The Mid Yorkshire Hospitals NHS Trust

Pontefract Hospital

Quality Report

Friarwood Lane
Pontefract
WF8 1PL
Tel: 0844 811 8110 or 01924 541000
Website: www.midyorks.nhs.uk

Date of inspection visit: 15–18 July and 27 July 2014
Date of publication: 04/11/2014

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Mid Yorkshire Hospitals NHS Trust is an integrated trust, which provides acute and community health services. The trust serves two local populations; Wakefield which has around 325,837 people and Kirklees with around 422,458 people. The trust employs around 8,060 members of staff, including 755 medical & dental staff.

The acute services are provided in three hospitals, Pinderfields Hospital, Dewsbury District Hospital and Pontefract Hospital. Pontefract Hospital is situated in Pontefract and serves a population of 325,837 people in the local Wakefield and Pontefract area. The hospital has approximately 50 inpatient beds.

There were plans in progress for the reconfiguration of services at the trust with the aim of centralising children's services; consultant led maternity services and acute emergency services at Pinderfields Hospital. This had caused a level of anxiety amongst both the local population and the staff working at the trust. This new clinical strategy was subject to consultation.

We inspected the trust from 15 to 18 July and undertook an unannounced inspection on 27 July 2014. We inspected this trust as part of our in-depth hospital inspection programme. We chose this trust because it was considered a high risk service.

Overall, we rated Pontefract Hospital as required improvement. We rated it as required improvement for providing safe care, effective, being responsive to patient's needs and being well-led. We rated it good for being caring.

We rated Accident and emergency, surgery, maternity and medical care as requires improvement. We rated outpatients as inadequate.

Our key findings were as follows:

We observed areas of good practice including:

- Generally patients being cared for on the wards gave positive feedback about their experiences.
- There were arrangements in place to manage and monitor the prevention and control of infection. We found all areas we visited to be clean.

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

Importantly, the trust must:

- Ensure that the reporting of performance, risk and unsafe care and treatment is robust and timely to the Trust Board so that appropriate decisions can be made and actions taken to address or mitigate risk to patient safety.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Address the backlog of outpatient appointments, including follow-ups, to ensure patients are not waiting considerable amounts of time for assessment and/or treatment.
- Ensure clinical deteriorations in the patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments.
- Review the 'did not attend' in outpatients' clinics and put in steps to address issues identified.
- Ensure the procedures for documenting the involvement of patients and relatives in 'Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) are in accordance with national guidance and best practice at all times.
- Ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards

Summary of findings

- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for resuscitation and safeguarding; staff working in urgent care settings where appropriate undertake level 3 safeguarding training.
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) are embedded in theatre practice.
- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated caring and being well led as good. Improvements were required with safety and responsiveness. We did not rate effectiveness. The A&E department was clean, with arrangements in place for the prevention and control of infection. There were systems in place to manage deteriorating patients. Staff learnt from incidents. However, improvements were required in the management of medicines and not all staff were aware of the procedures for assessing the patient's mental capacity. Medical staff covered both Pontefract and Pinderfields A&E departments, but there was no dedicated paediatrician or sick children's nurse within the department. Seriously ill or injured children would be directed straight to Pinderfields General Hospital. Medical cover for the department was in place during the day between the hours of 9am and 12 midnight. During night-time hours medical cover was provided by GPs with A&E experience. Care and treatment was provided in line with national and best practice guidance. Patients were treated with dignity and respect and were positive about care in the department. Generally the trust was meeting the 95% target for patients being treated within four hours in A&E however there were some occasions when they didn't meet this. The trust had identified the time patients were waiting in A&E to be handed over from the ambulance staff was a concern since June 2013. The issue of handover times was discussed subsequently throughout the year. Despite some improvements during the course of the year, in April 2014 it was noted that ambulance handovers remained a problem. Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Further protocols were being developed. Assessment of pain was undertaken as part of the admission process and

dealt with as quickly as possible. Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.
Staff reported there was strong leadership in the department and staff were supported to raise concerns. We saw good team working across disciplines and staff were trained and supported effectively.

Medical care

Requires improvement

We rated medicine as good for caring.
Improvements were required with safety, effectiveness, responsiveness and being well led.
The medical units were clean and well maintained with systems in place for the prevention and control of infections. There was sufficient nurses but shortages in some medical staff roles. There were mechanisms in place to manage incidents and monitor some safety aspects. However, we had concerns over the low level of harm-free days, and in particular the number of new pressure ulcers experienced. Mandatory training was variable across the division and there was little training in the Mental Capacity Act 2005.
Patients were very positive about their care and felt involved in decisions about their treatment. However, there was little patient information available in different languages and interpreting services were not always used.
Clinical audits took place to ensure that staff were working to expected standards and following guidelines, although some areas needed improvements Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans.
Interpreting services were available, but there was little patient information available in different languages.
There had been a lot of change to management structures. Patient and staff engagement was improving. However, risks had been identified by the trust, but for some of them insufficient action had been taken to address them or sustain changes where these had been made.

Surgery

Requires improvement

We rated surgical services as good for caring, but improvements were required for safety,

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effectiveness and being well led. We had serious concerns over the number of patients waiting to be admitted for treatment (the target for the referral to treatment at 18 weeks was not being met) and at times the arrangements for the access and flow of patients on to the wards and in theatres was ineffective.

Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Staffing establishment levels and skill mix across all surgical services were not always sustained at all times of the day and night. There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and daily checks of equipment were not consistently carried out. Staff awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were limited.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

We observed positive, kind care provided to patients and patients spoke positively about the standard of care they had received.

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards.

Summary of findings

There was good ward leadership and staff felt supported. Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working. There were changes in management structures and reconfiguration of services that had led to low staff morale, particularly in theatres.

Maternity and gynaecology

Requires improvement

We rated the maternity service as good for effectiveness, being responsive and caring, but improvements were required for safety and well led. Maternity areas were clean and there were effective systems in place to monitor infection control. There was an incident reporting mechanism in place and lessons learnt from investigations were shared. However, staffing levels did not meet best practice national guidance. Records were not consistently completed and updated.

Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31. Community midwifery ratios were 1 midwife to 127-133 women which exceeded best practice guidance of 1:100.

We found staff did not always check emergency equipment daily to ensure it was available in the event of an emergency situation.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

Staff were reported as kind and understanding. The service ensured women received accessible, individualised care, while respecting their needs and wishes.

Summary of findings

The service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives.
An external review had been commissioned as there had been a cluster of eight serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

Outpatients and diagnostic imaging

Inadequate

We rated outpatients as inadequate for safety and being responsive, caring we rated as good and we rated well led as requiring improvement. We did not rate the effectiveness of the service. There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for assessment and treatment. There had been a validation process in place, which had reduced the numbers waiting, but this had not addressed the risks to patients whose condition may be deteriorating.
There were two separate arrangements in place to manage outpatients clinics, a central system and a system which was directly led by the specialties. The systems operated in different ways. Incidents were reported but learning from these was not always shared so that improvements could be made. Outpatient areas were clean and well maintained with measures in place for the prevention and control of infection. Staff rotated across all three hospital sites depending on need and demand of the service. Outpatient clinics were, in general, comfortable and friendly, with suitable facilities. Essential equipment was not always easily available such as wheelchairs and blood pressure monitors.
Within clinics, staff treated patients with dignity and respect. Patients told us that they were very

Summary of findings

satisfied with the service they received. However, there were high numbers of complaints going back many months reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. The Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%. The trust was unable to give reasons for this. Analysis of data showed from February 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients.

Pontefract Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Maternity; Outpatients

Contents

Detailed findings

Background to Pontefract Hospital

Pontefract Hospital is part of the Mid-Yorkshire NHS Trust. It is situated in Pontefract and serves a population of 325,837 people in the local Wakefield and Pontefract area. The hospital has approximately 50 inpatient beds and a number of day case facilities.

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

Pontefract Hospital provides a range of services including: Accident and Emergency, Rehabilitation unit, Surgical Short Stay Unit, Outpatient services for adults and children, Day surgery for adults and a Midwife-led Maternity Unit There were 45,554 attendances in the accident and emergency department (A&E) between May 2013 and May 2014 at Pontefract General Infirmary, of which 23,117 were by children (under 18 years old). Although children had their own waiting area, they were assessed and treated in the same department as adults. The hospital did not receive any trauma injuries; patients were transported to Pinderfields General Hospital. Another hospital in West Yorkshire received all major trauma cases and had been the designated major trauma centre for West Yorkshire since April 2013.

Pontefract Hospital has two medical wards, the rehabilitation unit, mainly for stroke patients, and the medical unit. The medical unit has ten beds, which were for patients who could be stepped down from acute care or who were at the point of being medically fit for discharge but had complex needs and were waiting for a comprehensive discharge plan to be put in place. There was also one cubicle that was used for patients who had attended the emergency department.

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

During 2013 the Pontefract midwife-led unit had 328 births in the unit and 78 home births. Between January and June 2014 there were 143 births in the unit and 70 home births.

The Mid Yorkshire Hospitals NHS Trust provides a wide range of outpatients clinics at Pinderfields, Dewsbury and Pontefract Hospitals. In 2013–2014 over 400,000 patients attended outpatient's clinics across all three hospitals, with over 90,000 of these patients attending outpatients clinics at Pontefract Hospital.

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

The inspection team inspected the following five core services at Pontefract Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Maternity and family planning
- Outpatient services

Pontefract Hospital was inspected in May 2013 inspection and was found to be meeting the required standards.

Our inspection team

Our inspection team was led by:

Chair: Dr Bill Cunliffe

Team Leader: Julie Walton, Head of Hospital Inspection, CQC

The team included CQC inspectors and a variety of specialists including medical consultants, junior doctors, senior managers, nurses, midwives, paramedics,

palliative care nurse specialist, a health visitor, allied health professionals, children's nurses, school nurse and experts by experience who had experiencing of using services.

How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information that we held and asked other

Organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), the Trust Development Authority (TDA), NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Wakefield 14 July 2014, where 35 people shared their views and experiences of the Mid-Yorkshire Hospitals NHS Trust. As some people were unable to attend the listening events, they shared their experiences via email or telephone. We also attended additional local groups in Dewsbury and Wakefield to hear people's views and experiences.

We carried out the announced inspection visit between 15 and 18 July 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection in the evening on 27 July 2014.

Facts and data about Pontefract Hospital

In 2012 -13, Mid-Yorkshire NHS Trust had a total of 153,990 inpatient admissions, 456,169 outpatient attendances and 226,583 attendances at the Accident & Emergency departments.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Urgent and emergency services

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

Information about the service

There were 45,554 attendances in the accident and emergency department (A&E) between May 2013 and May 2014 at Pontefract General Infirmary, of which 23,117 were by children (under 18 years old). Although children had their own waiting area, they were assessed and treated in the same department as adults. The resuscitation room was shared between adults and children and was equipped for both, being able to treat two people at a time. Any patient requiring admission was transported to Pinderfields General Hospital.

From the attendance figures we received, the A&E department saw an average of 13 people each night. During the night hours the A&E department was staffed by local GPs with experience of A&E. The hospital did not provide ambulatory emergency care.

In the adult A&E there were three trolley bays; one of those bays was equipped for patients with higher care needs. X-ray facilities were situated adjacent to the area. A further three bays were available for children but were also used by adults at periods of higher demand. Unless an acutely ill child was brought to the hospital by accompanying adults, all children requiring transportation by ambulance were taken to Pinderfields General Hospital. The only exception to this was a child in cardiac arrest, when they would be stabilised before being transported to Pinderfields General Hospital. The ambulance service did not take any children to the A&E department between 9pm and 9am.

For patients who walked into the department, there was a minor injury or illness service. Patients were seen and treated by emergency nurse practitioners; doctors were available for support when necessary.

Pontefract Hospital did not admit any patients from its A&E department. The hospital had one medical bed available to them on a medical ward for the short-term care of patients waiting for admission to Pinderfields General Hospital. If the patient deteriorated while on the ward, they were transferred back to A&E for treatment.

The hospital did not receive any trauma injuries; patients were transported to Pinderfields General Hospital. Another hospital in West Yorkshire received all major trauma cases and had been the designated major trauma centre for West Yorkshire since April 2013. Patients were also transported to the designated major trauma centre when they had suffered severe heart attacks or leaking aortic aneurisms.

Urgent and emergency services

Summary of findings

We rated caring and being well led as good. Improvements were required with safety and responsiveness. We did not rate effectiveness.

The A&E department was clean, with arrangements in place for the prevention and control of infection. There were systems in place to manage deteriorating patients. Staff learnt from incidents. However, improvements were required in the management of medicines and not all staff were aware of the procedures for assessing the patient's mental capacity. Medical staff covered both Pontefract and Pinderfields A&E departments, but there was no dedicated paediatrician or sick children's nurse within the department. Seriously ill or injured children would be directed straight to Pinderfields General Hospital. Medical cover for the department was in place during the day between the hours of 9am and 12 midnight. During night-time hours medical cover was provided by GPs with A&E experience.

Care and treatment was provided in line with national and best practice guidance. Patients were treated with dignity and respect and were positive about care in the department.

Generally the trust was meeting the 95% target for patients being treated within four hours in A&E however there were some occasions when they didn't meet this. The trust had identified the time patients were waiting in A&E to be handed over from the ambulance staff was a concern since June 2013. The issue of handover times was discussed subsequently throughout the year. Despite some improvements during the course of the year, in April 2014 it was noted that ambulance handovers remained a problem.

Clinical guidance for the treatment of patients with specific needs or diseases was available and being used appropriately by staff. Further protocols were being developed. Assessment of pain was undertaken as part of the admission process and dealt with as quickly as possible. Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.

Staff reported there was strong leadership in the department and staff were supported to raise concerns. We saw good team working across disciplines and staff were trained and supported effectively.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The A&E department was spacious, clean and tidy. Equipment was checked regularly and staff were seen to be using alcohol gel or washing their hands between patients. There were systems in place to manage deteriorating patients.

There were processes in place to ensure all staff learned from any patient-related incidents in the department. Medicine management was not always robust, for example a patient group directive was overdue for review.

Patient records were kept securely and consent was gained from patients before procedures were undertaken. Some staff were unsure of the procedures to follow if patients could not give informed consent, although they knew how to raise concerns about adults and children who may be at risk from harm. Mandatory training was actively encouraged in the department.

Twelve consultants provided a service across Pontefract and Pinderfields A&E departments in the trust, although at the time of our visit only nine were available for duty. There was no specialist paediatric emergency medicine consultant for Pontefract; there was a trust-wide paediatric emergency lead who worked regular shifts at Pontefract A&E department. Medical cover for the department was in place during the day between the hours of 9am and 12 midnight. During night-time hours medical cover was provided by GPs with A&E experience, some of whom had worked in the department earlier in their careers.

The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. This was not available in the department. This meant the department was not working within the standards for children and young people in emergency care settings.

Agency nursing staff were rarely used. There were no specialist mental health nurses or children's nurses available in the department.

Incidents

- Between April 2013 and March 2014 there had been no reported serious untoward incidents within the A&E department at Pontefract Hospital.
- All staff except one knew how to report any incidents in the department using incident forms on the trust's electronic Datix system; one gave an example of when they had done so. We were informed by the staff that feedback could be better, because it was not always timely or comprehensive.
- The trust's three A&E departments had produced the first issue of a monthly newsletter for all its staff in June 2014. This was produced by the nursing leads for each A&E. It highlighted the results of checks undertaken, such as hand hygiene, and areas for improvement, such as documentation. We saw this was available to staff in the department.
- There was a handover book in which immediate lessons from shifts could be communicated to all members of staff.
- Monthly clinical governance meetings were attended by doctors and senior nurses only. However, the lead nurse was to be invited to the next meeting.

Safety thermometer

- The A&E did not have its own patient safety information displayed in the department. However, individual audits, for example hand hygiene, were visible for staff and patients.
- We were informed some work was about to begin that would address the issue.

Cleanliness, infection control and hygiene

- Areas were clean and odour-free. Surfaces were dust-free and mattresses were clean; we observed thorough cleaning of equipment and trolleys between patients.
- 'I am Clean' stickers were seen in use. Hand washing facilities and alcohol gel were available in all areas and staff were seen to use them automatically.
- The monthly hand hygiene results for the previous month in the department was reported as 100%.
- All staff were reported as being bare below the elbows in the previous month's audit, as per the trust's policy. All staff we saw were bare below the elbows.

- There was no specific isolation area within the department. A sign was available if required identifying 'infection risk'. Once the cubicle had been used for an infectious patient, a 'red clean' is requested; everything was deep cleaned and cubicle curtains were replaced.
- Infection prevention and control was part of staff's annual mandatory training.
- Clinical waste bins and sharps containers were not filled beyond the maximum line.
- Daily cleaning records for the general areas of the department were seen and dated back to 2012.
- There was no facility in the department for decontaminating a patient exposed to chemicals who self-presented. In such an instance, a tent would have to be set up outside. Plans had been approved to turn one room into such a facility.

Environment and equipment

- All treatment areas were spacious and call-bells were available.
- There was sufficient equipment for monitoring and treating patients, for example cardiac monitors and infusion pumps.
- Any faulty equipment was taken out of use, labelled as such and reported, and a log number obtained.
- Equipment and linen stores were well stocked, labelled and accessible.
- Bariatric equipment was available and accessible in the emergency department when required.
- Equipment we saw had been serviced and was in working order.
- Resuscitation equipment was appropriate and checked daily with regular auditing.

Medicines

- Patients with any known allergies to drugs were identified during the triage process. A note was made on the patient's record.
- We looked at the way the department kept their controlled drugs. We saw three examples where drugs were checked and stocks were correct. We saw the department undertook a regular check.
- There was a separate 'grab bag' located in the cupboard that contained controlled drugs; these were correct.
- We looked at eight prescriptions. All were completed correctly and signed by the prescriber.
- Patient group directives (PGDs) were kept in the triage room for nurse administration of drugs, such as Paracetamol and Tetracaine gel. PGDs were authorised correctly but had no list of named nurses and the review date of the PGD was overdue (June 2014).
- The review date on the PGD for one drug was overdue by two years.
- Any controlled drugs brought into the department by patients were kept in a separate register. We found an error in the register; this was followed up and rectified.
- Drug fridges were the correct temperature and were checked appropriately. However, minimum and maximum temperatures were not recorded, despite the facility for doing so being available.
- Medication charts were found to be signed and dated correctly.

Records

- Patient's records were kept at the doctors/nurses desk and were only accessible to healthcare professionals.
- Documentation for the assessment of patients was completed for all new patients in A&E.
- Vital signs, such as temperature, blood pressure and pulse, were recorded. Analgesia (pain-relieving medicine) was prescribed when necessary.
- Staff informed us they did not routinely print out the ambulance electronic patient record form. The form captured important information such as observations and medication given when in transit. There was a risk of a patient receiving identical medicine that had already been given.
- There was no allocated paperwork for identifying risks to patients, for example falls. We were informed clinicians and nurses used their own professional judgement to identify if someone was at any particular risk. If they were, the appropriate risk assessments would be completed. We did not see any patients where this had occurred.
- Notes from previous admissions could be obtained electronically within a few minutes. A&E notes were scanned and uploaded on a regular basis and made available to hospital staff. Paper records were then shredded.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients who required procedures under an anaesthetic had their written consent obtained before the process was undertaken.

- Patients told us they were asked for their verbal consent before any procedure was undertaken.
- There was no documentation to support or assist clinicians in assessing capacity, although this was available on the trust's intranet. We were given contradictory information by different staff groups about who was responsible for the assessment.
- Three members of staff were not confident in how to assess capacity; one staff member had not received Mental Capacity Act 2005 training in the previous two years. Another member of staff had undertaken the training in the previous six weeks knew the capacity assessment forms were accessible to staff on the trust's intranet facility and was able to tell us when they would use them.

Safeguarding

- Staff were aware of the trust's safeguarding procedures for adults and children, what constituted abuse and how to report it.
- 75% of nursing staff had received safeguarding level 3 training. Middle grade and senior doctors had all received safeguarding level 3 training, with foundation doctors receiving level 2 training. The Safeguarding Children and Young People: roles and competences for health care staff Intercollegiate document March 2014 states all staff working in urgent care settings should undertake level 3 safeguarding training. The document specifies this refers to medical and registered nursing staff who work in Accident and Emergency departments, urgent care centres minor injury/illness units and walk in centres. This meant the department did not ensure all staff were trained to the appropriate level for safeguarding children.
- There was a trust safeguarding lead and staff in the department was aware of this.
- The trust electronic system automatically prompted safeguarding questions when children presented to the A&E department with a possible non-accidental injury.
- There was a clear pathway in place for any potential non-accidental injuries to children. Children would be referred directly to the paediatric team in Pinderfields General Hospital. All such children were admitted to a children's ward as a matter of course.

Mandatory training

- The mandatory training matrix was clearly displayed on the office wall. Two staff had not completed it for 2013/14 because of shift patterns and fewer than 10 had not had fire training; that training had been booked for 23 July 2014.
- Mandatory training was actively encouraged in the department.
- The trust's mandatory training included infection control, health and safety and safeguarding.
- Staff were allocated one day on an annual basis to complete the training.
- The training was mainly provided via e-learning, although some elements, for example fire training, were undertaken via face-to-face lectures.

Initial assessment and treatment

- Patients who walked into the department would be booked in by the receptionist.
- Patients would be streamed according to their presenting complaint into either "walk in" or "majors". Those requiring immediate attention would be directed immediately to the main A&E.
- If the patient was referred into majors, they would be instructed to sit in the waiting room to be called into a trolley bay, where they would be seen for initial assessment by the triage nurse, who was located next to the waiting room.
- There were protocols and procedures in place for specific conditions, for example patients presenting with chest pain.
- Ambulance transfers would be transferred directly into the department.

Assessing and responding to patient risk

- Following a patient's initial assessment, observations such as temperature, pulse and blood pressure were inputted into the computer, which created a National Early Warning Score automatically. If scores were elevated (over 4), senior support was sought.
- The National Early Warning Score is a simple, physiological score and its primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- Reception staff could observe patients in the waiting room during the course of their shift. If they were concerned about a patient they would alert nursing staff.

Urgent and emergency services

- The A&E department was not part of the local trauma network. Any seriously injured patients were taken to Pinderfields General Hospital.
- A nurse informed us stabilisation and transfer protocols for children had changed and the A&E used paediatric observation charts used by the specialist transport service for critically ill infants and children in Yorkshire and the Humber. This had been introduced in February 2014.
- The nursing coordinator on duty was responsible for arranging patients' transfer to Pinderfields or Dewsbury Hospitals.
- The trust had standard operating procedures in place for managing emergency demand in any of the hospitals to ensure risks to patients were minimised.
- We witnessed a patient deteriorating; they were quickly moved into the resuscitation area of A&E for further treatment.
- The trust had standard operating procedures in place for managing emergency demand in any of the hospitals to ensure risks to patients were minimised.

Nursing staffing

- A&E had a full complement of its own nursing staff. The levels had been reduced for qualified staff from 21.63 WTE (whole time equivalents) in June 2013 to 15.33 WTE in April 2014.
- Two nurses were on duty between 7pm and 7.30am.
- The Royal College of Paediatrics and Child Health had set standards for children and young people in emergency care settings. These included the availability of a qualified children's nurse on each shift. This was not available in the department. This meant the department did not meet the standards from the Royal college of Paediatrics and Child Health.
- A comprehensive induction programme was in place for newly appointed staff, followed by a competency programme to ensure staff acquired the skills required to work in A&E.
- Staff felt well supported by the lead nurse in A&E.
- One nurse informed us they did not feel a children's nurse was necessary because the department only saw children who were able to walk in and not really sick.
- Nurses in the department had been trained in paediatric immediate life support.
- There were no specialist mental health nurses in the A&E.
- The department was proactive in managing sickness levels, which were at 4%. This had been as low as 2% two months earlier.

Medical staffing

- Twelve consultants provided a service across Pontefract and Pinderfields A&E departments in the trust, although at the time of our visit only nine were available for duties. Locum doctors were employed to fill these vacancies.
- The Royal College of Emergency Medicine recommends 12 specialist consultants for an A&E department seeing between 80,000 and 100,000 patients a year. Pontefract and Pinderfields A&E departments saw 150,253 between them for the period May 2013 to May 2014. It is acknowledged patients seen at Pontefract A&E required less medical intervention.
- There was no specialist paediatrician for A&E. There was no specialist paediatric emergency medicine consultant for Pontefract; there was a trust-wide paediatric emergency lead who worked regular shifts at Pontefract A&E department.
- Funding for two A&E paediatric consultant posts within the trust had been confirmed and an advert was due to be placed.
- Medical cover for the department was in place during the day between the hours of 9am and 12 midnight. This consisted of middle-grade doctors. Any gaps in the rota were filled by locums; these ideally had either worked in the department before or were used on a regular basis and therefore knew the department.
- An A&E consultant worked in the department 9am to 5pm on Monday to Friday. An on-call service was provided from Pinderfields at night and weekends.
- During night-time hours medical cover was provided by GPs with A&E experience, some of whom had worked in the department earlier in their careers.

Major incident awareness and training

- Pontefract A&E department did not receive patients as a result of a major incident. However, 87.5% of nursing staff had received theoretical training for major incidents and had an understanding of The National Strategy for Chemical, Biological, Radiological, Nuclear, and Explosives.
- Nine staff had received practical updates since January 2014.
- There was no major accident equipment kept in the department.

Urgent and emergency services

Personal safety

- The department is protected by Closed Circuit TV.
- When we spoke with staff about feeling safe, they informed us they didn't always feel safe when on duty. There were concerns that security staff may be removed from the A&E department in the future.
- At the time of our visit a member of security staff was available 24 hours a day. Staff informed us they normally took two minutes to reach the department if requested to do so.
- Two members of portering staff were also available in the department between 9am and 5pm, but one member during the evening and at night.
- Police were called when it was necessary to the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Clinical guidance for patients with specific needs or diseases was available and was used appropriately. Assessment of pain was undertaken as part of the admission process and dealt with as quickly as possible. Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.

Patients were confident in the staff's ability to deliver high-quality care. We saw good team working across disciplines and staff were trained and supported effectively.

Evidence-based care and treatment

- There was a protocol in place with the ambulance service with regard to which patients could be transported to Pontefract Hospital A&E for treatment. The list included adult cardiac arrest, occluded airway, hypoglycaemia and head injuries with no loss of consciousness.
- Patients who did not fit the criteria were taken to Pinderfields General Hospital A&E department.
- The A&E was managed effectively and in accordance with the clinical standards for emergency departments.
- We saw there were specific ways of dealing with patients with particular problems, for example infections and heart attacks. They all related to guidelines from National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine.

Pain relief

- An assessment of pain was undertaken on a patient's arrival in the hospital as part of the admission process.
- We spoke with one patient who had been administered pain relief. They told us it had been given quickly.

Nutrition and hydration

- Patients in the A&E department for any length of time were offered something to eat and drink when this was appropriate and safe to do so.
- Water coolers were available in the main treatment area and in the waiting room. Vending machines with chocolate bars were also available in the waiting room.
- We saw patients and relatives with mugs of tea supplied by staff. They informed us they had appreciated being given a drink.
- A limited variety of food was available for patients when required. This included cereals, biscuits, rice pudding and cheese and biscuits.
- Older people were assisted to take food and fluids if this was necessary.

Patient outcomes

- The A&E department had undertaken the College of Emergency Medicine audits on seven topics in the past six years, the last one being in 2013 on consultant sign-off. Results showed that 91% of all patients had been seen by an emergency department doctor; this was higher than other UK A&E departments.
- Unplanned re-attendance rates within seven days across the three A&E departments for the trust were higher than the England average. This was running at 7.5% and 8% compared with the standard rate of 5%.

Competent staff

- Patients felt confident in the staff's ability to care for them appropriately.
- All the nursing staff felt competent to undertake their role and told us they had opportunities to develop their knowledge and skills.
- Staff were aware of national guidance for particular illnesses, for example the asthma care bundle.
- 80%of staff across the emergency departments had received up to date resuscitation training.

Urgent and emergency services

- Medical staff felt supported in their role by line managers.
- They further informed us they had no difficulty in obtaining study leave and had time to undertake personal development planning.
- Regular continuous performance development days were offered to both medical and nursing staff.
- Staff we spoke with had received annual appraisals. The time was also used to identify training needs and discuss development opportunities.
- In addition, staff could attend peer-led awareness sessions to discuss particular topics.

Multidisciplinary working

- We saw excellent team working between medical and nursing staff throughout our visit.
- X-ray and scanning facilities were available next to A&E.
- There was no haematology service on site in the evenings or at weekends; blood samples were sent to Pinderfields Hospital. This could take up to two hours to report back. Staff told us sometimes the samples could be lost.
- We spoke with a patient who had been waiting for two hours for blood results.
- Discharge letters were created electronically and printed off to either be sent by post to the GP or given to the patient to deliver.
- Patients requiring referral to psychiatric services were seen within 1.5 to 2 hours by the crisis team. Staff informed us it was a good service.

Are urgent and emergency services caring?

Good

Patients felt they were listened to by health professionals and were involved in their treatment and care. We saw examples of caring professional interactions with patients given in a quiet and dignified manner.

Staff were aware of the grieving process and knew how to treat relatives experiencing bereavement with dignity and respect. The chaplaincy service provided 24-hour support if required.

Compassionate care

- The A&E Friends and Family Test is calculated using the proportion of patients who would strongly recommend the A&E department minus those who would not recommend it or who are indifferent. 100 is the highest score that can be awarded.
- In June 2014, 25% of patients had responded, which is higher than the national average. Of those who responded, 79% stated they were extremely likely to recommend the department to their family and friends. The overall score was 77.
- All the patients we spoke with in A&E were complimentary of the care they had received.
- One patient told us, “They’ve been fantastic. I can’t fault them.” Another said, “I wouldn’t want to go anywhere else, they’ve been great. They are all so kind.”
- We saw examples of caring professional interactions with patients given in a quiet and dignified manner. All patients had call bells within their reach and a drink available when it was safe for them to have one.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes were long waiting times in accident and emergency department and car parking cost and availability. The positive themes related to experiences the caring staff across all sites.

Patient understanding and involvement

- Staff introduced themselves to patients.
- Patients told us they understood what had been said to them and had felt well informed about their care and treatment options.
- The Friends and Family test questionnaire was readily available for patients to complete and staff encouraged them to complete it.
- Patients who had been admitted to the hospitals from A&E departments across the trust and who had completed the Inpatient Survey in 2013 had scored 7.8 and 8.9 out of 10 respectively when asked if they had received enough information about their treatment and been treated with privacy and dignity.
- The TV screen in the waiting room did not provide patients with waiting times.

Urgent and emergency services

- There was a large range of patient information leaflets available covering various illnesses.

Emotional support

- We spoke with staff about caring for relatives who had just lost their loved ones in A&E. We were informed that family members were taken to the relative's room in the emergency department.
- There was no designated area for relatives to view their loved one. It depended on how busy the department was.
- When possible, their loved one was placed in a vacant clinical examination room and relatives were given the opportunity to spend time with them if they wished to.
- We were informed relatives could stay as long as they wished in the department after a patient's death; drinks were provided and patients were not moved until the relatives were ready.
- Relatives had the opportunity to visit the multi-faith chapel in the hospital. A member of the chaplaincy serving Christian and Muslim faiths was contactable at any time via the hospital switchboard.

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

Requires improvement

An electronic system was in place for tracking how long patients had been in the department to ensure they were admitted to wards or discharged home in a timely way. The department had not always achieved the 95% target for patients being treated within four hours for the previous ten weeks before our visit. There was a clear escalation policy in place when the department came under pressure.

The trust had identified the time patients were waiting in A&E to be handed over from the ambulance staff was a concern since June 2013. The issue of handover times was discussed subsequently throughout the year. Despite some improvements during the course of the year, in April 2014 it was noted that ambulance handovers remained a problem.

There was a clear escalation policy in place for when the department came under pressure. Key triggers resulted in specific actions, though it was acknowledged the success of these depended on the capacity and 'flow' to the rest of the hospital.

Patients informed us they felt treated as individuals and information was available to them about various illnesses and the complaints process if required. Staff had access to translation services through the use of a specialist telephone line.

Support for vulnerable patients, for example those with a learning disability or mental health condition, was available; 50% of staff were trained in the care of patients living with dementia.

Complaints and serious incidents, with any lessons learned from them, were discussed at monthly clinical governance meetings in the department. Information leaflets and posters about how to make a complaint were visible in the department.

Service planning and delivery to meet the needs of local people

- The A&E department served the population of Pontefract and the surrounding area. In the last financial year, the department had 41,733 attendances.
- The majority of patients attending A&E arrived by private car or on foot.
- In April 2014, 23 patients had arrived by ambulance compared with 115 in January 2014.
- A triage nurse assessed all patients and directed them to the appropriate area of the emergency department.
- Patients arriving by ambulance went straight into the clinical area for assessment. This meant patients were given privacy and dignity during this process.
- Walking patients were greeted by a receptionist, booked in and triaged as soon as possible. Children were directed to the appropriate waiting area.
- There was a separate small paediatric waiting area providing toys for children waiting to be treated. As patients had to raise their voices to speak with the receptionist, patients were at risk of being overheard while giving confidential information.

Access and flow

- During our inspection we visited A&E twice. We saw staff were able to deal with the number of patients requiring care and treatment.

Urgent and emergency services

- Trust data for the previous quarter showed that over 96% of patients had been admitted, transferred or discharged within four hours of their arrival at an A&E department at the trust.
- The trust had identified that the time patients were waiting in A&E to be handed over from the ambulance staff was a concern. On 5 June 2013, the trust's Clinical Executive Group (CEG) approved a Turnaround/ Handover National Target paper. The issue of handover times was discussed subsequently at CEG. Despite some improvements during the course of the year, on 23 April 2014 it was noted that ambulance handovers remained a problem.
- Trust-wide information showed that over a period of 3 months (April – June 2014) a total of 1745 patients had waited over 15 minutes to be handed over from the ambulance staff against a target of zero; 205 patients had waited more than 30 minutes and 5 patients had waited more than an hour to be handed over.
- We spoke with ambulance personnel who transport patients to Pontefract Hospital on a regular basis. They informed us handover times to hospital staff in the A&E were "Good".

Meeting people's individual needs

- Patients we spoke with felt they were treated as individuals in their own right.
- One person told us, "I've been treated really well. The staff have been great."
- All signage and notices were in English, but braille was evident under the writing on the signs.
- The hospital had access to translation services through the use of a specialist telephone line. Staff were aware of this and knew how to use it. We did not see it in use during our visit.
- We did not see any printed information for patients in any language other than English.
- We did not speak with any patient who had a learning disability.
- A&E staff knew about 'health passports' to aid their communication with people with a learning disability. Staff informed us that people with a learning disability were seen as soon as they could.
- We were informed staff had access to a specialist learning disability nurse if required, but had not contacted them recently.
- We spoke with members of staff about their ability to help patients living with dementia when they needed to go to the department. Dementia training was delivered once as part of the training for all levels of staff, but 50% of nursing staff had not received it. There were plans in place to address this.
- The department had access to a bariatric wheelchair and trolley when required.

Learning from complaints and concerns

- We were provided with a complaint summary at trust-wide level for the period December 2013 to May 2014.
- Response rates varied from meeting the targets between 21% in one month to 100% in four other months.
- From information in June 2014, we saw the department had received one complaint.
- Information leaflets and posters about how to make a complaint were visible in the department.
- Informal complaints could be received by any member of the A&E team. These were dealt with by the most appropriate person.
- A Patient Advice and Liaison Service was signposted within the hospital.
- Complaints and serious incidents, with any lessons learned from them, were discussed at monthly clinical governance meetings in the department.

Are urgent and emergency services well-led?

Good

Staff were proud of the work they did. They felt a good rapport existed between all levels of staff and we saw this during our visit.

Governance processes did not involve all disciplines of staff, although this was going to change. However, lessons were learned and practices changed as a result of any incidents or complaints because this was fed back to staff.

There was strong leadership from the lead nurse in the department, which other staff respected. They were aware of the positive impact the department had on patients but unsure of the future of the department. Visits from senior managers in the trust were rare and staff were supported to raise concerns and the trust's whistleblowing policy gave them protection.

Urgent and emergency services

Vision and strategy for this service

- Staff knew the trust vision and values, but could not name them all. These were 'Caring Respect, High Standards, and Improving.'
- Senior members of the nursing staff told us of the positive impact they had on patients but were worried for the future of the service.

Governance, risk management and quality measurement

- We asked staff if or how they would raise issues about safety concerns or poor practice in their department. Staff told us they felt very confident taking any concerns to their line manager and knew they would be dealt with.
- There were structured governance meetings in place. However, the lead nurse for the department had not attended such meetings in the past, but was waiting for an invitation to the next one.
- We saw there were two risks clearly identified on the risk register for A&E within the medicine division. Appropriate actions had been taken to mitigate the risks. One person in the department was responsible for all root cause analysis of incidents.
- Any department breaches were investigated locally on a daily basis, but they had also been subjected to an external review. The service leadership had not felt this had been sufficiently thorough, and had thus undertaken their own more stringent review.

Leadership of service

- Staff felt a good rapport existed between all levels of staff and we saw this during our visit.
- The lead nurse informed us they had developed a good relationship with the matron for emergency medicine across the trust and the lead clinician for all A&E departments. They worked together and met or spoke with the matron on a regular basis.
- We spoke with a range of staff in the department. They were knowledgeable about the services they delivered and proud to work in the department. Staff informed us the clinical lead had an open door policy and they felt confident in their leadership.

Culture within the service

- Staff told us morale had improved.
- All staff we spoke with throughout the emergency department told us they felt well supported by their line managers and could raise issues with them.
- Staff informed us there was an open culture with the sharing of complaints and incidents.
- Discussions were held on lessons learned from them and practices changed where appropriate.
- The trust had a whistleblowing policy in place and staff were aware of it.

Public and staff engagement

- When we asked if staff had seen any of the executive team in the department, we were told a senior manager had visited recently but they had not seen a member of trust staff at that level for the previous 17 months.
- Public feedback was obtained using the A&E Friends and Family Test.

Medical care (including older people's care)

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides medical care (including older people's care across three sites. Pontefract Hospital has two medical wards, the rehabilitation unit, mainly for stroke patients, and the medical unit. The medical unit has ten beds, which were for patients who could be stepped down from acute care or who were at the point of being medically fit for discharge but had complex needs and were waiting for a comprehensive discharge plan to be put in place. There was also one cubicle that was used for patients who had attended the emergency department.

The rehabilitation unit had 30 beds, but only 20 were open at the time of the inspection. There were six medical patients with the other patients receiving rehabilitation following a stroke. The average length of stay was 26 days.

We looked at the care records of five patients and nine prescription charts. We spoke with five patients and ten staff, including doctors and nursing staff. We visited both units. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We rated medicine as good for caring. Improvements were required with safety, effectiveness, responsiveness and being well led.

The medical units were clean and well maintained with systems in place for the prevention and control of infections. There was generally sufficient nurses but shortages in some medical staff roles. There were mechanisms in place to manage incidents and monitor some safety aspects. However, we had concerns over the low level of harm-free days, and in particular the number of new pressure ulcers experienced. Mandatory training was variable across the division and there was little training in the Mental Capacity Act 2005.

Patients were very positive about their care and felt involved in decisions about their treatment. However, there was little patient information available in different languages and interpreting services were not always used.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines, although some areas needed improvements Access to diagnostic services was provided seven days a week, although some patients had to wait over a weekend to access some tests and scans.

Interpreting services were available, but there was little patient information available in different languages.

Medical care (including older people's care)

There had been a lot of change to management structures. Patient and staff engagement was improving. However, risks had been identified by the trust, but for some of them insufficient action had been taken to address them or sustain changes where these had been made.

Are medical care services safe?

Requires improvement

There were mechanisms in place to manage incidents and monitor some of the safety aspects of the units, such as specific patient harms. This was done using nationally recognised tools. The safety thermometer dashboard indicated the medical unit had a low level of harm-free days from January to June 2014. In five of the months it showed 10% or more of patients where new harm was recorded with a figure of 22% for new pressure ulcers.

We found the units were clean and well maintained. There was sufficient equipment to meet people's treatment and moving and handling needs.

Record keeping on the units was generally good, although we found some gaps on medication prescription sheets. There were a number of vacancies across the medical division, but the units at Pontefract Hospital were sufficiently staffed. Mandatory training was variable across the division, which meant that staff were not always up to date with current guidance, practice and procedures. There was little training in the Mental Capacity Act 2005 and we found that attendance training in medicine management was poor for some staff across the medicine division. We did not have the specific rates for training on the medical units at Pontefract Hospital.

Medicines management required improvement across the trust because staff shortages meant a lack of support and advice from pharmacists. Pontefract Hospital's ward-based medicines management appeared to be good.

Incidents.

- There had been nine serious incidents reported trust-wide for medical areas between April 2013 and May 2014. There were systems in place to report incidents. Incidents were reported using an electronic Datix system.
- Staff were also made aware of the learning from incidents through a regular patient safety bulletin that was emailed to all staff. Staff were able to tell us about learning from these bulletins.Other systems were in place to feedback learning from incidents. These included electronic feedback to staff who had reported incidents and safety briefings at nursing handover.

- Regular mortality and morbidity meetings were held.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety thermometer information was clearly displayed at the entrance to each unit. This included information about the last time a patient had a fall on the ward, had developed a grade 3 or 4 pressure ulcer, or had developed venous thromboembolism or urinary tract infections in patients with catheters.
- The trust was performing worse than the England average for pressure sores and catheter-acquired infections, according to nationally collated data.
- The rehabilitation unit was rated as harm-free (green rating) for four of the six months from January to June 2014. The medical unit had no harm-free months for the same period; in five of the six months it also had 10% or more of patients for whom new harm was recorded, and a figure of 22% for new pressure ulcers.
- Risk assessments for falls were taking place on patients and the trust was undertaking work to try to reduce the incidence of avoidable falls.

Cleanliness, infection control and hygiene

- We found the units were clean and well maintained.
- From May 2013 to 31 May 2014, the trust performed slightly worse than the England average for Methicillin-resistant Staphylococcus Aureus (MRSA) infections, but better for both Clostridium difficile (C.difficile) and Methicillin-sensitive Staphylococcus Aureus (MSSA) infection rates.
- The units displayed information about how long they had been infection-free in relation to MRSA or C. difficile. There was personal protective equipment, and alcohol hand gels were available at the entrance to the units and throughout the units. Staff were observed using personal protective equipment and hand gels when they entered and left patient areas.
- There were policies and procedures in place to ensure that any patients carrying an infection were managed appropriately, including barrier nursing procedures where applicable. We saw that some patients on the units were being barrier nursed (barrier nursing is used to ensure that cross infection is eliminated by use of protective equipment such as gloves, aprons and isolation).
- Staff were regularly audited to make sure that they were following the correct hand hygiene techniques. Any staff members identified as not using the correct techniques were given information about where their technique was lacking and retested. We saw evidence of these audits.

Environment and equipment

- When we carried out observations on the units, we found that there was enough equipment to safely meet people's needs. For example, there were sufficient hoists and slings and walking frames to make sure that people were supported to move in the most appropriate and safe way. There was enough equipment for staff to undertake observations and tests on the units we visited.
- There was resuscitation equipment available on the units, which was routinely checked.

Medicines

- The pharmacy department was unable to deliver what it believed was an adequate clinical pharmacy service to all wards because of severe staff shortages. Current staffing levels only permitted 60–70% of the clinical pharmacist presence on wards that the pharmacy aimed to provide. Available resources were allocated to ensure that highest risk wards were covered. However, some staff on long-term absence were now returning to work and three junior pharmacists had recently been appointed.
- Pontefract Hospital required approximately five whole-time equivalent (WTE) pharmacy staff to be in work every day. There was a core group of staff who only worked at Pontefract and additional rotational staff who worked at Pinderfields General Hospital but also supported Pontefract, particularly when core staff were absent.
- We reviewed nine prescription charts and eight had been reviewed by a pharmacist. There were two gaps in administration records, with other records being complete.
- Trust wide action had been taken in response to a never event involving medicines at Pinderfields General Hospital.
- The trust had conducted audits on medicine reconciliation, which is the process to ensure that any changes to prescribing when a patient enters hospital are intended by the doctor. The number of patients

whose medicines were reconciled within 24 hours of admission had fallen by about 10% since January 2014. In June 2014, 55% of patients had their medicines reconciled in the first 48 hours after admission.
- An extensive audit of prescriptions was conducted by the trust in October 2013. The audit found that nurses mostly recorded the administration of medicines. There were two unexplained gaps in administration records of the nine prescription charts seen during our inspection at Pontefract. This confirmed the trust's previous findings from October 2013.
- We reviewed the controlled drugs, the medicine fridge and medicine cupboard. Medicines were appropriately stored and checked.

Records
- The standard of record keeping on the units was good. We reviewed five patient records on the two units. Most demonstrated risk assessments had been carried out and acted on, and observations had been recorded and acted upon.
- The trust had carried out clinical audits of records, identified some areas for improvement and was working with staff to implement improvements.
- Some records were in an electronic format and accessible on computers, tablets and mobile phones. The majority of staff were able to access and contribute to these records.
- The healthcare records management policy did not refer to the most up-to-date best practice guidelines from the Nursing and Midwifery Council published in 2009, although this was available via a hyperlink; it referenced 2005 guidance for records and record keeping.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- There was documentary evidence that patients were consented for treatments appropriately. We observed staff asking people for verbal consent before assisting them.
- From training records we noted that training about the Mental Capacity Act 2005 was not part of mandatory training. The trust told us that Mental Capacity Act 2005 training was being delivered in a number of ways at different levels. There was some basic awareness training on induction, which 1456 staff had attended in 2013/14. It was also briefly covered in safeguarding adults training, which 1169 clinical staff had attended in 2013/14. There was also a full day of Mental Capacity Act training, which 58 clinical staff had attended in 2014/15, and bespoke training for groups of staff, which 45 clinical staff had attended in 2013/14.
- From our discussions, we found that a limited number of staff understood the Mental Capacity Act 2005 and were able to identify when it should be used and apply it appropriately.
- The lack of understanding and awareness of the Mental Capacity Act, and how to use the nursing assessment tool to assess capacity, was recorded on the medicine division's risk register.The trust were in the process of recruiting a part-time trainer for Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Safeguarding
- Staff were aware that there was a safeguarding policy and the action they should take if they had any safeguarding concerns.
- According to records in July 2014, staff attendance at vulnerable adult's level 1 and children level 1 safeguarding training was 100% in the medical division. For level 2 within the medical division, it was 72% for adults and 68% for children safeguarding training. However, attendance from some wards, specifically acute medicine, at level 2 was as low as 49%.

Mandatory training
- Overall for the division of medicine the completion of core mandatory training was 73.6% (1200 staff out of a possible 1630) in June 2014.
- Information provided to us by the trust showed that core mandatory training for medical staff was at 91% against a target of 95% completed for the medicine division in June 2014.
- For the division of medicine fire training was 75% against a target of 95% and role-specific training was 72% against a target of 80%.
- The rate of attendance for various specialties and courses within the medical division varied between 49% and 100% according to June 2014 figures.
- 100% of staff had received moving and handling theory training. However, only 59% of staff on acute medicine, 70% of staff on cardiology and 65% on elderly care wards were up to date with their practical moving and handling training. This meant that patients were not always supported by staff who had received an update in accordance with the trust's policy.

Medical care (including older people's care)

- Trust data showed that approximately 82% of staff had received their resuscitation training. For those staff requiring the training every year, only 69% had received it. According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates.
- Medicines management training was also variable, with 65% (544/832 staff) receiving theory training at level 2. Only 51% of staff in the care of the elderly wards had completed this training, 58% in acute medicine and 60% in cardiology and respiratory wards. Staff told us that their competency to administer medications was not routinely checked or recorded unless incidents were identified. We observed a number of incidents where best practice administration was not followed by staff. This meant patients were at the risk of not receiving medication or the correct medication.

Assessing and responding to patient risk

- The trust used the National Early Warning Score to monitor if a patient was deteriorating.
- The trust was introducing an electronic observation recording tool (Vital Pac) at Pontefract Hospital. This allowed staff to improve the monitoring of whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating.
- The trust had introduced hourly roundings, where staff routinely checked on patients every hour. This meant that staff could assist patients and also identify any changes in their conditions. We saw the hourly roundings recorded in the majority of patients' notes.
- When patients were identified as deteriorating, staff told us they were aware of what action to take. They told us that they were able to access medical support Monday to Friday during the day from medical staff on the ward, or out of hours from the doctor who was on-call. They said there were not usually any problems accessing support if patients were deteriorating.
- If a patient deteriorated and required a transfer to another hospital, this decision was taken by the reviewing doctor in conjunction with the appropriate speciality, usually at Pinderfields General Hospital.

Nursing staffing

- The trust had calculated staffing levels for wards/units in November 2013 using the Safer Nursing Care Toolkit and these were to be reviewed and reported to the Trust Board in July 2014.
- A new software tool had been purchased that measured the acuity and dependency of patients and patient flows to help plan safe staffing levels on the wards. We noted this would be rolled out from August 2014.
- The planned and actual staffing levels were displayed on a noticeboard in the corridor on each ward. On the days we inspected the units, the staffing levels were the same as the planned staffing levels. We saw from rotas and Board reports, and staff told us, that this was usually the case.
- Bank and agency nurses were occasionally used to fill gaps in the staffing rotas, where possible. Figures from May 2014 indicated that the rehabilitation ward was fully staffed and the medical unit had 11% vacancies, which equated to less than 1.5 WTE posts.
- The trust was actively recruiting to the vacancies. We were told that 30 nurses had recently been appointed from overseas. We saw some of these nurses working on the wards in a supernumerary capacity until their induction was complete. The trust was also recruiting newly qualified nurses, some of whom would start in September 2014. Recruitment was ongoing.
- Staffing was reviewed at the trust's daily operational bed meetings and a situation, background, assessment; recommendation tool was used to raise any concerns.
- We were told about how staff handed over as each shift changed. Staff discussed each patient's changing needs and any changes in their treatment or health, and had a paper record of their patients to refer to.
- Board reports indicated that all ward managers had full supervisory status. During our inspection we noted that sometimes they worked clinically for part of each week because of staff shortages.

Medical staffing

- Across the trust there were a number of medical staff vacancies at all grades, including middle and consultant level. The trust was using locum medical staff to cover vacancies. We were told that the trust mainly used one locum agency, which helped ensure quality and fill rate for the rotas.

Medical care (including older people's care)

- The rehabilitation ward had a stroke consultant ward round twice a week with a specialist stroke registrar attending the units on most days. For the non-stroke patients there were medical ward rounds twice a week with the designated consultant.
- Staff told us that Monday to Friday during the day there was staff grade medical cover.
- Patients in the medical unit were seen routinely by a registrar once a week.
- Staff told us out-of-hours cover for the units was from an on-call anaesthetist who was in the emergency department or in hospital accommodation adjacent to Pontefract Hospital.
- The medical senior leadership informed us each of the medical specialities were developing their own weekend cover, to start in Autumn 2014, which would include a review of all new admissions, effective management of any patients who deteriorated and the discharge of those patients able to go home on a Saturday or Sunday.
- Junior doctors told us that senior medical staff were contactable by phone out of hours if they needed any support.

Major incident awareness and training

- The trust had plans in place to manage unexpected or unprecedented events that would enable services to continue to be delivered. This included a Resourcing Escalatory Action Plan, which we saw in operation during the unannounced visit because of bed capacity issues.
- The trust was developing a number of initiatives to manage winter pressures. This included introducing an acute ambulatory care model from September 2014 based on pilot work to date. A review of schemes to manage winter pressures had been completed and business cases put forward for 2014/15.

Are medical care services effective?

Requires improvement

Access to diagnostic services was provided seven days a week, including bank holidays. However, patients reported there were times when they had to wait over a weekend to access some tests and scans. Additionally, there was reduced medical input on the units over the weekends, with some patients not being seen by a doctor unless they were deteriorating.

Competency checks for nursing staff were not robust. Nurses did not have competency checks for administering medication.

Clinical audits took place to ensure that staff were working to expected standards and following guidelines. There were a number of national audits, including stroke that required additional focus to ensure patient outcomes were at the national average or above.

There was evidence of good multidisciplinary working on the units and on the whole patients we spoke with were happy with their access to pain relief.

Evidence-based care and treatment

- The service followed best practice and national guidelines.
- Clinical audits took place to ensure that staff were working to expected standards and following guidelines. These showed in some areas such as Myocardial infarctions and the national Diabetes in-patient audit the trust were performing worse than the England average.
- The Commissioning for Quality and Innovation (CQUIN) framework aims to secure better outcomes for patients and improvements in quality and innovation above the baseline mandated in the NHS National Contract. The trust achieved 89% of the CQUIN goals in 2013/14.
- There was a trust-wide annual audit priority programme for 2014/15 that included 28 audits for the division of medicine. Examples of audits included the sentinel stroke national audit programme, chronic heart failure management, national diabetes foot care, and falls and fragility fractures.
- The trust's elderly care strategy focused on implementing and standardising practice in accordance with the national 'Quality care for older people with urgent and emergency care needs' (the Silver Book). This was monitored by the 'Elderly care task force'.
- In March 2014 the trust launched the 'Forget Me Not' scheme and was recruiting volunteers to aid implementation. This would also be monitored through the CQUIN goals.

- Analysis of data showed that the screening for patients living with dementia, over 75 years was red rated quarter (Q) 4 in 2012/13, Q1, Q2, Q 3 and Q4 in 2013/14. The percentage of over 75 years who were referred to a specialist was also red in all these quarters.

Pain relief

- Patients were able to request pain relief and there were systems in place to make sure that additional pain relief could be accessed via medical staff if required.
- Patients we spoke with had no concerns about how their pain was controlled. One patient said, "I'm in pain, but they keep me topped up with pain relief".
- Pain assessments were carried out with some patients, but this was not recorded consistently across the medical division.

Nutrition and hydration

- Patients were able to access suitable nutrition and hydration, including special diets during meal times and when these had been pre-planned.
- Patients reported that on the whole they were content with the quality and quantity of food.
- We observed that there were jugs of water on patients' side tables. Red jugs were used to help indicate to staff which people required support and encouragement with drinking.
- We reviewed two fluid balance charts, both contained entries and were fully completed.
- The Malnutrition Universal Screening Tool (MUST) was in use within the trust to better identify patients at risk of malnutrition and dehydration and we saw evidence of this mostly being completed in the notes we reviewed.

Patient outcomes

- There were no Tier 1 mortality indicators for the trust, which meant that there was no evidence of risk for the composite indicator for in-hospital mortality and Dr. Foster composite of hospital standardised mortality ratio indicators or the summary hospital-level mortality indicator.
- Clinical audits took place to ensure that staff were working to expected standards and following guidelines. The draft quality account for 2013/14 indicated that the trust participated in 91% of the national clinical audits and 100% of the confidential enquiries it was eligible to participate in. A further 213 local audits were completed in 2013/14. Examples of learning were included in the quality account and had been disseminated to the divisions.
- Although the trust participated in the Sentinel Stroke National Audit Programme, there was no data that was site-specific to Pontefract Hospital. However, at trust wide level, the Annual Stroke Peer Review (18 March 2014) found services had improved but concerns were raised over staffing levels, especially the stroke trained nurses and therapists. Speech and language therapy appeared reduced and there was an absence of psychological support.
- Staff were able to access local policies using the intranet and staff permanently allocated to the units were aware of specific policies that affected the work carried out on their ward.
- The risk of patients being readmitted to the trust was higher than the England average in elective gastroenterology and non-elective respiratory medicine, but site-specific data was not available.

Competent staff

- Ward managers were working towards making sure that nursing staff had the appropriate number of supervision sessions each year, and received an annual appraisal. According to performance information, there was still some work to do to achieve this. Supervision rates varied from ward to ward within the division. A number of staff commented that their supervision sessions had been cancelled because of work pressures.
- 53% of non-medical staff had an annual appraisal recorded against the target of 80% for the rolling 12-month period up to and including June 2014. The trust commented that this was because of an increase in pressure on frontline staff in recent months. The trust-wide medical division annual appraisal rate for June 2014 was 87% for consultants and 90% for non-consultants, with a target of 90%. There was no division/ward-specific information available.
- Junior doctors received support, appraisal assessment and guidance to ensure they were competent to carry out their role. Doctors commented about how supportive consultants were. However, some told us they did not always receive local training, for a number of reasons including being too busy with ward duties to attend.
- Doctors were subject to the revalidation process.

Medical care (including older people's care)

- The trust had developed a competency-based work book for all band 2 and 5 staff to complete. On the majority of the wards we visited, this had not been fully implemented or had only very recently started. We also found there were no routine competency checks in place for nurses who administered medication despite a higher than expected number of medication errors occurring across the trust.
- To ensure continuity of care, regular bank and agency staff who were familiar with the wards were used whenever possible. However, concerns were raised by a number of staff about the competency of bank and agency staff filling shifts at short notice. Internally staff commented that they were frequently moved from their own specialism to an area which they were less competent in and that agency staff did not always have the competencies for the speciality they were working within. We observed this in practice, for example intensive care nurses were moved to the care of the elderly wards and agency staff were not competent in inputting data into the electronic patient observation recording system.
- We were told by staff that there was limited induction for agency staff. The permanent staff gave the agency staff member a tour of the ward highlighting the key points, for example where the resuscitation trolley was.

Multidisciplinary working

- There was clear evidence of multidisciplinary working on the units, including a daily handover meeting Monday to Friday to discuss patients.
- There was regular input from physiotherapists, occupational therapists, dieticians and other allied health professionals when required.
- There was evidence that the trust worked with external agencies such as the local authority when planning discharges for patients.
- There were no psychology services for stroke patients.

Seven-day services

- Access to diagnostic services was available seven days a week, for example, x-rays, MRI and CT scans. However, some might have required a transfer of the patient to Pinderfields General Hospital if their condition deteriorated.
- Access to support services such as therapy services varied across the weekend. There was no routine physiotherapist over the weekend. There were two therapy assistants who worked some weekends.
- Dieticians and the speech and language therapy service were based at Pinderfields General Hospital and visited Pontefract Hospital two to three times a week. There was an on-call service, if required, Monday to Friday during the day.
- There was an on-call pharmacist available out of hours. The inpatients pharmacy was open 9am to 5pm Monday to Friday. On Saturday it was open 9am to 12noon and on a Sunday from 10am to 12.30pm. At other times there was an on-call rota for pharmacists.
- The consultant cover over a weekend was on-call only.

Are medical care services caring?

Good

Overall, patients we spoke with were content with the level of care they received from staff. Patients raised no concerns about their privacy and dignity being compromised and on the whole staff were thought to be polite, patient and caring. One of the five patients raised a concern about a nurse not listening to what their needs were.

Most patients we spoke with had been involved in discussions about their rehabilitation and future treatment needs. Patients were able to access support services, such as mental health and end of life practitioners.

The response rate and score for the inpatient survey Friends and Family Test for June 2014 on the units at Pontefract Hospital was variable. The response rate was much better than the average for the trust, with 76% for the rehabilitation unit and 40% for the medical unit.

Compassionate care

- From analysis of the CQC Intelligent Monitoring Report there was no evidence of risk regarding compassionate care, meeting physical needs, patient overall experience, treatment with dignity and respect and trusting relationships.
- The 2013 CQC Adult Inpatient Survey showed that the trust's performance was average when compared with other trusts in all the areas reviewed.
- The response rate and score for the inpatient survey friends and family test for June on the units at Pontefract Hospital was variable. The response rate was much better than the average for the trust, with 76% for the rehabilitation unit and 40% for the medical unit.

Medical care (including older people's care)

- Four of the five patients we spoke with were happy with the care and compassion they received on the ward. Comments included, "Staff are OK, they are very nice, you can have a laugh with them", "One nurse was a good nurse, but she didn't listen to you. They wouldn't put me back on my bed when I asked, as I get sore sitting in a chair" and "its brilliant here, spot on".
- Throughout the inspection we saw patients being treated with compassion and respect and their dignity was preserved.
- Call bells on the units were answered promptly and were in reach of patients who required them.
- Hourly roundings (checks to make sure patients were comfortable and had what they needed) had been introduced to make sure that staff were aware of any emerging needs patients had.
- Relatives were encouraged to be proactively involved in the care of patients and there were extensive visiting hours.
- Patient-led assessment of the care environment showed that the trust was higher than the England average for cleanliness, food and facilities, but slightly below the England average for privacy, dignity and wellbeing.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes were car parking cost and availability and concerns about care provided on elderly care wards. The positive themes related to the caring staff across all sites.

Patient understanding and involvement

- Patients on the whole felt that they were listened to by staff and were aware of what was happening in their patient journey.
- Most patients had not been involved in formulating their care plans, but they were aware of what treatment they would be having and why.

Emotional support

- Most patients reported that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- There was some information within the care plans to highlight whether people had emotional, mental health or memory problems.
- There were rooms available where private discussions and sensitive conversations could take place with patients and/or relatives.

Are medical care services responsive?

Requires improvement

Pontefract Hospital had two medical units, the rehabilitation unit, mainly for stroke patients, and the medical unit and therefore offered a limited variety of medical specialty services. The health needs of those patients suitable for care at Pontefract Hospital were mostly met and there was access to specific support services such as therapy support. The trust's dementia programme to improve caring for patients living with dementia was still being embedded.

For patients whose first language was not English, interpretation services were available, but most ward staff communicated using family and other staff within the hospital. There was no visual patient information available in different languages.

The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care.

The rehabilitation ward encouraged independence. There was a separate dining room and activity room, which patients were encourage to use. There was a newly formed gardening group for patients who were interested.

The majority of patients and relatives felt that they could raise concerns and were confident that they would be listened to. However, there was a lack of awareness on how to complain.

Service planning and delivery to meet the needs of local people

- Pontefract Hospital had two medical wards, the rehabilitation unit, mainly for stroke patients, and the medical unit, and therefore offered a limited variety of medical specialty services.
- The two units were designated as rehabilitation, primarily following a stroke, and step-down beds. However, the vast majority of the patients were also care of the elderly patients.

Medical care (including older people's care)

- During busy times the trust's Resourcing Escalatory Action Plan (REAP) came into operation, which we saw during the unannounced visit at Pinderfields General Hospital because of bed capacity issues across the trust.

Access and flow

- The data provided to us by the trust showed that occupancy levels overall were between 84% and 85.3%, which was lower than the national average.
- Staff told us that most patients only transferred to another hospital if their condition deteriorated. The units did take transfers from other hospital sites. These were usually planned as part of a patient's rehabilitation/step down care.
- We were told ten closed beds on the rehabilitation unit were opened as part of the escalation plans when the beds at Pinderfields General Hospital were full.
- Feedback from patients indicated they had been transferred to Pontefract as part of their package of care.
- Some patients on the medical unit were delayed discharges. They were medically fit for discharge but still an inpatient for a number of reasons: awaiting complex packages of care; further rehabilitation care package, 24 hour care or agreements still to be reached with the funding authority.
- The average length of stay for a patient on the medical unit was about a month, although there was one patient at the time of inspection that had been on the unit for four months and another had been waiting four to five weeks for a care package to be approved.
- We attended a bed management meeting at Pinderfields General Hospital that included the daytime site manager, night site manager, two matrons and the senior manager on-call. It also included, via teleconference, the other hospital sites (Dewsbury and Pontefract) and the executive director who was on-call. The meeting was to try and ensure patient flow throughout the hospital and REAP was discussed.
- The trust was significantly higher (38%) than the England average (21%) for delayed transfer of care while waiting for further NHS non-acute care, but significantly better at completing assessments; 6% delayed compared with the England average of 19%.

Meeting people's individual needs

- The Patient Experience Gap Analysis to Patient Feedback (April 2014) noted that the medicine division had to do," a great deal of work to achieve better patient experience" with regard to people living with dementia.
- The trust had put a dementia programme in place, a 'Forget me not' scheme with an accompanying action plan and was work in progress. Not all wards had implemented the scheme.
- The trust was working towards achieving a nationally agreed dementia CQUIN (Commission for Quality Innovation – a payment reward scheme agreed by local commissioners aimed at encouraging innovation), for which it was required to ensure that patients were identified and assessed on admission with regards to dementia. We saw in the trust Quality account 2013/14 they had improved against the CQUIN target for dementia at 40% for all 3 indicators, although this was still below the national target of 90%.
- There was a plan to improve ward environments for people living with dementia; for example, large clocks with the date and time in each room were being fitted during the inspection.
- Dementia and 'Forget me not' training had commenced across all staff groups, including nurses, housekeepers, diagnostic services, Board members, the Chief Executive and other senior managers.
- We saw a bed and chair alarm in place, which indicated to staff when a patient was trying to get out of bed or their chair so staff could be there to support them.
- The rehabilitation ward encouraged independence. There was a separate dining room and activity room, which patients were encourage to use. There was a newly formed gardening group for patients who were interested.
- The trust had access to interpreters and a telephone interpreting service. People who did not have English as a first language may not always understand the care, treatment and support choices available to them because staff did not always use appropriate interpretation services. Staff often used family or other staff members as interpreters, which might have breached confidentiality in some instances.
- There were no visible leaflets and patient information available in different languages.

Learning from complaints and concerns

- A trust review of complaints from October 2013 to March 2014 identified that there had been across the medicine division 32 high graded complaints.
- There were 103 medium graded complaints across the medicine division and 106 low graded complaints,

including complaints about delays in accessing test results. The trust acknowledged in the review that there been a backlog of test results and that actions had been taken to address this problem.

- Therefore from October 2013 to March 2014 the medicine division had received 241 formal complaints. Analysis showed that the top three were with regard to clinical treatment (166), staff attitude and behaviour (18) and administration/transfer/discharge procedures (15). The category of clinical treatment covered a number of secondary subjects such as poor nursing, clinical care, the delay in treatment, coordination of treatment and falls.
- Changes were introduced in the trust to bring together information about the patients' experience into one integrated report, which was discussed at the 'Learning from patient and staff feedback group' From complaints, and other patient feedback such as surveys and the family and friends test, Patient Experience Improvement Plans were developed. This was a fairly new initiative and incorporated information from other sources such as NHS Choices, compliments, incidents, CQC mock inspections, divisional assurance visits and audit results.
- We found that formal complaints were analysed and reported to the Trust Board, but a great deal of information on quality and the patient experience was received as informal complaints, which were not reported to the Trust Board. This meant that although the information was being correlated, analysed and local action plans developed from these, the Trust Board was not necessarily sighted on the data to help inform decision making.
- Complaints were discussed at the division of medicine monthly governance meeting and there was a weekly tracker in place to improve management of complaints.
- The governance manager kept a log of all complaints. Matrons saw all the complaints. Each complaint was approved by the lead nurse for medicine and signed off by the Chief Executive.
- Staff told us they were informed about the learning from complaints and concerns. Information was disseminated to staff at daily safety briefings or by email. We saw evidence of this.
- Most of the patients we spoke with were not aware of the complaints procedure. The majority of patients and relatives felt that they could raise concerns and were confident that they would be listened to.
- The number of days since the last compliant was displayed at the entrance to each ward.

Are medical care services well-led?

Requires improvement

Leadership throughout the division had lacked stability and direction because of many staff changes. The senior division leadership had all been in post for less than a year and there had been many staff changes over the last year, across all grades. The matron and a senior sister we spoke with on the rehabilitation unit were both new in post.

The senior leadership had a good understanding about their roles within the division and were aware of the risks and developments required to improve patient care. A number of developments were being implemented, but it was too early to say whether they would be effective and sustainable.

The trust had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital.

Patient engagement was improving and there were a number of initiatives in place to further improve engagement with both patients and staff.

Although the division was aware of many of the risks that we identified, we did not feel that these had been adequately addressed at the time of our inspection.

Vision and strategy for this service

- The trust had a clear vision and strategy and this was displayed throughout the hospital.
- Staff on the units were aware of this strategy and the changes to service provision the trust was planning.
- Most staff were aware of the changes that were to be implemented to improve patient flow and experience within acute medicine.

Governance, risk management and quality measurement

- The wards/units used and displayed quality information and the safety thermometer to measure their performance against key indicators. Where wards were consistently falling below the expected levels of performance, action plans were put in place to improve performance and maintain safety.

Medical care (including older people's care)

- There were regular, usually monthly, governance meetings for the division of medicine and the outcome of these was fed back to staff via email, and some wards used newsletters, such as "AAU News", which had started in April 2014.
- There were risk registers at a number of levels within the trust from Board to division. On review of these they identified many of the risks we had identified during our inspection, such as staffing levels. However, we were concerned that improvements not been made despite the trust's awareness. We were also given two different versions of the register during the inspection, which may have led to a lack of clarity as to what the key risks and actions were.

Leadership of service

- Leadership throughout the division had lacked stability and direction because of many staff changes.
- The senior division leadership (clinical director, senior associate division of nursing and associate director of operations, which was an interim role) had all been in post for less than a year. The matron and a senior sister we spoke with on the rehabilitation unit were both new in post.
- The senior leadership had a good understanding about their roles within the division and were aware of the risks and developments required to improve patient care.
- There was a workforce strategic plan for the medicine division.
- Staff and managers told us there had been many staff changes over the last year, across all grades, and this had not been good for developing confidence or accountability within the trust. However, most staff supported their new managers and felt that the recent changes would improve patient care and their work experience.
- Some staff told us they felt the senior leadership was remote because it was based at Pinderfields General Hospital and they rarely saw them.
- There was a management structure in place in the units we visited. Units had a band 7 ward manager.
- Matrons were in post within the division to oversee operational issues and assist with arranging additional staff. Two of the matrons had been recently appointed to the trust. Some matrons covered more than one site.

Culture within the service

- There was good team working on the units between staff of different disciplines and grades.
- Service-level data was not available for specific wards but trust-wide results of the staff survey showed they were lower than the national average; 34% of staff said they were able to provide the care that patients needed and only 40% of staff recommended the trust as a place to receive treatment.

Public and staff engagement

- The trust took part in the friends and family test. Results were displayed at the entrance to each ward.
- There was information in public areas about the Patient Advice and Liaison Service and how to make a complaint.
- The medicine division was using patient stories as a way of trying to improve the quality of care people received and raise awareness of the impact that poor care can have on patients. This was recorded within the governance meeting's minutes.
- The trust had been proactively encouraging and facilitating staff engagement. This had included listening events, which have been held since April 2013. Evaluation of the events indicated that staff were proud of the teams they worked in and the care they gave to patients. The most significant change cited for future developments was the successful recruitment and retention of staff for all clinical areas. Staff noted this was starting to happen and felt this would improve the poor staff morale.

Innovation, improvement and sustainability

- We saw examples of improvements the trust was making to ensure patients received appropriate care and treatment in a timely manner.
- The trust was introducing electronic recording of patient observations. This helped to ensure that key observations were done in a timely manner and enabled both nursing and medical staff to see at a glance whether recordings had been delayed and whether the patient was improving or deteriorating. The system was also audited for effectiveness and we saw examples of this system at Dewsbury, where it was already operational.

Surgery

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

Information about the service

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

We talked with eight patients and 11 members of staff, including ward managers, nursing staff, medical staff (both senior and junior grades) and managers. We observed care and treatment. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Summary of findings

We rated surgical services as good for caring, but improvements were required for safety, effectiveness and being well led. We had serious concerns over the number of patients waiting to be admitted for treatment (the target for the referral to treatment at 18 weeks was not being met) and at times the arrangements for the access and flow of patients on to the wards and in theatres was ineffective.

Surgical areas were clean and there were arrangements in place for the prevention and control of infection. Staffing establishment levels and skill mix across all surgical services were not always sustained at all times of the day and night.

There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and daily checks of equipment were not consistently carried out. Staff awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were limited.

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

Surgery

showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

We observed positive, kind care provided to patients and patients spoke positively about the standard of care they had received.

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue. We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards.

There was good ward leadership and staff felt supported. Some staff reported a 'disconnect' between middle management and themselves, and felt there was a lack of communication and flexibility to support autonomous working. There were changes in management structures and reconfiguration of services that had led to low staff morale, particularly in theatres.

Are surgery services safe?

Requires improvement

There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which were in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

Staffing levels were safe and there was ongoing monitoring to ensure staffing levels were flexible and met the dependency needs of patients.

There were processes in place for staff to recognise and respond to changing risks for patients, including responding to the warning signs of rapid deterioration of a patient's health.

There had been three never events in surgery, two related to retained swabs and the other related to a retained instrument. However, the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completely embedded in theatres and briefings before and after surgery were not consistently taking place.

There was little evidence to show effective use and staff knowledge of the principles of the Mental Capacity Act 2005 and the Deprivation of liberty safeguards.

There were arrangements in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment, although there were gaps in the daily checks for anaesthetic equipment. Care records were completed accurately and clearly.

Appropriate plans were in place to respond to emergencies and major incidents. Staff were aware of their roles and responsibilities in urgent and emergency situations.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. We found staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system, and were encouraged to report them.
- There had been no never events reported at this hospital and no serious incidents relating to surgery. There had been three never events in surgery at other

trust locations, two related to retained swabs and the other related to a retained instrument. We saw serious incident investigations had been undertaken in two cases and one investigation was on-going.
- A safer surgery group had been established and all staff had been made aware of the never events and the learning from them. This included changes to peri-operative documentation and the swab count policy.
- There had been 11 serious incidents reported trust wide for surgical areas during 2013/14. The themes related to areas which included clinical care, management of the deteriorating patient and surgical error. A safer surgery action group had been developed to review all surgical processes and a root cause analysis investigation was being carried out. Root cause analysis is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again.
- Mortality and morbidity meetings were in place in all relevant specialities. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety thermometer information was clearly displayed at the entrance to every surgical ward. This included information about the last time a patient had a fall on the ward, had developed a grade 3 or 4 pressure ulcer, or developed a venous thromboembolism (VTE) or urinary tract infections in patients with catheters.
- The patient safety thermometer showed the service was providing 100% harm-free care.
- Data showed 100% of inpatients had received a VTE risk assessment on admission to hospital. This was against a target of 95%.

Cleanliness, infection control and hygiene

- Ward areas were clean and we saw staff regularly wash their hands between patients and between interventions. Staff were bare below the elbows, in line with trust policy and national guidelines.
- All freestanding equipment in theatres was noted to be covered and dated when cleaned.
- Methicillin-resistant Staphylococcus Aureus (MRSA) rates for the trust were within expected limits. There had been no reported cases of Clostridium difficile for surgical wards at Pontefract.
- Clinical waste bins were covered and had foot opening controls, and the appropriate signs were used for the disposal of clinical waste.
- We saw that in ward areas there were separate hand washing basins, and hand wash and sanitizer were available.
- All elective patients undergoing orthopaedic surgery were screened for MRSA and patients were isolated in accordance with infection control policies.
- Records of a recent environmental audit showed the service was 100% compliant with infection control procedures.
- Nursing staff had received training in Aseptic Non Touch Techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The unit participated in the ongoing surgical site infection audits run by Public Health England. The last published results for October to December 2013 showed there were no surgical site infections relating to hip replacements.

Environment and equipment

- We observed that checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.

Medicines

- Medicines were stored correctly and securely on the wards and theatres.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use, for example, for treatment and care of patients who have suffered from a fractured neck of femur.

Surgery

- The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- We saw in the clinical governance meeting minutes (March 2014) the themes from the trust wide audit on record keeping were shared. It was noted that improvements in countersignature of deletions, alterations, author designation and author printed were needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had been consented appropriately and this was in line with the trust policy and Department of Health guidelines.
- Staff told us mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team. The trust had identified the lack of training in its corporate risk register. An action plan was in place to deliver training to all clinical staff. This meant that staff would not necessarily be working in accordance with the Mental Capacity Act 2005 as they had not received the necessary training.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.
- Compliance with training for adult and children's safeguarding level 1 was 100% across all surgical areas. However, data showed that by May 2014 (Safeguarding Paper May 2014) only 62% of staff had completed level 2 in safeguarding adults training.

Mandatory training

- The performance report for June 2014 showed that 92% of staff in the division of surgery were up to date with their mandatory training.
- Trust data showed approximately 68% of staff in the division of surgery had received yearly resuscitation training. According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates.

Assessing and responding to patient risk

- The surgical wards used the National Early Warning Scoring System, a recognised early warning tool for the management of deteriorating patients.
- There were clear directions for escalation printed on the observation charts and staff were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- We saw a surgical safety checklist re-audit January 2014 had been undertaken. Information showed that of the forms audited at the Pinderfields site 58% had been fully completed. Compliance across the whole trust was 61%.
- We were unable to observe how theatre staff practiced the 'Five steps to Safer Surgery World Health Organisation (WHO) checklist as there were no theatre lists running at the time we inspected the hospital.
- We were told a further audit of the WHO checklist had been undertaken in March 2014 we asked the trust to provide us with the results of the audit but these have not been given to us. An observational audit of the WHO checklist was planned for the end of July 2014.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken by the trust to reassess the staffing levels on wards and the trust was in the process of increasing them. This was to ensure that staffing establishments reflected the acuity or dependency of patients.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster.
- We reviewed the nurse staffing levels on the orthopaedic ward and found that levels complied with the required establishment and skill mix.

Surgery

- In theatres there was a current shortfall in establishment of 23 hours, because of maternity leave, secondments and long-term sickness. Staff told us the shortfall was being covered by permanent staff to ensure safe staffing levels in theatres.
- There was limited use of bank or agency staff.
- Staff told us they were regularly asked to cover staff shortages at Pinderfields General Hospital.

Surgical staffing

- The orthopaedic ward at Pontefract was run by advanced nurse practitioners.
- Medical cover was provided by a resident medical doctor who looked after the whole hospital at night, including stroke, respiratory and renal patients. We were unable to speak to the doctor because they had been called to a crash call in A&E.

Major incident awareness and training

- Business continuity plans for surgery were in place. These included the risks specific to each clinical area and the actions and resources required to support a return to normal services.
- A trust assurance process was in place to ensure compliance with NHS England core standards for Emergency Preparedness, Resilience and Response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Requires improvement

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges. Other indicators showed improvements were required in areas such as patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours, and the number of emergency admissions following elective admissions.

Treatment and care was in accordance with best practice and national guidance. However, improvements were needed over the access to specialist surgery for patients with a fractured neck of femur, the number day cases undertaken and sending out discharge letters to GPs. Patients told us they were well supported by staff. We observed compassionate and caring interactions on the wards.

Evidence-based care and treatment

- Patients were treated based on guidance from the National Institute of Health and Care Excellence, the Association of Anaesthetists of Great Britain & Ireland and the Royal College of Surgeons. We saw in minutes of the clinical governance meetings discussions about NICE guidance. For example, updates were given on revised guidance for negative pressure wound therapy for the open abdomen in the December 2013 meeting.
- Enhanced recovery pathways were used for patients admitted for fractured neck of femur. This was in line with the British Orthopaedic Association and British Geriatrics Society guidelines. Data showed the pre-operative assessment of patients by a geriatrician was better than the England average.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- We looked at examples of local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery. Results showed 100% compliance.

Pain relief

- Pre-planned pain relief was administered for orthopaedic patients who were on the enhanced recovery pathway.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool.

Surgery

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool. When patients were at risk of malnutrition, records showed a referral had been made to the dietician.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied, depending on whether the surgery was in the morning or afternoon.
- Patient-led Assessments of the Care Environment scored the trust 88.7% for food.

Patient outcomes

- There were no current CQC mortality outliers relevant to surgery. This indicated that there had been no more deaths than expected for patients undergoing surgery.
- The trust participated in the National Hip Fracture Audit. Findings from the 2013/14 report showed the trust was better than the expected England average in areas such as patients receiving a bone protection medication assessment, pre-operative assessment by a geriatrician and falls assessment. The trust was worse than the England average for patients being admitted to orthopaedic care within 4 hours and surgery within 48 hours. For example, 80% of patients with a fractured neck of femur were seen within 48 hours compared with the national target of 87%.
- Day case surgery was performed below national expectation in orthopaedics at 55%. The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.
- The average length of stay between December 2012 and November 2013 showed most surgical specialties were better than the national average, with the exceptions of trauma and orthopaedics.

Competent staff

- The trust had a target for the division to achieve 90% compliance for appraisal by the end of the year. Records for April – June 2014 showed that 67% staff in surgery had received an appraisal. The proportion of staff who received an appraisal in the last 12 months was as expected.
- We spoke to staff and observed from the training matrix that appraisals were undertaken annually and there were also informal one-to-one meetings for staff if requested.
- Monthly staff meetings were taking place.

Multidisciplinary working

- We observed effective multidisciplinary working on the wards. There was allocated physiotherapy and occupational therapy support and daily board rounds were carried out with members of the multidisciplinary team.
- Staff told us there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- Communication was sent to the GP electronically on discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken. However, data showed that only 31.1% of discharge letters had been sent electronically to the GP within 24 hours which was below the target of 90%.
- There was also a backlog of un-typed clinical letters over five days. The divisional management team told us training was being provided for clinicians on the electronic discharge system and all urgent and cancer information was marked as a high priority. The management team gave assurances that all urgent letters were being completed within timescales. However, this meant there is a lack of clinical information available for example to the patient's GP. The management team were aware of the impact on patient care in terms of delayed treatment and results not being acted on which they had identified on the divisions risk register with a review date of August 2014.

Seven-day services

- Access to diagnostic services was available seven days a week, for example, x-rays, MRI and CT scans. However, some might have required a transfer of the patient to Pinderfields General Hospital if their condition deteriorated.
- Access to support services such as therapy services varied across the weekend. There was no routine physiotherapist over the weekend. There were two therapy assistants who worked some weekends.
- Dieticians and the speech and language therapy service were based at Pinderfields General Hospital and visited Pontefract Hospital two to three times a week. There was an on-call service, if required, Monday to Friday during the day.

- There was an on-call pharmacist available out of hours. The inpatients pharmacy was open 9am to 5pm Monday to Friday. On Saturday it was open 9am to 12noon and on a Sunday from 10am to 12.30pm. At other times there was an on-call rota for pharmacists.

Are surgery services caring?

Good

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

We observed compassionate and caring interactions on the wards. Staff were aware of the emotional aspects of care for patients and ensured specialist support was provided for patients when needed.

Compassionate care

- Staff provided compassionate care and treated patients with dignity and respect. Patients we spoke with during our inspection were positive about the care and treatment they had received.
- Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment.
- We spoke with four patients. They told us, "The care I get here is perfect"; "could not fault the care"; "the care is excellent, I have no complaints" and "I have received excellent care, they really look after me here."
- We observed nurses speaking to patients in a considerate, professional and respectful way and answering call bells quickly.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes were related to other areas of the trust. The positive themes related to the caring staff across all sites.

Patient understanding and involvement

- We observed that each patient had a named nurse on admission to both the surgical day ward and the orthopaedic surgical ward.
- In the cancer patient experience survey 2013 the trust scored in the highest 20% of trusts for patients being given a choice of different types of treatment. However, the trust scored in the lowest 20% of trusts for how staff had explained how the operation had gone in an understandable way
- All patients we spoke with said they were made fully aware of the surgery that they were going to have undertaken and this had been explained to them.

Emotional support

- Assessments for anxiety and depression were done at the three-month pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and post-operatively.

Are surgery services responsive?

Requires improvement

Surgery had systems in place to plan and deliver services to meet the needs of local people. The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.

We found that staff were responsive to people's individual needs, but that there were serious concerns over waiting times, such as the 18-week referral to treatment times, waiting for care once in hospital and the high number of medical outliers on surgical wards.

Services were available to support patients, particularly those who lacked capacity to access the services they needed. Support was available for patients living with dementia and learning disabilities.

Information about the trust's complaints procedure was available for patients and their relatives. There was some evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The trust had an escalation and surge policy and procedure to deal with busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.

- Capacity bed meetings were held daily to monitor bed availability in the hospital; they reviewed planned discharge data to assess future bed availability.
- During high patient capacity and demand, elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- The orthopaedic team performed a high number of hip and knee replacements in response to the needs of the local population.

Access and flow

- A pre-assessment meeting was held with the patient three months before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage.
- Patients requiring assistance from social services on discharge from the surgical day and orthopaedic ward were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- Over the previous year there had been an issue with referral to treatment times. The patient safety dashboard meeting minutes (June 2013) stated that 86.5% of the admitted pathways completed in June 2013 were completed within 18 weeks against the 90% target. In a patient context, this meant that of the 3,158 admitted pathways completed in June 2013, 426 were over 18 weeks. Of this 426, 316 were permitted in line with the national 90% tolerance. We saw this theme continued and in meeting minutes from the Clinical Executive G group (CEG) on 20 November 2013 a robust recovery plan for ENT had been put in place. However at the time of our inspection we saw the trust was still not meeting the national 18-week maximum waiting time in orthopaedics, ENT, ophthalmology and urology. A recovery plan was in place including the use of waiting list initiatives to reduce the number of patients waiting by September 2014.
- The trust reported 304 last minute planned operations cancelled for non-clinical reasons. One patient was not treated within 28 days of a cancelled procedure. The trust was better than the expected targets in these areas.
- Information about patients requiring home care packages were sent to the hospital social work team at the time the patient was admitted. The hospital social worker team visited the patient before discharge to undertake an assessment of their needs in line with the requirements of the NHS and Community Care Act 1990. This ensured discharge arrangements met the needs of patients in more vulnerable circumstances, for example those with no support at home.

Meeting people's individual needs

- The service was responsive to the needs of patients with a learning disability. The unit had a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- There were dedicated theatre lists for vulnerable patients and they were encouraged to visit the ward with their carers before surgery. They could remain in their own clothes if this helped to reduce anxiety.
- Patients with learning disabilities were provided with a VIP hospital passport. This document held all the relevant individual patient health details and personal choices, for use when they were unable to tell medical and nursing staff themselves.
- Information leaflets were available in a pictorial and easy-read format and described what to expect when undergoing surgery and post-operative care.
- The surgical units had access to an interpreter if required. Requests for interpreter services were identified at the pre-assessment meeting.
- There was access to an independent mental capacity advocate for when best interest decision meetings were required.
- There was a multi-faith centre in the hospital that patients can access.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.
- The trust had introduced patient experience improvement plans to address themes and share learning from complaints, these were discussed at the Learning from Patient and Staff Feedback Group. Each ward/department had their own plan to address issues raised from complaints and these were monitored through the Patient and Staff Feedback Group.

- Complaints management information formed part of the chief nurse report to the Trust Board and included the number and grading of complaints, trends by division, the latest performance data and examples of service improvements.
- Complaints and concerns were discussed at monthly staff meetings where training needs and learning were identified as appropriate.
- If patients or their relatives needed help or assistance with making a complaint, the Independent Complaints Advocacy Services contact details were visible in the wards and throughout the hospital.
- The unit at Pontefract Hospital had not received any formal complaints for over a year.

Are surgery services well-led?

Requires improvement

The trust's vision, values and strategy had been cascaded to wards and departments. Some staff had a clear understanding of what these involved, but this was not the case in all surgical areas.

Risks at team and divisional level were identified and captured. There was some alignment between the risks on the risk register and what individuals said were on their worry list. However we saw some action plans were not fully implemented.

The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust's values and objectives had been cascaded across the surgical wards and were visible on ward areas. Some staff had a clear understanding of what these involved.

Governance, risk management and quality measurement

- The division of surgery held monthly governance meetings. The meeting minutes showed complaints, incidents, audits and quality improvement projects were discussed and action taken where required, including feedback to staff about their individual practice.
- We saw an action plan had been developed as a result of three never events in the division of surgery. In the report on the actions 7 May 2014 we saw the division believed three out of the five steps to safer surgery were being undertaken. The safer surgery group agreed that they would oversee the implementation of steps one and five whilst improving compliance with steps two to four. We saw this action had been due to be completed by the 26 March 2014 and this was being reported as incomplete. It was unclear from the action plan when the division anticipated this would be completed and all the steps implemented.
- The safer surgery group monitored action plans for never events and managed subgroups tasked with implementing elements of the action plan. Minutes dated May 2014 showed changes had been made to the swab count policy and perioperative pathway.
- We saw in March 2014 the division had developed an action plan for CQC compliance. On that we noted the division had identified issues in relation to not all wards having adequate staffing levels for service provision on the days the mock inspections had been undertaken. However we noted at the time of our inspection on some wards staffing levels still failed to meet minimum safe staffing levels.
- Risks at division level were identified and captured. There was some alignment between the risks on the risk register and what staff said was on their worry list. However we saw in some action plans were not fully implemented.
- The surgical safety checklist re-audit January 2014 concluded that over sequential audits "full form completion" levels had not improved and, in numerous sections, evidence of a reduction in full completion had been found. This meant actions put in place to address this had not managed to sustain improvements in practice.

Leadership of service

- Staff told us that the leadership of the service up to matron level was good. They said there was good staff morale and they felt supported at ward level.

Surgery

- Staff commented that senior staff were based at Pinderfields and weren't very accessible; this made some staff on the Pontefract site feel less involved.
- Staff raised concerns that they were regularly taken off the day surgery unit to cover staff shortages at Pinderfields General Hospital. This was on average once a week and staff felt that this was not always reciprocated across sites.
- Some staff did not feel respected or valued. They told us they had raised concerns about not wanting to work on different wards because they didn't have the specialist skills to work in areas such as the stroke unit, but they felt these concerns had been ignored.
- Staff told us there was limited engagement and visibility of the Chief Executive and the Board of Directors at the Pontefract site.

Culture within the service

- Staff reported an open and transparent culture on the surgical wards. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on. However this was not the case for issues that were escalated above ward level.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.

Public and staff engagement

- The NHS staff survey data showed the trust scored as expected in 11 out of 28 areas and better than expected in one area. There were negative findings in areas such as staff engagement, communication with senior management, job satisfaction and work pressures.
- The friends and family test showed 95% of patients attending Pontefract were extremely likely or likely to recommend the service to their family and friends.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audit and learning from incidents, complaints and accidents.
- Evidence showed staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the provision of care and treatment for patients with learning disabilities. This work had been recognised by the trust as good practice and was being championed across the hospital sites.

Maternity and gynaecology

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides women's services over three sites. There are obstetric consultant-led units at Dewsbury District Hospital and Pinderfields General Hospital, and a midwife-led unit at Pontefract General Hospital. There are community midwifery services across all sites. The service includes early pregnancy care, antenatal, intrapartum and postnatal care.

During 2013 the Pontefract midwife-led unit had 328 births in the unit and 78 home births. Between January and June 2014 there were 143 births in the unit and 70 home births.

The inspection of Pontefract Hospital included the antenatal day unit, antenatal clinic and the birthing unit (which had four en-suite rooms). We spoke with one woman and partner who used the service and 13 staff, including midwives and senior managers. We also held meetings with midwives and community staff to hear their views of the service they provide. We inspected one set of patient care records and reviewed the trust's audits and performance data.

Summary of findings

We rated the maternity service as good for effectiveness, being responsive and caring, but improvements were required for safety and well led. Maternity areas were clean and there were effective systems in place to monitor infection control. There was an incident reporting mechanism in place and lessons learnt from investigations were shared. However, staffing levels did not meet best practice national guidance. Records were not consistently completed and updated.

Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31. Community midwifery ratios were 1 midwife to 127-133 women which exceeded best practice guidance of 1:100.

We found staff did not always check emergency equipment daily to ensure it was available in the event of an emergency situation.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were

Maternity and gynaecology

obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

Staff were reported as kind and understanding. The service ensured women received accessible, individualised care, while respecting their needs and wishes.

The service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives.

An external review had been commissioned as there had been a cluster of eight serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

Are maternity and gynaecology services safe?

Requires improvement

The unit was clean and well maintained. There were effective systems in place to monitor infection control.

Where incidents had been identified, staff had been made aware and action was taken. Between January 2013 and January 2014 there were eight reported serious incidents across the trust in women's services. We saw these related to the monitoring of care and treatment of women in early pregnancy, the antenatal period, labour and delivery.

Medical and midwifery staff reported delays in recruitment processes trust-wide and this included anaesthetists. We found the birth to midwife ratio was 1:33; the national guidance was 1:28. We were informed that 13 midwife appointments had been made the previous week and would be in post by October 2014, which would bring the birth to midwife ratio down to a ratio of 1:31. Community midwifery ratios were 1 midwife to 127-133 women which exceeded best practice guidance of 1:100.

Incidents

- Between January 2013 and January 2014 there were eight reported serious incidents across the trust in women's services. We saw these related to the monitoring of care and treatment of women in early pregnancy, the antenatal period, labour and delivery.
- A root cause analysis (RCA) is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again. A RCA had taken place in all cases, which highlighted lessons learnt and contributing factors. An action plan summary was shared with all staff, together with the completed and planned actions. Additionally, we saw information which showed staff received updates regarding guidelines, which had been introduced or changed to ensure staff were kept informed and patients received safe care. For example, we saw updated guidelines for antenatal screening for obesity.
- Staff stated they were encouraged to report incidents. We saw they received weekly patient safety bulletins, which were designed to rapidly disseminate learning

from incidents or other concerns that had occurred within the trust. We also saw a newsletter; 'Maternity Measured' (Issue 1, June 2014) had recently been introduced. This also aimed to make positive changes by sharing information and learning from incidents and risks to improve patient safety and care.

- We saw information in the 'Maternity Measured' newsletter which indicated not all incidents had been logged on the incident reporting system. For example the newsletter highlights that the number of Postpartum Haemorrhages incidents, where the amount of blood loss was not considered significant, was lower on the incident reporting system than those highlighted on the clinical records system. This may mean that not all incidents were being reported by the appropriate system. One of the eight serious incidents related to a woman who suffered a Postpartum Haemorrhage.
- Additionally, staff received a bi-monthly, lessons learnt from incidents in obstetrics and maternity feedback. We saw from the staff feedback from the 16 to 30 June 2014; there had been 117 reported incidents, with no moderate ones reported in this period. Information included when areas were short staffed /or there were a lack of suitably qualified trained staff and details of changes made from lessons learnt. Additionally, we were told, 'As a quick fix' and 'Short term' when the staff handovers took place if something became evident; it was added to the safety brief for staff.
- We also saw a newsletter; 'Maternity Measured' (Issue 1, June 2014) had recently been introduced. This also aimed to make positive changes by sharing information and learning from incidents and risks to improve patient safety and care.
- Multi-professional perinatal mortality and morbidity meetings took place monthly. Midwifery and medical staff were encouraged to attend and the venue changed between the three sites to encourage attendance.

Cleanliness, infection control and hygiene

- The maternity unit was visibly clean and all staff reported they had infection control training. Trust policies were adhered to in relation to infection control; these included staff washing their hands, the use of hand gel and the bare below the elbow dress code.
- Between April and June 2014, an audit was carried out each month for compliance on staff hand washing across women's services in Dewsbury, Pinderfields and Pontefract. They met their target of 98%.
- The trust integrated performance report dated May/ June 2014, reported no incidents of MRSA or Clostridium difficile infection between January and July 2014.
- We saw equipment had stickers on it showing it had been cleaned and this included portable electrical equipment.

Environment and equipment

- The environment in the maternity unit was secure. The birthing unit had a separate locked entrance and entry was via an intercom system controlled by the staff on duty.
- There were four large birthing rooms, each equipped to provide a less clinical environment in which low-risk women could give birth.
- One room contained a birthing pool and women were encouraged to bring into the unit their own music to play during their stay.
- Each birthing room had appropriate emergency neonatal resuscitation equipment and an adult resuscitation trolley was also available. We saw the equipment was cleaned and checked daily and records had been completed consistently.
- We saw equipment was available to meet people's needs, such as Entonox and piped oxygen in each birthing room.

Medicines

- We inspected the medicines in the birthing unit and antenatal clinic and found they were stored correctly. Appropriate daily checks of controlled drugs on the birthing unit were carried out.
- The temperature of the refrigerator located in the antenatal clinic (where the whooping cough vaccine was stored) had not been recorded daily as per medicines guidance. The temperature had been recorded on 17 and 19 June, 1, 8 and 10 July 2014. This was discussed with staff at the time of the inspection. The lack of recording on Wednesdays was because the clinic did not run on that day. Staff told us they would ensure when the clinic operated that daily temperatures would be recorded. Satisfactory temperatures were seen for the days recorded; between 4.2 and 4.8°C (normal range is between 2 and 8°C).

Maternity and gynaecology

Records

- We looked at one set of care records; they were in paper format and of a good standard of record keeping. When not in use we saw they were kept safe in line with data protection. We also saw the use of national, antenatal hand-held notes.
- Information provided by the trust in July 2014 showed an audit had taken place of seven sets of antenatal hand-held records, and eight sets of intrapartum and postnatal records. The results showed documentation had been completed appropriately.

Safeguarding

- The trust had a safeguarding lead who was also a midwife. They were employed to provide safeguarding training in both adults and children. We were told that training at safeguarding children level three had been given to all community midwives and the band 7 midwives across the service. This met with trust guidance and was in agreement with the local safeguarding children's board. We were told by staff each community midwife had eight hours safeguarding supervision each year; three group sessions all of which were face to face. These were all rostered in advance and monitored by the individual community managers.
- Staff we spoke with knew the procedure for reporting allegations or suspected incidents of abuse, including adults and children and staff members we spoke with confirmed they had received training.

Mandatory training

- Staff told us they were up to date with mandatory training. This included attending annual cardiac and pulmonary resuscitation training and training specific to their role. The trust provided us with information about women's service training across the trust. Figures for 2014 showed 216 out of 279 staff had attended annual adult resuscitation training and 73 out of 90 have attended the three-yearly training. 100% of staff had received health and safety, safeguarding adults and children's training and 94.44% of staff had completed venous thromboembolism training.
- Midwives reported not all staff had been trained in advanced neonatal life support. Further places had been arranged for staff to have this training. Healthcare assistants were not currently offered neonatal resuscitation training, which concerned them because they often assisted the midwives at births.
- Midwives reported a number of mandatory training modules took place online. Staff who attended the focus group said they had to complete the training in their own time; trust managers told us that staff got this time back. We were also told mandatory courses were booked for staff via their electronic staff roster (e-roster) and sometimes this was on their days off; the training was arranged with their consent and they were paid for their time.
- The trust had trainers in obstetric emergencies and the staff confirmed they had training every year and involved all members of the multi-professional team. An example of obstetric emergency training included cord prolapse.
- Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and support.

Assessing and responding to patient risk

- The unit used the Modified Obstetric Early Warning Scoring to manage deteriorating patients. We saw the tool had been used correctly in the one set of records we inspected and the information had been escalated appropriately.
- Where patients needed consultant-led care there was an appropriate transfer procedure in place. Staff confirmed the procedure included arrangements for transportation by ambulance. This also included having a neonatal 'pod' for safe transfer of neonates to a consultant-led unit.

Midwifery staffing

- There was a part-time band 7 midwife in post who had managerial responsibility for the birthing unit.
- The executive summary of the meeting of the trust executive board (June 2014) showed they discussed safe staffing levels and what they needed to achieve to ensure compliance with the new guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' (NHS Quality Board, November 2013). This included using evidence-based tools to describe staff capacity and capability and submitting a report to be discussed at the trust board every six months. The board report would contain details of reviews and actions taken to meet the recent guidance, including updates on actual staff versus

planned staffing levels shift by shift; impact on quality and safety; reasons for shortfalls, impact and action taken. Safe staffing levels were also reported on the trust's corporate risk register.

- The midwife to mother ratio across the midwifery service was published at 1:33, the national guidance being 1:28. Evidence shows that achieving a 1:28 ratio ensures a midwifery service will be able to provide 1-1 care in labour to mothers and meet the dependencies of all mothers; accessing care in pregnancy, childbirth and the postnatal period. When the ratio of 1:28 midwife to mothers is not achieved services risk not being able to provide safe and appropriate care to women. Staff were aware 13 midwife appointments had been made the previous week and there were further plans to address shortfalls with funding having been approved to recruit five more midwives.
- The midwives in the community reported their caseloads to be 1 midwife to 123-137 mothers' national guidance states the ratio should be 1 midwife to 100 women.
- Staff told us they worked flexibly between community and the unit to cover the service. They told us the trust had introduced flexible retirement, which had been successfully supported. They also told us the staff at Pontefract supported each other and although there were staff shortages they maintained safe levels of care through everyone working together and covering shifts as needed The unit had 1.4 WTE staff on sick leave and staff told us they were covering these people's shifts.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed roster. Staff in each area we inspected were aware of the protocol and in the antenatal clinic we were shown how the computerised system was used to complete the incident documentation when they had a shortage of staff. Community staff told us there were occasions when the delivery suite was short staffed that they had been asked to work there. Staff also reported cross department/site team working when needed to address shortfalls.
- Figures provided by the Local Supervising Authority in their annual audit report, 'Monitoring the Standards of Supervision & Midwifery Practice' (October 2013) gave the ratio of supervisors of midwives to midwives as 1:16, the national guidance being 1:15. We were informed there were four midwives in training to be supervisors and this would bring the ratio to the expected level.

Medical staffing

- Consultant-led antenatal clinics took place at the Pontefract site on Monday, Tuesday, Thursday and Friday. This enabled mothers planning to have their babies at Dewsbury or Pinderfields Hospitals to have antenatal care closer to their home.
- One clinic session every three weeks was carried out by a midwife consultant for normality, where advice and care is given to women whose clinical condition may currently exclude them from midwife-led care to ensure their pregnancy choices are explored.

Major incident awareness and training

We saw a live obstetric drill (major obstetric haemorrhage drill) had taken place in the birthing unit in May 2014. We saw recommendations from the drill had been made and changes requested to help organise the team better in the event of an emergency.

Staff attended Yorkshire Medical Emergency Training, which was jointly attended by clinicians and midwives and included scenarios such as what action to take in the event of a cord prolapse.

Are maternity and gynaecology services effective?

Good

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure staff followed recognised national guidance. However we saw information in the external review of midwifery services from May 2014 three of the serious incident cases reviewed involved women who were obese or morbidly obese, and one was overweight. It was apparent the management of obesity in the cases reviewed was not managed in line with national guidance.

The service had weekly information updates, which informed staff about new guidance to ensure they were up to date with best practice.

Maternity and gynaecology

The trust and community service had achieved the baby friendly, UNICEF Award Level 3. 25 new breastfeeding champions had been identified and peer support training had commenced (July 2014) and supported breast feeding in these areas. Breast feeding figures provided by the trust showed that whilst they were not meeting national targets but there was an upward trend of mother's breast feeding at delivery

Multidisciplinary working took place across the trust and encouraged an integrated approach to the services provided. There was a Maternity Service Liaison Committee (MSLC). The group discussed maternity provision across the trust and included service managers, providers and funders, as well as local representatives from children's and parent services.

Evidence-based care and treatment

- The maternity unit used a combination of NICE and Royal College of Obstetricians and Gynaecologists guidelines (such as 'safer childbirth: minimum standards for the organisation and delivery of care in labour').
- The trust provided us with examples of audits carried out during the year, which included using the National Early Warning Score to monitor deteriorating patients. The audits of these records for July 2014 showed they had been completed appropriately.
- The National Neonatal Audit Programme 2012 showed 100% of babies had their temperature checked within the first hour of delivery.
- In April and June 2014, 16.9% and 20.7% of women were smoking in pregnancy at delivery, which was meeting the trust target of less than 23% (national average 19%).
- Women in Wakefield and Kirklees were offered a choice of midwife-led care or consultant-led care based on their clinical need. The majority of antenatal care was carried out in the community setting with input from appropriate professionals as required. This may include community midwives, general practitioners, consultant obstetricians and other specialists such as dieticians and diabetic consultants.
- Community midwives were attached to GP surgeries and this enabled them to see the same women and offer continuity of care in pregnancy.

Pain relief

- Pain relief was available for mothers in labour and this included Entonox, TENS therapy and opiates.

Nutrition and hydration

- We saw drinking machines in the antenatal clinic waiting room for women and families.

Breastfeeding

- Breast feeding figures provided by the trust showed that whilst they were not meeting national targets, there was an upward trend of mother's breast feeding at delivery. Between April and June 2014 figures showed 56.3% to 60.3% of mothers were breastfeeding at delivery. The national target was 75%. The trust had an action plan as to how they would address the shortfalls.

The trust and community service had achieved the baby friendly, UNICEF Award Level 3.25 new breastfeeding champions had been identified and peer support training had commenced (July 2014) and supported breast feeding in these areas.

Patient outcomes

- In 2013 there were 328 births in the midwife-led unit and 78 home births. Between January and June 2014 there were 143 births in the midwife-led unit and 70 home births.
- Approximately 100 women were transferred to Pinderfields Hospital delivery suite from the Pontefract birthing unit each year. This is within expected levels for a midwife-led unit.
- The maternity service had seven serious incidents since January 2013, with six occurring between November 2013 and January 2014. In addition to an internal inquiry, an external review was commissioned. The service had been proactive in reviewing its practices and guidelines ahead of the external review and changes have been made where the need for improvements had already been identified.

Competent staff

- Midwives had statutory supervision of their practice and access to a supervisor of midwives for advice and support. There was a supervisor of midwives on-call for every 24-hour period who was contactable by a mobile phone that was handed over from one supervisor to another. Midwives were aware of how to contact the supervisor on-call.
- Midwives we spoke with all reported having had an annual review within the last 12 months.

Maternity and gynaecology

Multidisciplinary working

- Multidisciplinary working took place across the trust and encouraged an integrated approach to the services provided.
- Recent rotation of midwifery and support staff between the three maternity units, including the birthing unit at Pontefract, had been successfully introduced. This was in preparation for the relocation of consultant-led services from Dewsbury to Pinderfields Hospital. Staff reported that this had improved both working relationships and clinical skills.
- We saw clinical governance meetings took place and people who were involved in those meetings included consultants in obstetrics, gynaecology, urology and midwifery, the clinical governance midwife, governance midwife and audit facilitators. Areas discussed included complaints and serious incidents.
- There was a Maternity Service Liaison Committee (MSLC). The group discussed maternity provision across the trust and included service managers, providers and funders, as well as local representatives from children's and parent services.
- Staff reported midwives and doctors worked closely and the consultant staff were very approachable.
- The antenatal clinics were also attended by specialist midwives such as the drug liaison midwife and the young women's midwife.
- Frequent communication with the ambulance service took place to ensure they continued to provide a rapid response service.

Seven-day services

The midwife-led unit operated 24 hours a day, seven days a week.

Are maternity and gynaecology services caring?

Good

Pontefract Hospital maternity unit provided compassionate individualised care to people visiting the service and people were treated with privacy, dignity and respect. We saw letters and cards of appreciation and positive comments about people's experience of the unit.

The trust used a national survey to find out about the experiences of people who received care and treatment.

The National Patient Survey 2013 showed positive responses for partners being involved in labour. Midwives had received bereavement training and the trust was advertising to appoint a midwife specialised in this area.

The trust had a community midwife who had developed advanced skills in listening and worked in a specialist role offering support to women with mental health issues. The midwife was trained in cognitive behaviour therapy. We were told that all staff had received bereavement training and the trust was advertising to appoint a midwife specialised in this area.

Compassionate care

- The birthing unit encouraged birth partners to accompany and stay with women when they were in labour.
- Women received one to one care and support in labour. A service audit had taken place and showed 90% compliance with this.
- Throughout our inspection we witnessed women being treated with compassion, dignity and respect.
- We observed three staff members talking to mothers on the telephone. The staff were kind, caring and helpful and gave the mothers support and advice.
- We saw photos, letters and cards with positive comments about people's experience of the unit.
- The trust used a national survey to find out about the experiences of people who received care and treatment. During summer 2013, a questionnaire was sent to all women who gave birth in February 2013 and 195 responses were received. People were asked to answer questions about different aspects of their care and treatment. Based on their responses, each NHS trust was given a score out of 10 for each question (the higher the score, the better). Each trust also received a rating of 'Better', 'About the same' or 'Worse'. For being involved enough in decisions about their care during labour and birth, The Mid Yorkshire Hospitals NHS Trust scored 9 out of 10 (average compared with other trusts). For feeling they were treated with kindness and understanding by staff after the birth, the trust scored 8 out of 10 (above average compared with other trusts).
- In the 2013 trust survey, 95% of women stated that, when they were in labour, their partner or someone else close to them was involved in their care as much as they wanted.

- The survey showed that 88.7% of women had skin-to skin-contact (baby naked, directly on their chest or tummy) with their baby shortly after the birth.
- Postnatal visiting by the community midwives sometimes exceeded that recommended in NICE guidelines. However, staff reported the visits were based on the individual clinical and emotional needs of the mother and baby.

Patient understanding and involvement

- People reported in the survey that they had been involved in decisions regarding their choice of birth location and were informed of the risks and benefits of each.
- Friends and family test results for June showed 100% of patients would recommend the service.

Emotional support

- The trust had a community midwife who had developed advanced skills in listening and worked in a specialist role offering support to women with mental health issues. The midwife was trained in cognitive behaviour therapy. A pre-conception, pregnancy and postnatal service was offered to women with anxiety- and stress-related conditions. An example was given where a mother with a needle phobia was seen and successfully counselled before pregnancy. By the time she was using maternity services, she was able to have blood tests performed. This was an example of where midwives have been supported in developing an innovation in midwifery practices that benefited mothers. The trust also offered a debriefing discussion with the community midwife, with the option of referral to a more senior midwife if required.
- We were told that all staff had received bereavement training and the trust was advertising to appoint a midwife specialised in this area. Written information about bereavement services and support was available. The information could be provided in different languages on request. We were also told translation services would be arranged when needed.
- We saw a chapel and Muslim prayer room were available in the hospital.

Are maternity and gynaecology services responsive?

Good

The service was responsive and ensured women received accessible, individual care while respecting their needs and wishes. Staff rotated between Pinderfields and Dewsbury maternity units. This ensured they had the knowledge and skills to work in different areas/locations if they were needed. Staff also worked flexibly between units when there were staff shortages.

We saw multidisciplinary working to meet the needs of patient groups in relation to a young women's team of midwives to support women under the age of 19.

A reconfiguration of women's and children's services was due to be completed 2016 and would provide a service to meet the needs of the local population. When concerns or complaints had been identified, they were dealt with quickly and changes made, if appropriate.

We saw there was a complaints leaflet and clear instructions on how to make a complaint or express appreciation. The information included what to do if people were not happy with the response from the trust, and how to contact the Patient Advice and Liaison Service.

Service planning and delivery to meet the needs of local people

- Information provided for women wishing to use the service stated that women with uncomplicated pregnancies and with no history of other medical conditions can be cared for in the unit. The decision to go to the unit can be made at any time during pregnancy or when the women are in labour at home.
- The trust had an escalation policy to deal with busy times and staff shortages. Staff worked flexibly between delivery and the community and across the trust to meet staff shortages and service needs. 13 midwives had been appointed to address staffing shortfalls.

Access and flow.

- There was continuity of care in the antenatal period because community midwives were general practice-based and had their own caseloads of women. (The same midwives could see the person throughout their pregnancy and delivery.)

Maternity and gynaecology

- The birthing unit was staffed by midwives and rosters were developed to provide two midwives and a healthcare assistant on the day and night shift each day. Community midwives participated in the roster for the unit.
- There was a care pathway if a women needed to be transferred to consultant-led care. We were told by staff the transfer time was 20–25 minutes.
- An hourly, free bus service begins in July 2014, taking visitors and patients between Dewsbury, Pontefract and Pinderfields Hospitals, seven days a week.

Meeting people's individual needs

- A team of specialist midwives had been developed to care for young women aged under 19 and who had particular clinical or social needs. Based on risk assessment, vulnerable young women were cared for by one of three midwives who provided individualised care to approximately 70 women a year. An audit of this service had been undertaken and was awaiting publication.
- We saw a drug liaison midwife was employed by the trust.
- Interpreters were readily available and staff reported they were able to book interpreters or accessing their services
- Active birth classes were provided to women to encourage a normal birth philosophy.
- Birthing pools were available for use in the community. Funded by the trust, this was an initiative that came directly from user involvement through the Wakefield Maternity Services Liaison Committee.

Learning from complaints and concerns

- We saw there was a complaints leaflet and clear instructions on how to make a complaint or express appreciation. The information included what to do if people were not happy with the response from the trust, and how to contact the Patient Advice and Liaison Service.
- There had been seven complaints between March and May 2014. We saw concerns and complaints were listened to and investigated within three days, meeting the 100% trust target. Outcomes of investigations, lessons learned and changes to practice were disseminated to staff in the form of bulletins, newsletters, meeting and emails.

Are maternity and gynaecology services well-led?

Requires improvement

In March 2014 women's services were placed into one directorate and they had a clear strategy and vision for the changes that were to take place over the next few years. We found the service was well-led at unit level and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of service. However, there were mixed messages about how open the culture was within the leadership team and staff sometimes felt senior managers were not always visible.

An external review had been commissioned as there had been a cluster of serious incidents in a short space of time. Concerns previously raised in 2011 and 2012 had resulted in a number of actions; it was not clear how these actions had been monitored by the trust to ensure the service had acted on identified concerns and sustained improvements in practice.

The midwife to mother's ratios were above national guidance at one midwife to 33 mothers. The trust was aiming to improve this with recruitment to one midwife to 31 mothers' national guidance states this ratio should be one to 28. Community midwives were also working outside of national guidance of one midwife to 100 mothers. When the midwife to mothers ratios are not achieved services risk not being able to provide safe and appropriate care to women. We were unable to establish the rationale from the trust as to why the service was not aiming to achieve best practice in relation to national guidance.

Staff reported that they had several changes in managers in the last five years, with more changes planned in the near future. There were a number of senior clinical and managerial staff in interim or acting positions, which had affected the availability of clinical staff, particularly midwives. There were fewer midwifery management positions above band 7 than would have been expected for a service of this size, leading to additional responsibility being placed on senior clinical staff.

Maternity and gynaecology

Vision and strategy for this service

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

Governance, risk management and quality measurement

- We saw information in the Quality Committee minutes (14 February 2014), which stated an external review of the serious incidents in maternity had been commissioned as there had been a cluster of serious incidents in a short space of time. Depending on the findings of the review the investigators would look at action plans from a previous review carried out in 2011 and the CQC report in 2012, which also raised concerns. The director of nursing confirmed action plans from these had been delivered at the time but there may be an issue with actions not being sustained. It was not clear how these actions were monitored by the trust to ensure the service had acted on concerns and sustained safe practices.
- We looked at the report of the external review of maternity services in May 2014. The objectives of the review indicated the investigators would investigate whether recommendations made by the 2011 review of maternity services had been successfully implemented and had improved practice. We could not see any information in the report which indicated whether the trust had acted on the recommendations from the previous review. This meant the service could not demonstrate they learned from incidents and changed practices to ensure patients received safe care.
- The external review of maternity services 2014 highlighted that the trust must be assured that there was a robust system for the review, development and writing of clinical guidelines based on the most up to date available evidence. For example at the time of the serious incidents the obesity guideline was out of date, and did not reflect national standards. It had since been amended, and approved by the trust.
- The review also found the investigations of the serious incidents did not always identify the root cause and specific learning points were not always identified in the learning points.
- The governance committee for the maternity service met monthly. We looked at the minutes for May 2014 and saw agenda items covered areas such as accidents, access to appointments, admission, transfer and discharge. We saw actions taken to address shortfalls and lessons learned.
- The midwife to mother's ratios were above national guidance at one midwife to 33 mothers. The trust was aiming to improve this with recruitment to one midwife to 31 mothers' national guidance states this ratio should be one to 28. Community midwives were also working outside of national guidance of one midwife to 100 mothers. When the midwife to mothers ratios are not achieved services risk not being able to provide safe and appropriate care to women. We were unable to establish the rationale from the trust as to why the service was not aiming to achieve best practice in relation to national guidance.
- The women's quality and performance meeting occurred monthly. We looked at the minutes for April 2014. We saw heads of wards and department were included in the meeting and were updated on management changes across the trust. This included the appointment of an interim Director of Clinical Services for Women's & Children's, who would be in post by May 2014. Other areas of discussion included the recruitment process, consultant updates and staffing. The trust had a risk register identifying areas of concern, actions and timescales of implementation.
- Team leaders demonstrated awareness of governance arrangements. They detailed actions taken to monitor patient safety and risk. Staff were aware of their responsibility to report incidents. Root cause analysis into serious incidents occurred and provided learning points for staff. For example, in the case with postpartum haemorrhage, analysis found assistance was not sought early enough on recognition of a heavy bleed. The recommendations were to use a pro-forma to aid clinical consistency and act as an aid memoire to promote clear documentation and instructions. We saw evidence the pro-forma had been used as recommended in records we inspected.

Maternity and gynaecology

Leadership of service

- In March 2014 women's and children's services were placed into one directorate. We were told this was in response to a number of serious incidents within maternity services. Interim senior management posts were developed.
- Staff told us they were informed that the previous head of midwifery had been released for a secondment opportunity and an interim head of midwifery had taken her place. This person had previously held the position of consultant midwife for normality for the service.
- The team leaders demonstrated awareness of governance arrangements. They detailed actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits.
- A sample of meeting minutes from March and May 2014 showed the community team manager held meetings with their staff. The information showed not only did the manager report on incidents and updates, they praised staff for their work and congratulated them on achievements. Staff told us they felt valued.

Culture within the service

- The staff told us they felt listened to and supported by their line managers. They also told us, although it was 'early days', the new head of midwifery was very supportive and they were hopeful the culture would change. The staff survey showed staff felt under appreciated. We were told actions had been implemented, with additional staff being recruited and increased communication, so there was now a very different culture. Staff told us local leadership was good.
- Staff told us they could raise concerns and they felt they would be dealt with appropriately, and this included whistle-blowing. Staff also told us they would recommend this unit as a place to work.

Public and staff engagement

- At a meeting of the West Yorkshire Combined Authority, a service that gives people a chance to give their views on proposals to reconfigure hospital services, people expressed their views of needing a convenient, reliable way of traveling between the trust's three hospital sites. As a result of that meeting, a free bus service for patients and visitors was set up.
- The MSLC consists of a group of lay and professional people who meet regularly to discuss local maternity service provision. Mid Yorkshire is served by two MSLCs, one based in Wakefield, the other in Dewsbury, serving different demographic profiles. Senior staff demonstrated good engagement with the MSLCs and identified areas where innovative work was taking place to improve engagement with low socio-economic groups through liaison with existing support groups.
- We saw staff received a 'MY Bulletin' and were kept up to date with guidance, changes to practice and updates of information within the trust. We saw the bulletin referred to the Pulse check deadline and reminded staff to complete the staff questionnaire to provide a snapshot of how they were feeling at a given moment in time.

Innovation, improvement and sustainability

- A Teenage Pregnancy Service was available for people under 19years of age. We saw from the clinical practice care pathway relating to this service, they followed NICE guidance. The role was introduced as a flexible, accessible service to support vulnerable young women in conjunction with other health providers and other external support services across the trust.
- Baby Friendly UNICEF award level three had been achieved across the trust and community service. The award is based on evidence-based standards, designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.
- One of the ward managers had developed a 'Glimpses of Brilliance' list, in which they collated positive comments received through the friends and family test and compliments given by mothers in letters or thank you cards. The list was available in clinical areas for staff and visitors to see and enabled the sharing of positive comments with the wider team.
- Consultant midwives for normality and public health were in post. However, the consultant for normality was currently working as the interim head of midwifery.

Outpatients and diagnostic imaging

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

Information about the service

The Mid Yorkshire Hospitals NHS Trust provides a wide range of outpatients' clinics at Pinderfields, Dewsbury and Pontefract Hospitals. In 2013–2014 over 400,000 patients attended outpatients' clinics across all three hospitals, with over 90,000 of these patients attending outpatients' clinics at Pontefract Hospital.

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

The main focus of the inspection was the core outpatient services, which included central bookings, appointments and a call centre based at Pinderfields Hospital. We found there were five dedicated outpatient areas at Pinderfields General Hospital and three areas at both Dewsbury and Pontefract Hospitals. A dedicated team of outpatient nurses, receptionists and administration staff provided support to all three hospitals. The focus of our inspection centred mainly within the 60% core service across all three hospital sites.

The service employed approximately 50 nursing staff (registered and unregistered), and 83 reception, administrative and clerical call centre staff to provide and support the core outpatients services.

At the time of inspection there were a reduced number of clinics in operation because of audit activity across the hospital. We inspected clinics for haematology, Ear, Nose and Throat (ENT) and ophthalmology. We spoke with eight members of staff and four patients.

We looked at two sets of medical records along with other information provided to patients about their care and treatments. We also looked at the patient environment, cleanliness and availability of equipment.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatients as inadequate for safety and being responsive, caring we rated as good and we rated well led as requiring improvement. We did not rate the effectiveness of the service. There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for assessment and treatment. There had been a validation process in place, which had reduced the numbers waiting, but this had not addressed the risks to patients whose condition may be deteriorating.

There were two separate arrangements in place to manage outpatients clinics, a central system and a system which was directly led by the specialties. The systems operated in different ways. Incidents were reported but learning from these was not always shared so that improvements could be made. Outpatient areas were clean and well maintained with measures in place for the prevention and control of infection. Staff rotated across all three hospital sites depending on need and demand of the service. Outpatient clinics were, in general, comfortable and friendly, with suitable facilities. Essential equipment was not always easily available such as wheelchairs and blood pressure monitors.

Within clinics, staff treated patients with dignity and respect. Patients told us that they were very satisfied with the service they received. However, there were high numbers of complaints going back many months reporting distress and frustration at delays in accessing appointments, multiple cancellations of appointments, changes in location of appointments and the poor communication with the services.

We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%. The trust was unable to give reasons for this. Analysis of data showed from February 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients.

Are outpatient and diagnostic imaging services safe?

Inadequate

There was a significant backlog of outpatient appointments, which meant that patients were waiting considerable amounts of time for follow-up appointments which could mean there were delays in treatment. Between July 2013 and March 2014 had not put adequate measures in place to manage the backlog of appointments. Since March 2014 specialty level action plans have been in place as a result the back log had been reduced by approximately 10,000 between March and July 2014. However it was unclear how this process addressed the risks to patients whose condition may be deteriorating. Senior managers told us that to date there had been no adverse clinical risks reported from the divisional clinical risk reviews.

Staff were aware of how to follow the trust's policies and procedures for reporting incidents. However, evidence to support how learning from incidents was shared and improvements were implemented was not provided.

It was not clear how staff in the Trust learned lessons from serious incident investigations. Staff were unable to tell us if themes and trends from safety incidents were monitored and acted on.

Implied consent was not being routinely recorded and the processes staff used to assess a person's mental capacity to provide consent was unclear. We were unable to determine from the mandatory training information provided whether outpatients staff were up to date with mandatory training.

Incidents

- Staff were aware of how to follow the trust's policies and procedures for reporting incidents.
- We looked at a sample of the reported incidents within the first quarter of the year and saw these were managed in accordance with the trust's incident management policies.
- We saw the recommended actions and learning from one recent incident had been completed in accordance with the investigation outcomes.

Outpatients and diagnostic imaging

- The senior member of staff told us they provided the staff with verbal feedback from incidents and the health and safety bulletins were available on the intranet and these were printed and displayed in the staff room for staff to sign once read.
- However, evidence to support informal and formal discussions with staff and on any changes implemented as a result of learning discussions from incidents was not provided.
- We were told the trust had introduced a new patient administration system in September 2013. In October 2013 the trust had identified a high volume backlog of patients across all of the clinical specialties who were overdue for their follow-up outpatient appointments. Staff and senior managers in the trust told us the number overdue was initially estimated to be around 30,000. As of March 2014 this figure was reported as 19,200.
- We found the issue had been escalated onto the corporate risk register and actions to manage the backlog were on-going at the time of inspection. The monitoring of this backlog was being undertaken by the Executive Access, Booking and Choice steering Group, which the Chief Executive Officer was the chair. The issue was also monitored by the Trust Board and the Executive Quality Board..
- There have been four serious incidents recorded on STEIS in 2013/14 in relation to outpatients. Three incidents related to patient care and the fourth incident related to the non-issuing of appointment letters by an external supplier.
- The serious incidents led to a full root cause analysis. Root cause analysis is a method of problem solving that tries to identify the root causes of incidents. When incidents do happen, it is important that lessons are learned to prevent the same incident occurring again.
- Similar incidents to the issues identified by the trust in October 2013 had also been identified from a root cause analysis investigation in 2012. Therefore it is not clear how the trust learned lessons from the serious incidents in 2012 to prevent similar incidents occurring again.
- The trust had developed an operational plan (updated 30 June 2014) to prevent the backlog of appointments occurring again by implementing a number of actions. At the time of our inspection this work was on-going, but we saw from the plan some actions were taking longer than anticipated and timescales had changed.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool used in inpatient areas for measuring, monitoring and analysing patient harms and 'harm-free' care. There is no national specific safety thermometer directly related to outpatients. We found the department did monitor and record any falls on a monthly basis. We found there had been no patient falls recorded in July 2014. Staff were unable to tell us if themes and trends in relation to falls were monitored and acted on.

Cleanliness, infection control and hygiene

- The most recent infection control audit results were publicly displayed and showed the department had achieved 100% compliance scores in June 2014 for bare below the elbows, hand hygiene, environment, cleaning and decontamination.
- We saw clinical and non-clinical areas appeared clean and staff adhered to the bare below the elbows policy.
- Staff wore protective aprons and gloves when required and regularly used hand gel between patients.
- Hand washing signage was clearly displayed throughout the department and there was sufficient supplies of hand wash gel available.
- Cleaning audits were publicly displayed and records of cleaning schedules were checked, signed and up to date.
- The outpatients department had link nurses to promote continuous service improvements in compliance with infection prevention and control best practice guidelines.

Environment and equipment

- All of the outpatients areas we visited appeared to have ample seating, with drinks and refreshment facilities nearby.
- We looked at equipment and found it was appropriately checked and cleaned.
- Outpatient clinical and non-clinical areas appeared uncluttered.
- Resuscitation equipment was immediately available for use and daily checks of this equipment were up to date.

Medicines

- Medicines were stored and managed safely, including in locked cupboards and fridges where required. Medicines fridge temperatures were checked daily.

Outpatients and diagnostic imaging

Records

- Senior managers told us that the majority of patient records were held electronically and staff were able to access these records via the trust's secure records data base. We saw computer terminals were available in all of the consulting rooms for doctors to access the patients' records.
- Outpatient clinics also operated a paper patient record for each visit; these records included the patient's personal data, a medical history and correspondence sheet, consultation outcomes form along with patient identification labels.
- We found nursing staff were responsible for checking and recording each patient's height, weight and basic physiological signs, such as blood pressure and pulse rates. We saw these procedures were consistently completed before patient consultations.
- Medical staff completed the consultation records along with the outcomes form, which was passed to the receptionist to arrange follow-up appointments and/or discharge, as determined by the medical staff.
- Staff and managers told us the process was that within five days after consultation the paper records were scanned electronically into the patient's records.
- Staff also told us the historical paper records and any hard copy records that had not be scanned electronically were issued in advance of the clinics and these records were delivered in a timely manner and stored securely within the department.
- We looked at two electronic patient records and saw they included comprehensive health records such as the patients' medical histories, consultation records, and care and treatment interventions, medical and nursing notes along with diagnostic test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Senior staff reported that within the outpatients department implied consent is obtained from the patient before any care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and basic physiological signs. The General Medical Council defined implied consent in their guidance 'Consent: patients and doctors making decisions together' (2008) as "Patients may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken."
- Staff reported that if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding team for advice. However, it was unclear the processes staff used to assess a person's mental capacity and ability to make decisions.
- The staff reported that advance notice of people with special needs was provided through the bookings systems.
- The outpatients department had link nurses to promote continuous service improvements for people with learning disabilities. We saw a range of easy-read information leaflets, a learning disability information folder for staff's reference and talk boards to assist people with communication difficulties were available.

Safeguarding

- Staff we spoke with could identify issues of neglect and abuse and they knew the procedures to follow to report and escalate safeguarding concerns.

Mandatory training

- Staff reported that mandatory training was delivered by eLearning and face to face. They reported that reminders were received from their managers when updates were required and that they were up to date with their mandatory training. We were shown the departmental training matrix and we saw staff's training updates were monitored and systems and processes were in place to book staff's training updates.
- The mandatory training data supplied by the outpatients service showed that over 80% of staff had completed adult and children's safeguarding, fire and information governance training to date.
- However, on this information from the service we found there was no other training data included for other mandatory subjects, such as resuscitation, manual handling and medicines management.
- We also looked at the mandatory training information submitted by the Trust and saw that outpatient's data was included under the division of surgery. We saw the training required did not correspond with the information provided by the outpatient's service. We also found there were differences between the documents on the completion percentages particularly

for safeguarding training. For example the data supplied at the time of the inspection by the outpatient's service showed for safeguarding adults training 83% of staff had completed it. For the same category of training we saw the information provided by the trust showed the completion figure was 100%. From the information submitted we were unable to establish a clear account of the outpatients department's compliance with mandatory training and what training staff were expected to complete.

- According to the Resuscitation Council (UK) guidelines (2010), training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation. It also states clinical staff should have at least annual updates. The trust data showed that 71% of outpatient staff had received mandatory resuscitation training.

Assessing and responding to patient risk

- The trust had an 'Observations standard policy for all in-hospital patient care environments' for staff to follow, which sets out the standards for observations for all adult patients who are at risk of, or who are acutely ill, in all patient care environments.
- Patients attending outpatients had baseline physiological signs such as blood pressure and pulse rates taken before their consultation.
- Emergency resuscitation equipment was available for use; emergency medical and nursing staff were available to respond to emergencies.
- From March 2014 the Trust had carried out a clinical validation process led by consultants from within the specialty, who reviewed the clinical notes of the patients, carried out a risk assessment and prioritised patients for follow-up according to their perceived risk. However it was unclear from the Trust's validation process how they had assessed or identified patients whose condition may have deteriorated in the time between their original appointment and the follow-up appointment.

Staffing

- The core outpatients services consisted of a dedicated team of outpatient nurses, receptionists and administration staff, which covered clinics at all three hospital sites.
- The current staffing establishment included approximately 50 (registered and unregistered) whole time equivalent nurses (WTE), and 83 administrative, clerical and call centre staff to provide and support core outpatient services across all hospital sites.
- Pontefract's outpatients department had a full complement of qualified and unqualified nursing staff and recruitment for band two administration and clerical staff was in progress.
- Registered and unregistered nurse staffing had been escalated to the departmental risk register. Staffing risk assessments included optimum utilisation of clinic cover across all three hospital sites by rotating staff depending on need and demand of the service.
- There were systems and processes in place to request additional temporary staffing if required to provide cover for unexpected absences.
- Induction and competence training for staff in different roles was carried out to facilitate staff moving between departments.
- There were clear lines of management responsibility and accountability within the outpatients service.
- Nursing skill mix was approximately 20% qualified to 80% unqualified.
- Medical staffing to outpatients clinics along with clinic capacity and demand were agreed and reviewed with each clinical division.

Major incident awareness and training

- There was a trust policy, which staff were aware of and could refer to.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We saw trust policies were based and developed to include nationally recognised guidance such as NICE and Royal College guidelines.

The main outpatients service operated a five-day-a-week service with extra clinics at weekends and evenings to manage the high volume of backlog follow-up appointments. We found that the extra clinics operating at evenings and weekends did not have support from the

phlebotomy service. This meant patients could not have blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this.

Evidence-based care and treatment

- We saw trust policies were based and developed to include nationally recognised guidance, for example NICE and Royal College guidelines.

Patient outcomes

- During the inspection the majority of patients we spoke with who were attending outpatient appointments spoke positively about their experiences.
- All of the patients commented that they were satisfied with the appointments system and the care and treatment they received at the hospital.
- We noted from our observations of the touch screen system that patients' personal details could be observed. This issue was brought to the immediate attention of the senior manager for outpatients, who told us they would follow this up.
- We saw patients were kept informed of any delays to their appointment times and sufficient time was allocated for each patient's appointment.
- Staff were seen spending time explaining to patients the procedures they were to have during their visit.

Competent staff

- Departmental appraisal reports showed that 100% of appointments staff, 92% of reception staff, 97% of healthcare assistants and 88% registered nurses had received annual appraisals.
- Redeployment and sickness, maternity leave and new starters were recorded as reasons for not achieving 100% across all of the staff groups.
- Staff in the core outpatients service told us they received appraisal and supervision.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team.
- There was access to multidisciplinary teams and clinical specialists within outpatient clinics. For example, staff gave us examples of how the learning disability specialists had assisted them to care for patients with learning disabilities.

Seven-day services

- The main outpatients service operated a five-day-a-week service with extra clinics at weekends and evenings to manage the high volume of backlog follow-up appointments.
- Radiology and imaging provided a 24-hour, seven-day service.
- Phlebotomy services were available from 8.30am to 4.30pm for people to have their blood samples taken.
- We found that the extra clinics operating evening and weekends did not have support from the phlebotomy service. This meant patients could not have their blood samples taken at the time of their outpatient appointment and would have to return to the hospital for this. This would build in delay in the results being available to clinicians responsible for the treatment of the patient.

Are outpatient and diagnostic imaging services caring?

Good

Patients and relatives commented positively about the care provided from all of the outpatients staff. Staff working in the department treated patients courteously and with respect.

Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- Patients and relatives commented positively about the care provided from all of the outpatients staff.
- We observed all of the staff interacting and speaking with patients in a caring, courteous and friendly and manner.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their appointments and medical conditions.
- Patients also contacted CQC by telephone and wrote to us before, during and after our inspection. There was a mixture of positive and negative feedback; however the common themes were the delay in treatment and difficulties with the appointment system.

Outpatients and diagnostic imaging

- We held a listening event on 14 July 2014 to hear people's views about care and treatment received at the hospitals. We also held community focus groups with the support of Regional Voices who was working with Voluntary Action groups so that we could hear the views of harder to reach members of public. We also received information from members of the public via Healthwatch. There was a mixture of positive and negative feedback relating to Pinderfields Hospital and Dewsbury Hospital; however the common themes for outpatients were concerns about getting outpatient appointments.
- We asked the trust to make comment cards available to patients and staff across the trust sites before and during our inspection. We received 46 comments cards from the acute hospital sites. There was a mixture of positive and negative comments; 13 comments cards had negative comments. The main negative themes related to outpatients were the long waiting times for outpatient's appointments and car parking cost and availability. The positive themes related to experiences at Pontefract Hospital and the caring staff across all sites.

Patient understanding and involvement

- Patients felt involved in decision-making about their care and treatment.
- Individual outpatient consultation and examination rooms were available to promote and maintain patient confidentiality.
- A range of information leaflets were available, which provided patients with details about their outpatient appointment and clinical supporting literature to assist them in their understanding of their medical condition.

Emotional support

- Staff were always nearby and/or in the consulting rooms to support the patients emotionally in the event of receiving difficult news.

Are outpatient and diagnostic imaging services responsive?

Inadequate 

In September 2013, the trust introduced a new patient administration system, which created a number of operational issues in managing outpatient appointments that had the potential to affect the management of patients' clinical risks.

From review of the outpatients overdue follow-ups action plan, we saw for some services such as cardiology and gastroenterology the trust anticipated that all patients would have received a follow-up appointment by February 2015. However, it was not indicated from the information in this action plan, the operational plan or the executive steering group when the trust anticipated all patients who required a follow-up appointment would be seen. It was also unclear from the trust's validation process how they had assessed or identified patients whose condition may have deteriorated while waiting for their follow-up appointment.

The Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%.

Analysis of data showed that since February 2014 the trust was not consistently meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients. The trust had made an agreement with the trust development authority and the local clinical commissioning groups not to meet the target until end September 2014.

Service planning and delivery to meet the needs of local people

- In September 2013, the trust introduced a new patient administration system, which created a number of operational issues in managing outpatient appointments that had the potential to affect the management of patients' clinical risks.
- The operational issues identified by the trust following the introduction of the new system involved patients receiving duplicate appointment letters or reminder letters for appointments they had not been sent. At the

listening event three people told us they were often confused as to when and where their appointment was and they often received multiple appointments for the same clinic.

- We found patients were not being offered options of an appointment at their nearest hospital and patients we spoke with told us they often had follow-up appointments at a different hospital to their initial appointment. One patient told us, "At every appointment you have to start again".
- We also found that around the same time there was a five-week period when patient appointment letters were not distributed by the trust's external supplier. This created a high volume of rescheduled appointments, a backlog of follow-up appointments and complaint calls from patients to the appointment call centre.
- The trust had responded by producing plans to validate the backlog of follow-up appointments, which was initially reported to be around 30,000, and to standardise access, bookings and choice operating procedures together with the staffing across all of the outpatients services.
- Clinical divisions produced plans to validate and assess the clinical risks on the backlog of follow-up appointments within their speciality. This process involved consultants within each clinical speciality reviewing patients' medical records. Virtual clinics were set up on the patient administration system to capture the outcomes of their reviews. Consultants were also responsible for advising the trust on the action required to manage any identified risks. Senior managers told us that to date there had been no adverse clinical risks reported from the divisional clinical risk reviews. At the time of inspection the trust reported the outstanding backlog of follow-up appointments at the end of June 2014 was 9501.
- Additional outpatient capacity was arranged when required to ensure patients were seen in an appropriate timescale following the consultant's review. Staff confirmed that extra clinics were arranged at evenings and weekend to help to manage the backlog of appointments.
- From review of the outpatients overdue follow-ups action plan, we saw for some services such as cardiology and gastroenterology the trust anticipated that all patients would have received a follow-up appointment by February 2015. However, it was not indicated from the information in this action plan, the operational plan or the executive steering group when the trust anticipated all patients who required a follow-up appointment would be seen. It was unclear from the Trust's validation process how they had assessed or identified patients whose condition may have deteriorated in the time between their original appointment and the follow-up appointment.
- Each clinical division met weekly to monitor progress and updates from the meetings were presented and reviewed at the Executive Access, Bookings and Choice steering group chaired by the Chief Executive Officer.
- This group was responsible for overseeing and monitoring the governance of the patient access programmes and the minutes supported the group's governance responsibilities.
- An interim manager had been appointed to manage the outpatients services across the trust. The outpatients operational plan had been updated, with a significant number of phase one actions from April 2014 being transferred to phase two of the programme from July 2014.

Access and flow

- We saw information in the Clinical Executive group (CEG) meeting (10 July 2013), which reported there was a backlog of a 1,000 patients requiring follow-up in ophthalmology clinic. It was agreed in the meeting that processes and systems would be put in place to prevent this happening again across the trust. However, five months later the clinical lead for medicine identified that 370 patients were possibly at risk of having missed important follow-up appointments. A further 1,500 patients on the diabetic screening database were to be tracked weekly by the service.
- We saw information from the CEG meeting minutes on 18 September 2013, which identified a backlog of follow-up appointments had also been identified in relation to the ENT service. We saw in the CEG meeting minutes on the 25 September 2013 the medical director explained to the meeting the issue in relation to ENT was now a wider trust issue. Further information the trust had received identified there were other follow-up appointments that had been missed particularly in the division of medicine. The Chief Executive requested a centralised system was put in place to ensure measures were put in place to stop a recurrence in the future.
- However we saw in further minutes from this group on the 16 April 2014 the Chief Executive had commented

that despite significant input to improve outpatient services there had been no noted improvement. This meant since the issue first came to the trust's attention seven month's previously the measures put in place had not addressed the issue and patients were still experiencing delays in receiving their follow-up outpatient appointment and putting them at risk from delays in assessment or treatment.

- The trust provided information as part of the inspection which stated there were still 9,501 overdue follow up backlogs the week ending 14 July 2014.
- The senior manager told us that the trust applied a strict six weeks' notice period of cancellation of clinics. Any cancellation of clinics had to be authorised by the associate directors of operations.
- The managers also told us that within the core outpatients services one-stop clinics were not available except for certain specialities. One-stop clinics are established to help patients get quicker access to a diagnosis and mean they can be seen by multiple clinicians during one appointment. We were told these clinics were available and managed by the relevant clinical speciality, for example oncology and urology.
- We saw patients were kept informed on delays in clinics and waiting times were displayed.
- We found audit data in relation to clinic cancellations and delays was available. When we spoke to the manager we were told data was inaccurate and unreliable due to the new PAS system issues. This meant the service was not able to fully identify any themes or trends and actions to mitigate them where the trust did identify issues actions were put in place.
- The Trust provided the 'did not attend (DNA) rates from April to June 2014; the rates were above 9%, against a trust target of 8%..
- Analysis of data showed from February 2014 the trust was consistently not meeting the nationally agreed operational standards for referral to treatment within 18 weeks for non-admitted patients. The trust had made an agreement with the trust development authority and the local clinical commissioning groups not to meet the target until end September 2014.
- We found the trust was meeting the diagnostic waiting times for patients not waiting over six weeks for a diagnostic test and for all cancers the 62 days wait for first treatment from an urgent GP referral.
- From June 2014 the call centre was achieving 95% of all calls answered within the three-minute response times.

Meeting people's individual needs

- The directional information signs within the main entrance to the hospital was clear.
- Touch screen monitors were used by patients to check in their arrival for their outpatient appointment and there were only two languages available for patients to access.
- Patients waiting in the main entrance area following check in observed television monitors which were on open public display within the main entrance and café area. These monitors displayed patient's names and informed them of which outpatient's area to attend.
- We saw sufficient numbers of volunteers were on hand within the main reception to assist people who required help.
- Translation services were available for patients by request from their bookings forms. The staff explained the systems and processes in place for arranging translation services.
- The outpatients department had developed link nurses to promote continuous service improvements for people with learning disabilities. We saw a range of easy-read information leaflets, a learning disability information folder for staff's reference and talk boards to assist people with communication difficulties were available.
- Staff told us that for patients attending appointments who were known to have complex needs or required particular privacy; plans to meet their needs were arranged in advance of their appointments.

Learning from complaints and concerns

- The outpatients service had a process in place for managing informal complaints. Both formal and informal complaints and concerns were recorded through the trust's Patient Advice and Liaison Service, as well as informally by the department.
- We saw from the complaints numbers supplied by the trust that complaints peaked in November and December 2013, which coincided with the operational issues referred to earlier in this report. From March 2014 the numbers of complaints and concerns had reduced.
- Following the publication of the 'Review of the NHS Hospitals Complaints System – Putting Patients Back in the Picture Report' the trust Board requested six monthly reviews of complaints. The subsequent review of complaints report covering complaints received from 1 October 2013 to 31 March 2014, showed a high level of

dissatisfaction with delays in accessing appointments. The report details extracts from complaints received, one such example was, "I made an appointment as soon as I received the letter. When I checked the appointment the day before going I was told it had been cancelled, so I booked another, only to receive a letter saying that was cancelled too. Could you help me please?"

- We saw the lessons learned following the introduction of the new PAS system were reviewed. The senior managers told us that, along with these lessons, learning from concerns and complaints had been included within the revised outpatients operational service plan.
- We spoke with one of the Patient Advice and Liaison Service team and they confirmed that the outpatients appointment processes were a "lot better now".
- However, as part of the inspection process listening events were held and people who used services were invited to attend. We found there were themes from people's experiences that included confusing clinic letters with multiple appointments for the same clinic, people not getting appointments at the hospital of their choice, long clinic waiting times and delay in receiving appointments.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Approximately 60% of outpatient core activity and management is under the responsibility of the Division of Access, Booking and Choice. The remaining 40% of outpatient activity was managed by a number of other clinical services, such as diabetic medicine, ophthalmology and dermatology. This meant potentially there could be different systems in place across the trust to manage outpatient clinics.

Similar failures to distribute trust appointment letters to the ones identified by the trust in September 2013 were identified in 2012. Therefore it was not clear how the trust learned lessons from the serious incident in 2012 to prevent this from happening again. It was also not clear what monitoring and governance took place between 2012 and 2013 to ensure the recommendations from the serious incident were implemented and monitored.

Vision and strategy for this service

- The core outpatients services consisted of a central bookings and appointments call centre based at Pinderfields Hospital. There were five dedicated outpatient areas at Pinderfields Hospital and three areas at both Dewsbury and Pontefract Hospitals.
- Managers and staff had contributed to the outpatient operational service plans to improve the quality of the service.

Governance, risk management and quality measurement

- We found the trust had initially identified concerns with follow up appointments in Ophthalmology in July 2013 and ENT in September 2013. On further investigation the trust had found this was an issue across other services. However despite issues being raised in Ophthalmology in July 2013 and then wider Trust concerns about follow up appointments being raised in September 2013 the Trust between July 2013 and March 2014 had not put adequate measures in place to manage the backlog of appointments. Since March 2014 Specialty level action plans have been in place as a result the back log had been reduced by approximately 10,000 between March and July 2014.
- Furthermore the Trust did not have a timescale for when all the outstanding patients would have been seen in the relevant outpatient clinic. The trust provided information on when all patients due would be allocated an appointment date. The information indicated the last specialty to allocate appointments would do so by February 2015.
- The clinical division met weekly to monitor progress and updates on the backlog of follow-up outpatients appointments.
- All of the divisions were represented at the Executive Access, Bookings and Choice steering group chaired by the Chief Executive Officer. This group was responsible for overseeing and monitoring the governance of the patient access programmes.
- Similar failures to distribute trust appointment letters to the ones identified by the trust in September 2013 were identified in 2012. Therefore it is not clear how the trust learned lessons from the serious incident in 2012 to

prevent this from happening again. It is also not clear what monitoring and governance took place between 2012 and 2013 to ensure the recommendations from the serious incident were implemented and monitored.

- One of the actions from the 2012 trust investigation report was to develop a service-specific specification/ contractual agreement between the trust and the external supplier. The draft service level agreement submitted as part of the evidence at this inspection does not appear to include any references to previous agreements and is dated 1 June 2014 until 31 May 2015, with options to extend. Therefore it is difficult to determine from the information whether any existing agreement was developed as recommended in 2012 to minimise future risks.
- The Trust has continued to experience issues with the cancellation of outpatient appointments since 2010. This continued to be a major issue of concern for the trust at the time of our inspection. Therefore, despite awareness, actions taken to address this matter were ineffective, which continued to put patients at risk due to delays in treatments.

Leadership of service

- Approximately 60% of outpatient core activity and management is under the responsibility of the Division of Access, Booking and Choice. The remaining 40% of outpatient activity is managed by a number of other clinical services, such as diabetic medicine, ophthalmology and dermatology. This meant potentially there could be different systems in place across the trust to manage outpatient clinics.
- Plans were in place to centralise the outpatients services across the trust and staff had been involved and contributed to the change processes recently introduced. This is indicated on the operational plan of 30 June 2014 to be in phase two, but we were unable to identify in the plan when this is due to start or finish.
- The team of nurses, receptionists and records staff all worked together to provide support to all three departments across the trust.
- Staff told us that the leadership of the outpatients services and department had improved since April 2014 with the introduction of a new interim management team.

Culture within the service

- The team worked well to support each other and they were flexible and committed to providing good patient services.
- The service used staff flexibly across the three sites so that clinics were covered. Staff we spoke with were aware of the reasons why this was required.
- Staff told us that the service had improved over the past quarter because of the new interim management structure and there was clear line management, which staff understood.
- Staff were involved in providing their views about improving outpatients services for patients.

Public and staff engagement

- The majority of the staff we spoke with were aware of the trust's values and aims, which we saw were displayed throughout the hospital and departments. Staff were also aware of the Chief Executive Officer's methods of communication and how to get in touch with them if they needed to.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The trust put in actions to address concerns raised within this report and presented these at the Quality Summit on 13 October 2014. At the summit the trust gave assurance that they had taken immediate action to address serious concerns including the application of the Safer Nursing Tool, benchmarking practice over staffing with other trusts, appointing a Mental Capacity Act 2005 advisor, improved training and additional auditing systems.

The Care Quality Commission has a range of enforcement powers it can use under the Health and Social Care Act 2008 and associated regulations. The Care Quality Commission has required the trust to provide information on the actions taken to address issues identified since the inspection including progress with those yet to be completed. This will then be used to inform decisions over appropriate regulatory actions regarding identified breaches of regulation.

Importantly, the action the trust MUST take to improve

- Ensure that the reporting of performance, risk and unsafe care and treatment is robust and timely to the Trust Board so that appropriate decisions can be made and actions taken to address or mitigate risk to patient safety.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Address the backlog of outpatient appointments, including follow-ups, to ensure patients are not waiting considerable amounts of time for assessment and/or treatment.
- Ensure clinical deteriorations in the patient's condition are monitored and acted upon for patients who are in the backlog of outpatient appointments.
- Review the 'did not attend' in outpatients' clinics and put in steps to address issues identified.
- Ensure the procedures for documenting the involvement of patients and relatives in 'Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) are in accordance with national guidance and best practice at all times.
- Ensure staff follow the trust's policy and best practice guidance on DNA CPR decisions when the patient's condition changes or on the transfer of medical responsibility.
- Ensure recommendations from serious incidents and never events are monitored to ensure changes to practice are implemented and sustained in the long term.
- Ensure there are improvements in referral to treatment times to meet national standards
- Ensure staff are clear about which procedures to follow in relation to assessing capacity and consent for patients who may have variable mental capacity. This would ensure staff act in the best interests of the patient in accordance with the Mental Capacity Act 2005 and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.
- Ensure all staff attend and complete mandatory training and role specific training, particularly for resuscitation and safeguarding; staff working in urgent care settings where appropriate undertake level 3 safeguarding training.
- Ensure that issues with replacing pathology equipment are addressed to ensure that equipment is fit for purpose.
- Ensure the pharmacy department is able to deliver an adequate clinical pharmacy service to all wards.
- Ensure staff are trained and competent with medication storage, handling and administration.
- Ensure controlled drugs are administered, stored and disposed of in accordance with trust policy, national guidance and legislation.
- Ensure in all clinical areas minimum and maximum fridge temperatures are recorded to ensure medications are stored within the correct temperature range and remain safe and effective to use.
- Ensure all anaesthetic equipment in theatres and resuscitation equipment in clinical areas are checked in accordance with best practice guidelines.
- Ensure that the Five steps to safer surgery (World Health Organisation) are embedded in theatre practice.

Outstanding practice and areas for improvement

- Review the access and provision of sterile equipment and trays in theatres to ensure that they are delivered in good time.
- Ensure improvements are made in reducing the backlog of clinical dictation and discharge letters to GP's and other departments.
- Review and make improvements in the access and flow of patients receiving surgical care.
- Ensure staff in ward areas follow the correct procedures in identifying infection control concerns in deceased patients to protect staff in the mortuary against the risks of infection.
- Ensure staff follow the correct procedures to make sure the patient is correctly identified at all times, including when deceased.
- Ensure the high prevalence of pressure ulcers is reviewed and understood and appropriate actions are implemented to address the issue.

Action the hospital SHOULD take to improve

- The trust should review the service to improve in the number of emergency admissions following an elective surgical admission.
- Ensure information leaflets for relatives and carer's of dying patients are updated following the withdrawal of the Liverpool care pathway.
- The trust should review their lone working policy and its implementation as well as their anticipatory planning for major events.
- The trust should improve staff engagement between frontline staff, team leaders, middle management and the board.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use outpatient services were not protected from the risks associated with treatment delays at outpatients because the trust had not ensured that patients received an outpatient appointment in a timely way. People who use services in medical and surgery services were not protected against the risks associated with pressure ulcers because the trust had not planned or delivered care or treatment in a way that ensured the welfare and safety of the patient. The WHO safer surgery checklist was not routinely completed in surgery to ensure the safety and welfare of the patient. Regulation 9 (1)(a) ,(b)(i) and (b)(ii) HSCA 2008 (Regulated Activities) Regulations 2010: Care and welfare of service users.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Patients were not protected from the risk associated with unsafe care or treatment because the trust had not implemented or embedded a policy or procedure for the transition of care between children and younger persons and adult healthcare services. Regulation 10 (2)(c)(iii) HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The trust did not have suitable arrangements in place for obtaining consent from children because the trust does not have a current policy for children and young people within the children's service. The trust did not act in accordance with the best interests of the patient towards the end of their life because do not attempt cardiopulmonary resuscitation orders (DNACPRs) were not always completed appropriately. Outpatient services could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 68% of their staff had received appropriate training on this subject. The division of surgery services could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 69% of their staff had received appropriate training on this subject. The division of medicine could not demonstrate that they met the requirements of Section 4 of the Mental Capacity Act 2005 (best interests) because only 68% of their staff had received appropriate training on this subject Regulation 18 (1)(a) and (b) and 18(2) HSCA 2008 (Regulated Activities) Regulations 2010: Consent to care and treatment

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust has not safeguarded the health, safety and welfare of service users because appropriate steps have

This section is primarily information for the provider

Compliance actions

not been taken to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed or retained for the purposes of carrying on the regulated activity.

The midwife establishment for the trust is currently 1:31 which is above the recommended 1:28 ratio.

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The trust had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe because staff in the divisions of medicine and surgery were not fully aware or up to date with the national guidance and good practice in relation to Deprivation of Liberty Safeguards (DoLS). Regulation Reg 11(2)(a) and (b) of the Regulated Activities Regulations 2010, Safeguarding service users from abuse.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place for dealing with the storage, handling, administration and recording of medication. A recent medicines management audit from the trust demonstrated that the safety of medicines had broadly not improved since 2012. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines.