.

The service had low turnover rates for medical staff.

The service had low rates of bank and locum staff.

Managers could access locums when they needed additional medical staff.

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. During inspection we noted that across both sites there were 21 whole time equivalent (WTE) consultants employed. During inspection we saw that the service had recruited a further six consultants.

At the last inspection we found the service did not always have a good skill mix of medical staff on every shift. During this inspection we found that most shifts had sufficient skill mix and work had been undertaken to improve medical staffing overnight.

Records

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

Patient notes were not always comprehensive due to missing information but all staff could access them easily. We saw missing or incomplete information such as sepsis risk assessments.

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

Records were stored securely.

At the last inspection we found some patient records were not stored securely.

At this inspection we found all records stored appropriately.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

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

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

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

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

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw that the service had a policy around restraint and sedation and that all uses of sedation would be incident reported.

During the last inspection we saw issues with the recording of self administered medicines and with incomplete prescriptions, namely strengths and required doses. At this inspection we found all medicine records were completed fully and accurately.

Incidents

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

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

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

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. There was a positive culture around incidents. All staff told us that there was a 'no blame culture' and that incident reporting was a method of learning.

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

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

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

There was evidence that changes had been made because of feedback. We saw that there was a new falls prevention pathway. This was in relation to an increase in patient falls. Since the introduction of the new system the department had not recorded any falls.

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

Managers debriefed and supported staff after any serious incident.

Urgent and emergency services

Managers shared learning with their staff about never events that happened elsewhere.

Is the service effective?

Good ↑

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed the service's policies on the Mental Health Act and found them to be appropriate.

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

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

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

At the last inspection we checked if patients received pain relief soon after it was identified they needed it, or they requested it. However, in two of the records we checked there were no updated patient records so it could not be established if pain relief had been given.

Urgent and emergency services

At this inspection we found pain scores accurately completed in all records that we reviewed and that pain scores had been assessed and recorded. All patients that we spoke with told us that they had received prompt pain relief after requesting it. Audit information provided following inspection demonstrated that patients were consistently receiving pain relief when required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Following this inspection, we saw that the audit programme was organised to prioritise the areas of higher need such as sepsis management.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. We saw that senior staff utilised face to face training to ensure all staff were aware of audit results and where improvement was necessary.

Improvement is checked and monitored.

The service had a lower than expected risk of re-attendance than the England average.

Competent staff

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

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

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

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Following inspection, we were provided with information that demonstrated that only 83% of all non medical staff had received an appraisal against a trust target of 85%, we did note however, that managers were sighted on this and work was underway to address this.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Following inspection, we were provided with information that demonstrated that 97% of all medical staff had received an appraisal.

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

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff reported that they had opportunities to develop and gain more advanced skills.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve. We were given examples by senior leaders of how they would support staff to improve. We were given examples of extended preceptorship, further supernumerary working with close mentor support and additional training.

Multidisciplinary working

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

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

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

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We noted that the service in the preceding 12 months from inspection that they consistently achieved mental health assessment within 60 minutes of referral and reported 13 12 hour breaches in the preceding 12 months due to delays in allocation of suitable mental health admissions which were beyond the departments gift to influence.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Urgent and emergency services

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to give examples of how and when they assess a patient's capacity to consent. We saw that the trust had an update to date policy regarding consent to treatment. Following inspection we were provided with information that demonstrated that mental capacity was being consistently assessed in 82% of all appropriate patients.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw consent being recorded in the patient records that we reviewed and we also noted staff asking for consent to undertake procedures.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were able to articulate occasions where they had acted in a patient's best interest.

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

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS). We saw that 94% of staff had completed the required level of training against a trust target of 85%.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We saw that the Mental Capacity Act and DOLS were included in the departments audit programme.

Is the service caring?

Good 

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

Compassionate care

Urgent and emergency services

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff exhibiting positive behaviours when dealing with patients with acute mental health needs

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We observed staff dealing with distressed patients with compassion and understanding.

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

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Urgent and emergency services

We found that friends and family test results demonstrated an overall positive response in 61% of all responses received in the 12 months preceding the inspection.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. We noted that the department had specialist equipment to assist patients with additional needs and staff were aware of when to use them.

At the last inspection we observed the waiting area had patient information in relation to the services provided but not in multiple languages reflective of the population demographic of the area. During this inspection we found that additional languages were available through a displayed internet link, however, the displayed information was only in English and made the assumption that all patients would be able to access the technology required without taking individual needs into account.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

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

Urgent and emergency services

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

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff could give examples of how they would accommodate different diets such as kosher and halal.

Staff had access to communication aids to help patients become partners in their care and treatment.

We observed the waiting area had complaint information but not in multiple languages reflective of the population demographic of the area. During this inspection we found that additional languages were available through a displayed internet link, however, the displayed information was only in English and made the assumption that all patients would be able to access the technology required without taking individual needs into account.

Access and flow

People could access the service when they needed it and but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards.

Managers monitored waiting times but not all patients could access emergency services when needed. The department did not meet the four-hour standard in 69% of patients in the preceding 12 months. We saw that 31% of patients were waiting between four and 12 hours for admission onto a ward with the service averaging 8 breaches per month for patients waiting in excess of 12 hours for admission onto a ward in the preceding 12 months leading up to inspection

Managers and staff were working to make sure patients did not stay longer than they needed to. We saw that the service did not always meet the national standard for time to see a clinician within 60 minutes, the current wait times were up to 124 minutes.

The number of patients leaving the service before being seen for treatments was low. Information provided following inspection demonstrated that 8% of patients in the preceding 12 months left prior to being seen or completing their treatment. Senior leaders were aware of this, and work was underway to understand this further and to make improvements.

Managers and staff started planning each patient's discharge as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored patient transfers and followed national standards.

Managers monitored that patient moves between wards/services were kept to a minimum and only when appropriate.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Urgent and emergency services

Patients, relatives and carers knew how to complain or raise concerns. We observed staff encouraging feedback.

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

Managers investigated complaints and identified themes.

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

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

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

We saw that 100% of complaints were acknowledged within the trust timeframe but only 64% of complaints received were responded to within agreed timeframes.

Is the service well-led?

Good  

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

Leadership

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

All senior leaders were able to describe their role and how their skills and abilities enabled them to run the service.

All senior leaders could articulate the priorities and issues that the service faced and could describe how they wanted the service to improve.

All staff reported that there was support at all levels to develop their skills and take on senior roles. We were given examples of clear succession planning which led to all grades being able to progress professionally.

All staff reported that senior leaders were a visible presence within the department and that they were always approachable. We were given examples of staff feeling confident to escalate issues to all senior leaders without fear of negative reactions.

Vision and Strategy

Urgent and emergency services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

All senior leaders could articulate the vision and strategy for the service which included the five year plan for service development which was aligning all work with the trust values of 'The Patient At The Heart Of All We Do'. The development plan was at year two at the time of inspection and we were able to see progress since the last inspection such as in recruitment.

All staff could describe what the vision and strategy was for the service, and all could articulate how their role contributed to the strategy. All staff felt that they were consulted on proposed changes and that all roles had an equal voice.

Culture

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

All staff told us that they felt valued and as such were happy to work in the department. We spoke with staff who told us that they had previously left the department to undertake employment elsewhere but wanted to return. All staff, from across all grades and roles felt confident to raise concerns or to report incidents as they felt that they would be listened to.

We were given examples of individual members of staff being encouraged and supported to develop within their careers. All staff told us that managers were always prepared to help with development.

Senior leaders told us about their aim for an inclusive approach which included all staff, all staff told us that this approach was very evident.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the last inspection we were not assured leaders operated effective governance processes, throughout the service and with partner organisations.

At this inspection we found an extensive governance system had been introduced with key members of staff employed to monitor, audit and implement any necessary improvements. We saw regular governance meetings were held which had fixed agendas and covered all expected areas.

Urgent and emergency services

We saw evidence that issues from the previous inspection such as sepsis management and infection prevention and control had been identified and was being addressed by senior leaders. We saw that the pace of change for service improvement was sufficient to provide assurance that governance of the service was improving and it was evident that it was having a direct, positive impact on patient care.

Staff at all levels were clear about their role and accountability and we saw a consistent approach from staff regarding the completion of their accountabilities

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We reviewed the risk register and found all expected risks had been identified. We also noted that all were dated, with specific staff allocated, with dates for review and with mitigation, where appropriate.

We saw that the senior leaders were all sighted on the issues in the department and where performance was not at the required standard, such as sepsis management, they had commenced work to address the issues and improve performance.

We saw evidence that issues from the previous inspection such as sepsis management and infection prevention and control had been identified and was being addressed by senior leaders. We saw that the pace of change for service improvement was sufficient to provide assurances that the service had improved their management of risks and issues.

We saw that the service had a business continuity plan for dealing with unexpected events, all leaders were sighted on this and could give examples of when they had managed unexpected events.

All senior leaders were able to articulate how they maintained a flexible approach which enabled them to dynamically prioritise ongoing issues.

Information Management

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

We saw multiple examples of data being analysed to improve performance, make decisions, or make improvements. There were multiple audits provided that demonstrated how the service used data and all senior leaders could articulate how that data was being used to drive improvements.

We saw no examples of information being left unsecured.

The service ensured that systems were integrated to facilitate transfer of data with external organisation.

Engagement

Urgent and emergency services

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

Senior leaders were able to articulate how they maintained engagement with staff, and we saw evidence that demonstrated that engagement was ongoing. We saw that there were examples of regular staff engagement in the form of monthly staff meetings, clinical forums, clinical supervision, and ongoing staff surveys.

We saw that engagement with external groups such as the local NHS ambulance trust was a key priority, we saw that following engagement there were improvements in access and flow for patients who arrived in the department by ambulance. Senior leaders were sighted and motivated to build on existing relationships to drive improvement in the service.

Senior leaders were aware that staff survey results were not always reflective of current staff feelings due to the time between the survey being completed and results received, we saw that they had introduced more dynamic staff surveys that would allow for a quicker response to any issues raised.

Learning, continuous improvement and innovation

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

We saw a consistent approach to learning, continuous improvement and innovation. We saw examples of where issues had been identified and work undertaken to address them. We saw that the changes made to the initial triage and assessment processes had a positive effect of the patient and staff experience.

Areas for improvement

Pinderfields Hospital

Action the trust MUST take to improve:

- The trust must ensure that all risk assessments are completed and acted upon within national guidelines. **Regulation 12.**
- The trust must consider ways to improve access and flow. **Regulation 12.**
- The trust must ensure that all needs are considered to allow all patients to give feedback on the service. **Regulation 16.**

Pinderfields Hospital

Action the trust SHOULD take to improve:

- The trust should ensure that all mandatory training is completed in line with the trust's compliance target.

Urgent and emergency services

- The trust should ensure that appraisals are completed in line with the trust's compliance target.
- The trust should consider formalising the current process for the follow up of patients who have left the department prior to being seen or having treatment completed.
- The trust should consider how to continue to improve patient response to the friends and family feedback
- The trust should ensure that all complaints are responded to within the trust target.